Respondeat superior

From Wikipedia, the free encyclopedia

"***Respondeat superior***" (Latin: "let the master answer"; plural: *respondeant superiores*) is a legal doctrine which states that, in many circumstances, an employer is responsible for the actions of employees performed within the course of their employment.[1] This rule is also called the "Master-Servant Rule", recognized in both common law and civil law jurisdictions.[2]

In a broader scope, *respondeat superior* is based upon the concept of vicarious liability.

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In common law

When applied to physical torts an employer/employee relationship must be established and the act must be committed within the scope of employment (i.e. substantially within time and geographical limits, job description and at least with partial intent to further employer's business).

Historically, this doctrine was applied in master/servant or employer/employee relationships. If the employee or servant committed a civil wrong against a third party, the master or employer could be liable for the acts of their servant or employee when those acts were committed within the scope of the relationship. The third party could proceed against both the servant/employee and master/employer. The action against the servant/employee would be based upon the direct responsibility of the servant/employee for his conduct. The action against the master/employer is based upon the theory of vicarious liability, by which one party can be held liable for the acts of another.

Employer/employee relationships are the most common area wherein respondeat superior is applied, but often the doctrine is used in the agency relationship. In this, the principal becomes liable for the actions of the agent, even if the principal did not directly commit the act. There are three considerations generally:

1. Was the act committed within the time and space limits of the agency?
2. Was the offense incidental to, or of the same general nature as, the responsibilities the agent is authorized to perform?
3. Was the agent motivated to any degree to benefit the principal by committing the act?

The degree to which these are answered in the affirmative will dictate the degree to which the doctrine can be applied.

Common law distinguishes between civil and criminal forms of respondeat superior.

In International Law

At issue in the Nuremberg war crimes tribunal following the Allied occupation of Nazi Germany after World War II was a question concerning principles closely related to respondeat superior, which came to be known by the term command responsibility. The Nuremberg trials established that persons cannot use the defense that they were only following the orders of their superiors, if that order violates international norms but especially that superiors that ordered, or "should have known," of such violations yet failed to intervene are also criminally liable.

References

1. **^** Harger, Lloyd. "Workers' Compensation, A Brief History" (http://www.fldfs.com/wc/history.html) . Florida Department of Financial Services. http://www.fldfs.com /wc/history.html. Retrieved 22 June 2010.
2. **^** Owen, Ralph Dornfeld. "Tort Liability in German School Law" (http://www.jstor.org/stable/1190275) . *Law and Contemporary Problems* (Duke University School of Law) **20** (1): 72–79. http://www.jstor.org/stable/1190275. Retrieved 2010-06-21.

See also

- Frolic and detour
- Superior Orders
- Vicarious liability

External links

- Harvard Law Study Material on Tort (includes Respondeat Superior) (http://cyber.law.harvard.edu/torts3y/readings/CB-R-01.htm)

Find a Plan

- Medicare Eligible Health Plans
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Guaranteed Issue Coverage

Eligibility Requirements

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may be entitled to apply for an individual plan on a guaranteed issue basis (which means that you will not be rejected for underwriting reasons).

To be eligible, you must meet certain HIPAA eligibility requirements. You must have elected and exhausted all COBRA and/or CalCOBRA coverage that is available to you and you must apply to Blue Shield for guaranteed issue coverage within 63 days of the date of termination from the group plan.

Compare Coverage and Benefits

The Comparative Benefit Matrix provides a benefit summary to help you compare coverage and benefits and is a summary only. This comparative benefit summary is updated annually, or more often if necessary, to be accurate.

To obtain the most current version of the Department of Health Care's (DMHC) matrix for the Access+ HMO, Access+ Value HMO and the Shield Spectrum PPO℠ 5500, please visit their website at www.dmhc.ca.gov. You may contact the DMHC at (888) HMO-2219 for further assistance regarding the matrix.

To obtain the most current version of the Department of Insurance's (DOI) matrix for the Shield Savings 4000[1] and the Shield Spectrum PPO 5000[1], please visit their website, www.insurance.ca.gov. You may contact the DOI at (800) 927-4357 for further assistance regarding the matrix.

Uniform Health Plan Benefits & Coverage Matrix
Shield Spectrum PPO Plan 5500 (PDF, 666KB)
Access+ HMO (PDF, 666KB)
Shield Spectrum PPO Plan 5000 (PDF, 666KB)
Shield Savings 4000 (PDF, 666KB)
Access+ Value HMO (PDF, 666KB)

Rates (PDF, 445KB)

[1] Underwritten by Blue Shield of California Life & Health Insurance Company.

United States Court of Appeals,Seventh Circuit.

ROYAL MACCABEES LIFE INSURANCE COMPANY v. PETERSON

ROYAL MACCABEES LIFE INSURANCE COMPANY, Plaintiff-Appellee, v. Mona PETERSON, as Surviving Spouse and Designated Primary Beneficiary of Monte Peterson, Deceased, Defendant-Appellant.

No. 97-2317.

Argued Jan. 7, 1998. -- March 18, 1998
Before MANION, KANNE, and ROVNER, Circuit Judges.

Patrick A. Murphy, Michael J. Smith (argued), Chicago, IL, for Plaintiff-Appellee.Gary D. McCallister, Chicago, IL, Eric I. Unrein (argued), David, Unrein, Hummer, McCallister & Buck, Topeka, KS, for Defendant-Appellant.

Royal Maccabees Life Insurance Company (Royal) sued Monte Peterson in federal court; the company sought a declaration concerning its duty to provide Peterson with a $750,000.00 life insurance policy. Peterson counterclaimed, alleging negligence on Royal's part in unreasonably delaying its decision either to accept or reject his insurance application.1 The district court issued a declaratory judgment in Royal's favor; the court also granted Royal's motion for summary judgment with respect to Peterson's claims. We reverse.

I.

Monte Peterson was slated to become the president and CEO of High Sierra Sports Company; his compensation package was to include a $750,000.00 life insurance policy on his behalf (actually, on behalf of his wife as the designated beneficiary). Peterson planned to begin his new job on May 8, 1995, so it was presumed that his life insurance policy-to be issued by High Sierra's insurer, Royal-would be in place by that date. Peterson and a representative of High Sierra prepared and sent Peterson's application for life insurance which Royal received on April 4. Royal began to process the application, but asked Peterson to submit additional information, which he did. By all accounts (at least for purposes of Royal's motion for summary judgment in the district court), Royal believed Peterson to be insurable at least as early as May 2, 1995, six days before he was to start his new job. But Royal did not finally issue the policy until May 15, 1995.

In the meantime, on May 7, the evening before his new job was to begin, Peterson was rushed to the hospital; the doctors detected a collapsed lung which turned out to be cancer. Apparently Royal did not learn that Peterson had been in the hospital until much later, because it not only issued the policy in the full amount on May 15, but also collected a $1,500 premium on the same day and $2,500 a few weeks later. But in August Royal learned of Peterson's illness and rescinded the policy.

As noted above, Royal began this litigation by seeking a declaration of its duty to provide Peterson with life insurance; Peterson counterclaimed alleging Royal's negligence in unreasonably delaying the processing of his application. The court ruled that even though Royal delayed for at least six days (from May 2 to May 8) after finding Peterson insurable, "any unreasonable delay was not prejudicial because there is no evidence that Peterson could have obtained life insurance elsewhere during the six-day period when he was insurable [by Royal]."

Unfortunately, while Royal's motion for summary judgment was pending in the district court, Peterson died. The district court substituted his wife as his surviving spouse and designated beneficiary had Royal paid on the policy.

II.

As they did in the district court, the parties concede that Royal did not issue the policy for the six days between May 2 and May 8 even though it considered Peterson to be insurable. During that time period, which Peterson claims amounted to a negligent delay, Royal neither issued the $750,000.00 policy nor notified Peterson that his application for insurance had been rejected. So the only question facing the district court (and now facing us) is whether Peterson is entitled to a jury trial on his negligence claim.

The parties agree that Illinois law governs this diversity case. Under Illinois law, an insurance company like Royal has an affirmative duty to respond promptly to insurance applications. When a potential client applies for insurance, the company is legally obliged "to act with reasonable promptness on the application, either by providing the desirable coverage or by notifying the applicant of the rejection of the risk so that he may not be lulled into a feeling of security or put to prejudicial delay in seeking protection elsewhere." Talbot v. Country Life Ins. Co., 8 Ill.App.3d 1062, 291 N.E.2d 830, 832 (1973). Of course there is no general legal duty to issue policies (a point Royal hammers home); the duty is to act on an insurance application either by rejecting it or accepting it. What the insurance company cannot do is to in effect sit on the application by delaying or withholding its decision to approve or disapprove. In that circumstance, the insurer may have lulled the applicant into incurring an increased risk-he may not believe there is any reason to seek coverage elsewhere, but at the same time he has no coverage from the would-be insurer. See id. ("where an application was made for a life policy with a beneficiary being designated to receive the proceeds, a cause of action lodges in such beneficiary, upon the applicant's death, for unreasonable delay on the part of the insurer, in accepting or rejecting such application") (quoting Appleman, 12 Insurance Law and Practice, at § 7232, now stated in vol. 12A, § 7222 (1981)).

In this case, we are not asked to determine if Royal unreasonably delayed for six days before accepting or rejecting Peterson's application. Rather, Royal argues that it could not be liable to Peterson because its delay, even if unreasonable, caused him no prejudice. According to Royal (and the district court), Peterson could establish prejudice only by pointing to evidence that but for Royal's six-day delay, he could have obtained insurance elsewhere. Peterson had no applications pending at other insurance companies, and had

no evidence that other insurers found him generally insurable. And it is highly unlikely that if Royal had rejected the application on May 2 or 3, Peterson could have applied for and obtained coverage elsewhere.

Royal might be liable if its delay cost Peterson the chance to obtain insurance elsewhere, but Peterson instead argues that under Illinois law he could make his case by proving that Royal itself found him insurable and would (and should) have issued a policy during the period in which it unreasonably delayed. In other words, if Royal found Peterson insurable but delayed saying so, it can't escape liability by claiming that during the period of delay no other company declared him insurable. See Geraghty v. Continental Western Life Ins. Co., 281 Ill.App.3d 669, 217 Ill.Dec. 421, 427, 667 N.E.2d 510, 516 (1996) (stating plaintiff must prove "insurance applied for could have been secured or that the insurance could have been secured elsewhere" and affirming summary judgment for defendant Continental because plaintiff failed "to plead or produce any evidence that [deceased] was insurable by Continental or any other insurer") (emphasis added).2

While both parties (along with the district court) cite the Geraghty case, it plainly supports Peterson's argument that the district court did not apply the second part of the test. While the court correctly asked whether Peterson could have obtained insurance elsewhere, it also should have asked whether Peterson could have obtained the insurance from Royal itself. Preliminarily, at least, the answer to this second question appears to be "yes"-even Royal concedes for purposes of summary judgment that it found Peterson insurable as early as May 2. Accordingly, the court should not have granted Royal's motion for summary judgment. It should have allowed Peterson to argue to a jury that the period of six days (from May 2 to May 8)-in which Royal found him insurable but did not issue a policy-constituted an unreasonable delay under Illinois law. Royal, of course, could counter this with additional facts.3

As we noted above, Royal's argument to both this court and the district court is that it has no legal duty to issue policies, even to individuals it finds insurable. The argument misses the point. While Royal has no legal duty to issue policies, under Illinois law it does have a legal duty to rule on applications promptly, either by issuing the policy or rejecting it so the applicant can obtain insurance elsewhere. If it delays and does not promptly rule on the application, it may be liable for any damages caused by the delay. In this case, it concedes that it delayed for six days, and a jury will have to determine whether or not that length of time is appropriate. reversed and remanded.

FOOTNOTES

1. Peterson also claimed Royal breached its contract by unilaterally rescinding its insurance policy covering him. The district court dismissed that claim, but only the dismissal of the negligence claim is on appeal.

2. Though not controlling in this diversity case, we note that other circuit courts applying state laws recognizing negligent delay claims have phrased the plaintiff's burden in similar terms. See Huff v. Standard Life Ins. Co., 897 F.2d 1072, 1075 (11th Cir.1990) (applying

Florida law and stating that plaintiff could have met his burden "by showing that [decedent] was insurable under the [defendant] SLIC's rules, limits and standards"); Wilson v. Mass. Indemnity and Life Ins. Co., 920 F.2d 1548, 1553 (10th Cir.1990) (applying Oklahoma law and stating: "Mrs. Wilson must prove either that [defendant] Milico would have accepted Mr. Wilson as a standard risk before his death if it had acted more diligently, or that he was generally insurable and could have obtained insurance elsewhere had he not thought that Milico would accept his application.").

3. We note by way of background that there may have been good reasons for the delay in this case. For example, the record tells us that on May 4 Royal submitted Peterson's application to its reinsurer, which did not respond on the application for reinsurance until May 11. We express no opinion whether this circumstance justifies any delay on Royal's part, and leave the entire issue to a jury.

Insurance bad faith

From Wikipedia, the free encyclopedia

Insurance bad faith is a legal term of art that describes a tort claim that an insured person may have against an insurance company for its bad acts. Under the law of most jurisdictions in the United States, insurance companies owe a duty of good faith and fair dealing to the persons they insure. This duty is often referred to as the "implied covenant of good faith and fair dealing" which automatically exists by operation of law in every insurance contract. If an insurance company violates that covenant, the insured person (or "policyholder") may sue the company on a tort claim in addition to a standard breach of contract claim. The contract-tort distinction is significant because as a matter of public policy, punitive or exemplary damages are unavailable for contract claims, but are available for tort claims. The end result is that a plaintiff in an insurance bad faith case may be able to recover an amount *larger* than the original face value of the policy, if the insurance company's conduct was particularly egregious.

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Historical background

Most laws regulating the insurance industry in the U.S. are state-specific. In 1869, the Supreme Court of the United States held, in *Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 19 L.Ed. 357 (1869) that United States Congress did not have authority under its power to regulate commerce to regulate insurance.

In the 1930s and 1940s, a number of U.S. Supreme Court decisions broadened the interpretation of the Commerce Clause in various ways, so that federal jurisdiction over interstate commerce could be seen as extending to insurance. In March 1945, the United States Congress expressly reaffirmed its support for state-based insurance regulation by passing the McCarran-Ferguson Act (found at 15 U.S.C. §§ 1011-15) which held that no law that Congress passed should be construed to invalidate, impair or supersede any law enacted by a State regarding insurance. As a result, nearly all regulation of insurance continues to take place at the state level.

Such regulation generally comes in two forms. First, each state has an "Insurance Code" or some similarly-named statute which attempts to provide comprehensive regulation of the insurance industry and of insurance policies, a specialized type of contract. State insurance codes generally mandate specific procedural requirements for starting, financing, operating, and winding down insurance companies, and often require insurers to be overcapitalized (relative to other companies in the larger financial services sector) to ensure that they have enough funds to pay claims if the state is hit by multiple natural and man-made disasters at the same time. There is usually a Department of Insurance or Division of Insurance responsible for implementing the state insurance code and enforcing its provisions in administrative proceedings against insurers.

Second, judicial interpretation of insurance contracts in disputes between policyholders and insurers takes place in the context of the aforementioned insurance-specific statutes as well as general contract law; the latter still exists only in the form of judge-made case law in most states. A few states like California and Georgia have gone farther and attempted to codify all of their contract law (not just insurance law) into statutory law.

Early insurance contracts were considered to be contracts like any other, but first English (see uberrima fides) and then American courts recognized that insurers occupy a special role in society by virtue of their express or implied promise of peace of mind, as well as the severe vulnerability of insureds at the time they actually make claims (usually after a terrible loss or disaster).

In turn, the development of the modern cause of action for insurance bad faith can be traced to two landmark decisions of the Supreme Court of California: *Comunale v. Traders & General Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198, 68 A.L.R.2d 883 (http://online.ceb.com/CalCases/C2/50C2d654.htm) (1958) (third-party liability insurance), and *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 108 Cal. Rptr. 480, 510 P.2d 1032 (http://online.ceb.com/CalCases/C3/9C3d566.htm) (1973) (first-party fire insurance). Other state courts began to follow California's lead and held that a tort claim exists for policyholders that can establish bad faith on the part of insurance carriers. According to Stephen S. Ashley's treatise, *Bad Faith Actions: Liability and Damages*, 2nd ed. (Eagan, MN: Thomson West, 1997), §§ 2.08 and 2.15, courts in nearly thirty states recognized the claim by the late 1990s. In nineteen states, state legislatures became involved and passed legislation that specifically authorized bad faith claims against insurers.

Bad faith defined

An insurance company has many duties to its policyholders. The kinds of applicable duties vary depending upon whether the claim is considered to be "first party" or "third party." A common first party context is when an insurance company writes insurance on property that becomes damaged, such as a house or an automobile. In that case, the company is required to investigate the damage, determine whether the damage is covered, and pay the proper value for the damaged property. Bad faith in first party contexts often involves the insurance carrier's improper investigation and valuation of the damaged property (or its refusal to even acknowledge the claim at all). Bad faith can also arise in the context of first party coverage for personal injury such as health insurance or life insurance, but those cases tend to be rare. Most of them are preempted by ERISA.[1]

Third party situations break down into at least two distinct duties, both of which must be fulfilled in good faith. First, the insurance carrier usually has a duty to defend a claim (or lawsuit) even if some or most of the lawsuit is not covered by the insurance policy. Unless the policy is expressly structured so that

defense costs "eat away" at the policy limits, the default rule is that the insurer must cover all defense costs regardless of the actual limit of coverage. In one of the most famous decisions of his career, Justice Stanley Mosk wrote: "[W]e can, and do, justify the insurer's duty to defend the entire 'mixed' action prophylactically, as an obligation imposed by law in support of the policy. To defend meaningfully, the insurer must defend immediately. [Citation.] To defend immediately, it must defend entirely. It cannot parse the claims, dividing those that are at least potentially covered from those that are not."[2]

Second, the insurer has a duty of indemnification, which is the duty to pay a judgment against the policyholder, up to the limit of coverage, but only if the judgment is for a covered act or omission. As a result, most insurance companies exercise a great deal of control over litigation.

Bad faith can occur in either situation—by improperly refusing to defend a lawsuit or by improperly refusing to pay a judgment or settlement of a covered lawsuit.

In some jurisdictions, like California, third party coverage also contains a third duty, the duty to settle a reasonably clear claim against the policyholder within policy limits, in order to avoid the risk that the policyholder may be hit with a judgment in excess of the value of the policy (which a plaintiff might then attempt to satisfy by writ of execution on the policyholder's assets). If the insurer breaches in bad faith its duties to defend, indemnify, and settle, it may be liable for the *entire* amount of any judgment obtained by a plaintiff against the policyholder, even if that amount is in excess of policy limits. This was the holding of the landmark *Comunale* case.

Bad faith is a fluid concept and is defined primarily by court decisions in case law. Examples of bad faith include undue delay in handling claims, inadequate investigation, refusal to defend a lawsuit, threats against an insured, refusing to make a reasonable settlement offer, or making unreasonable interpretations of an insurance policy.

In some cases, the tort or the governing state statute allows punitive damages against insurance companies as a mechanism to prevent future behavior.

In California, the plaintiff in a bad faith action may be able to recover some of its attorneys' fees *separately* and in addition to the judgment for damages against a defendant insurer, but *only* up to the extent that those fees were incurred in recovering *tort* damages (for breach of the implied covenant) as opposed to contractual damages (for breach of the terms of the insurance policy).[3] The allocation of attorneys' fees between those two categories is usually a question of fact (meaning it usually goes to the jury).

Assignment or direct action

In some U.S. states, bad faith is even more complicated because under certain circumstances, a liability insurer may ultimately find itself in a trial where it is being sued *directly* by the plaintiff who originally sued its insured. This is allowed through two situations: assignment or direct action. The first situation is where an insured abandoned in bad faith by its liability insurer makes a special settlement agreement with the plaintiff. Sometimes this occurs after trial, where the insured has valiantly attempted to defend himself or herself by paying for a lawyer out of pocket, but went to verdict and lost (the actual situation in the landmark *Comunale* case); other times it occurs before trial and the parties agree to put on an uncontested show trial that results in a final verdict and judgment against the insured. Either way, the plaintiff agrees to not actually execute on the final judgment against the insured in exchange for an assignment of the assignable components of the insured's causes of action against its insurer.[4] The second situation is where the plaintiff does *not* need to obtain a judgment first, but instead proceeds directly against the insured's insurer under a state statute authorizing such a "direct action." These statutes have been upheld as constitutional by the U.S. Supreme Court.[5]

Lawsuits

Bad faith lawsuits are notorious for resulting in very large awards of punitive damages. The most famous example in recent memory was *State Farm Mutual Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (http://supreme.justia.com/us/538/408/case.html) (2003), in which the U.S. Supreme Court overturned a jury verdict of $145 million in punitive damages against State Farm Insurance. Bad faith cases may also be rather slow, at least in the third party context, because they are necessarily dependent upon the outcome of any underlying litigation. For example, the underlying lawsuit in the *Campbell* case arose from a fatal car accident in 1981.

Mold became a common litigation issue for bad faith lawsuits, with about half of the 10,000 "toxic" mold cases in 2001 being filed against insurance companies on bad faith grounds. Before 2000 the claims were uncommon, with relatively low payouts. One notable lawsuit occurred when a Texas jury awarded $32 million (later reduced to $4 million). In 2002 a suit was settled for $7.2 million.[6]

References

1. **^** *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988).
2. **^** *Buss v. Superior Court*, 16 Cal. 4th 35 (http://online.ceb.com/CalCases/C4/16C4t35.htm) (1997).
3. **^** *Cassim v. Allstate Ins. Co.*, 33 Cal. 4th 780 (http://online.ceb.com/CalCases/C4/33C4t780.htm) (2004).
4. **^** *Essex Ins. Co. v. Five Star Dye House, Inc.*, 38 Cal. 4th 1252 (http://online.ceb.com/CalCases/C4/38C4t1252.htm) (2006).
5. **^** *Watson v. Employers Liability Assurance Corp.*, 348 U.S. 66 (http://supreme.justia.com/us/348/66/case.html) (1954).
6. **^** Hartwig RP, Wilkinson C. (2003). Mold and Insurance (http://server.iii.org/yy_obj_data/binary/735870_1_0/Mold.pdf) . Insurance Issue Series.

External links

- Findlaw has links to statutes and administrative codes for most states that have them online. (http://www.findlaw.com/casecode/#statelaw)

Mistake
inAdverted
unilateral mistake
Ambiquity

breach of contract
illegimate denial of coverage
wrongful denial of coverage

Application - offer
Acceptance

Reformed
interests of Justice
Sophistication of the 2 parties
→ Deprivation of Rights!

Tort
breech civil duty
Rights
duty to cover her
Malpractise
mental state decline coverage
intentional
negligence

personally liable to the insured for such errors and omissions (*see ¶2:57*).

c. [2:83] **Effect of misstatements or omissions in application:** Material misstatements or omissions in an application for insurance are grounds for the insurer to *rescind* the policy, even after a claim arises (*see ¶5:143*). To prevent rescission, insureds often claim that they made full disclosure of all relevant facts to the person who prepared the application. The effect of such disclosures may depend on the status of the person who prepares the application:
— Misstatements or omissions of information contained in an application prepared by an *agent* of the insurer may be chargeable to the insurer (in which case it cannot rescind the policy).
— But if the application was prepared by an insurance *broker* (the agent of the insured), the application's contents are the *insured's* responsibility; i.e., the insurer is not charged with knowledge of other information allegedly disclosed to the broker. [*Imperial Cas. & Indem. Co. v. Sogomonian* (1988) 198 CA3d 169, 178, 243 CR 639, 642-643]

B. INSURANCE APPLICATIONS

1. [2:84] **Insurer's Right to Rescind for Material Misstatements in Application:** The insurance company's underwriting department relies upon the accuracy of the information disclosed in the insured's application in determining *whether* to underwrite a risk and what premium to charge. The insurer is therefore entitled to rescind the policy, even after a loss has occurred, for material misrepresentations in the application. The materiality of the information is determined solely by the probable and reasonable effect which truthful answers would have had upon the insurer. Rescission is proper even if no actual intent to deceive is shown. [*Imperial Cas. & Indem. Co. v. Sogomonian* (1988) 198 CA3d 169, 179, 243 CR 639, 643; see *Merced Co. Mutual Fire Ins. Co. v. State of Calif.* (1991) 233 CA3d 765, 772, 284 CR 680, 684; *Freeman v. Allstate Life Ins. Co.* (9th Cir. 2001) 253 F3d 533, 536 (applying Calif. law)]

Cross-refer: Rescission is discussed in detail at *¶5:143 ff.*

2. [2:85] **No Duty to Evaluate Applicant's Needs:** An insurance company's obligations to an insured are limited to those arising out of the policy issued. An insurer owes no independent duty to investigate to determine whether the policy applied for is adequate to meet the insured's economic needs or the availability of additional coverages. [*Gibson v. Government Employees Ins. Co.* (1984) 162 CA3d 441, 452, 208 CR 511, 519—failure to advise availability of underinsured motorist coverage and inadequate medical pay limits in auto policy; *Ahern v. Dillenback* (1991) 1 CA4th 36, 42, 1 CR2d 339, 342—failure to

advise availability of uninsured motorist coverage in international auto policy]

a. [2:86] **Effect:** Insurance applicants must assume the risk of selecting appropriate coverages. They cannot shift to their insurers losses resulting from their own negligence in ordering insurance coverages. [*Shultz Steel Co. v. Hartford Acc. & Indem. Co.* (1986) 187 CA3d 513, 522, 231 CR 715, 720—failure to advise as to adequacy of liability coverage limits]

b. [2:87] **Compare—broker liability:** Under certain circumstances, however, the insurance broker who sold the policy may be liable for *negligence*; *see ¶2:57 ff.*

3. [2:87.1] **Insurer's Right to Refuse:** Normally, an insurer can pick and choose the risks it chooses to insure: "An insurer does not have a duty to do business with or issue a policy of insurance to any applicant for insurance. Whether an insurer should be required to offer a particular class of insurance or insure particular risks are matters of complex economic policy entrusted to the Legislature." [*Quelimane Co., Inc. v. Stewart Title Guar. Co.* (1998) 19 C4th 26, 43, 77 CR2d 709, 718]

a. [2:87.2] **Limitation—unlawful discrimination:** However, insurers may be prohibited by federal or state laws from rejecting insurance applications based on the applicant's race, gender, age, disability or other protected characteristics. *See discussion at ¶11:340 ff.*

b. [2:87.3] **Limitation—unlawful restraint of trade:** Similarly, where a group of insurers conspires to refuse certain risks, their refusal may violate federal or state antitrust and unfair competition laws. [*Quelimane Co., Inc. v. Stewart Title Guar. Co.*, supra, 19 C4th at 47, 77 CR2d at 721; *see discussion at ¶6:2824*]

[2:87.4] *Reserved.*

C. OFFER AND ACCEPTANCE ISSUES

[2:87.5] Insurance, like any other contract, requires a "meeting of the minds." There must be both an *intentional* offer and an acceptance manifesting assent to the terms of the offer in a manner invited or required thereby. [*Quackenbush v. Omnicor, Inc.* (1995) 34 CA4th 1283, 1288, 40 CR2d 816, 819]

1. [2:87.6] **Effect of Mistaken Offer:** An offer made by mistake cannot be "snapped up" so as to create an enforceable contract. [See *Quackenbush v. Omnicor, Inc.*, supra, 34 CA4th at 1288, 40 CR2d at 819]

• [2:87.7] Insurance Co. notified Insured his life insurance had been *canceled* for nonpayment of premium. Later, by mistake, it sent out a "late premium notice" stating the policy

Shultz Steel Co. v. Hartford Accident & Indemnity Co. (1986) 187 Cal.App.3d 513 , 231 Cal.Rptr. 715

[No. B016361. Court of Appeals of California, Second Appellate District, Division One. November 26, 1986.]
SHULTZ STEEL COMPANY, Plaintiff and Appellant, v. HARTFORD ACCIDENT AND IDEMNITY COMPANY, Defendant and Respondent.

(Opinion by Ruiz, J., with Spencer, P. J., and Devich, J., concurring.)

COUNSEL

Donnelly, Clark, Chase & Smiland and William M. Smiland for Plaintiff and Appellant.

Hawkins, Schnabel & Lindahl and Kelley K. Beck for Defendant and Respondent.

OPINION

RUIZ, J.

Plaintiff and appellant Shultz Steel Company (hereinafter Shultz) appeals from an entry of a summary judgment against it and in favor of defendant and respondent Hartford Accident and Indemnity Company (hereinafter Hartford), wherein the trial judge found "no triable issue of any material fact raised with respect to the issue of whether a relevant duty is owed by Hartford Accident and Indemnity Company, ..." Judgment is affirmed.

Factual and Procedural Background

Shultz has a factory located in Los Angeles County where it manufactures certain steel products on its premises. These premises include several structures.

Hartford is an insurance company that writes multiple lines of insurance. Rowan-Wilson, Inc. (hereinafter Rowan) is a company engaged as insurance brokers and agents. From 1970 through 1985, Rowan had utilized approximately 100 different insurers to cover risks for its clients. Rowan has been **[187 Cal.App.3d 517]** an authorized agent of Hartford since 1895, and about 25 to 30 percent of Rowan's business was conducted on behalf of Hartford.

Shultz had purchased its liability insurance coverage through Rowan since 1957, and Rowan had placed much of Shultz's liability insurance with Hartford since that date. Hartford also provided Shultz with other lines of insurance, such as workers' compensation coverage, fidelity bonds and other types of coverage.

In December 1980, an electrical contracting firm had its employee, Steven J. Mascaro (hereinafter Mascaro), on Shultz's premises cleaning a volt switch at which time the employee was electrocuted and severely injured thereby. Within one year of this injury, Mascaro filed a civil action against Shultz and others for his injuries. Mascaro subsequently dismissed the action as against the other defendants and proceeded to trial in 1986 against Shultz obtaining a judgment against Shultz in excess of $5 million.

In 1982, Shultz filed a complaint against his own insurer, Hartford, and his own broker, Rowan, for negligence and to indemnify Shultz against any uninsured loss it might suffer should Mascaro prevail against Shultz.

In 1985, Hartford alone moved for and was granted a summary judgment. Rowan did not move for a summary judgment.

Contentions

1. Is an insurance carrier (Hartford) vicariously liable under the general agency principles for the alleged negligence of its agent (who is also an independent insurance broker) for the agent's failure to recommend increased liability insurance coverage? We answer in the negative.

2. Is there a material fact dispute that could cause Hartford to be liable to Shultz on the theory that Hartford ratified the agent's negligence? We answer in the negative.

3. Independent of the insurance contract, is there a material fact dispute whether Hartford is liable to Shultz on a special duty theory for failure to recommend an increase in liability insurance coverage? We answer in the negative.

Discussion

A. Summary Judgment

Code of Civil Procedure section 437c, subdivision (c) (hereinafter § 437c, subd. (c)) indicates that a summary judgment "shall be granted if all the **[187 Cal.App.3d 518]** papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of

law."

Hartford is the defendant. [1] "When the moving party is the defendant the latter must conclusively negate a necessary element of the plaintiff's case and demonstrate that under no hypothesis is there a material factual issue which requires the process of a trial." (Frazier, Dame, Doherty, Parrish & Hanawalt v. Boccardo, Blum, Lull, Niland, Teerlink & Bell (1977) 70 Cal.App.3d 331, 339 [138 Cal.Rptr. 670].)

[2] "The motion for summary judgment assumes the sufficiency of the pleadings, and calls for evidentiary affidavits to show whether there is any substantial proof to support the allegations." (6 Witkin, Cal. Procedure (3d ed. 1985) Proceedings Without Trial, § 280, p. 580.)

Section 437c, subdivision (b) indicates "[t]he motion shall be supported by affidavits, declarations, admissions, answers to interrogatories, depositions and matters of which judicial notice shall or may be taken."

Section 437c, subdivision (c) further indicates that the court "shall consider all of the evidence set forth in the papers, ... and all inferences reasonably deducible from such evidence, except summary judgment shall not be granted by the court based on inferences ... if contradicted by other inferences ...."

B. Hartford's Vicarious Liability

There is no dispute that Rowan is an insurance agent for Hartford for the purpose of selling its insurance policies. There is also no dispute that Rowan, as a duly authorized agent for Hartford, sold Shultz a $500,000 liability insurance policy. It will be assumed for the purposes of this appeal that Rowan imprudently advised Shultz regarding the amount of liability insurance coverage it should carry at all times. [3a] Thus, the main issue becomes whether Hartford thereby became vicariously liable to Shultz for the carelessness of Rowan under the doctrine of respondeat superior.

[4] "'An agent is one who represents another, called the principal, in dealings with third persons,'" (1 Witkin, Summary of Cal. Law (8th ed. 1973) Agency and Employment, § 2, p. 645.) and the principal is liable for the torts of the agent under the doctrine of respondeat superior. However, for this liability to be imposed on the innocent principal, the agent's tort must have been committed during the course and scope of his employment. (Id, at §155, p. 754.) **[187 Cal.App.3d 519]** [5] A principal may be liable for the torts of his agent if the principal directed or authorized him to perform the tortious act. (Id, at § 153, p. 753.)

[3b] The principal may become liable for an act he did not originally authorize, if the principal ratifies the act. (Id, at §154, p. 754.) In Weber v. Leuschner (1966) 240 Cal.App.2d 829, 838 [50 Cal.Rptr. 86], the principal learned of the agent's fraud and affirmed it, and thus made it his own.

In regard to vicarious liability of an insurer for the negligence of its agent/broker, two lines of cases have developed. [6] However, before discussing these cases, it should be noted that Reserve Insurance Co. v. Pisciotta (1982) 30 Cal.3d 800, 816-817 [180 Cal.Rptr. 628, 640 P.2d 764], provides that an insurance broker who negligently represents an insured with respect to obtaining the correct amount of coverage can be liable to the insured for loss suffered by the insured due to this negligence. [3c] In Pisciotta, our Supreme Court affirmed a jury verdict against an insurance broker who had been engaged by the insured and who negligently obtained a replacement policy in a face amount $200,000 lower than that required by the insured's "excess coverage" carrier, thereby exposing the insured to a gap in his insurance protection. This case deals with a broker, not an insurer or insurance company, and is thus not applicable to this case.

[7] It appears that the relationship between insurer and insured is a fiduciary relationship (Gibson v. Government Employees Ins. Co. (1984) 162 Cal.App.3d 441, 445 [208 Cal.Rptr. 511]), wherein the insurer is duty bound to conduct itself with the utmost good faith for the benefit of the insured. (Barbara A. v. John G. (1983) 145 Cal.App.3d 369, 382.) [3d] However, it must still be determined just how far the protection of this fiduciary relationship should be extended. (Gibson, supra, at p. 446.)

The first line of cases pertain to those situations wherein the fiduciary duty of the insurer was coextensive with the four corners of the contract of insurance entered into by the insurer and its insured. In Egan v. Mutual of Omaha Ins. Co. (1979) 24 Cal.3d 809 [169 Cal.Rptr. 691, 620 P.2d 141], the court focused on the right of the insured to obtain the benefits of his insurance contract.

In Bank of Anderson v. Home Ins. Co. (1910) 14 Cal.App. 208, 213 [111 P. 507], a business loan occurred, and a fire insurance policy was issued by the insurer's agent to the borrower and made payable to the lender. The policy stipulated that it would be void should the insured obtain a second policy, and it further provided that the insurer's agent could not waive the insurer's rights under the first policy clause except by proper endorsement **[187 Cal.App.3d 520]** of the policy. After the first policy was issued, the borrower informed the agent that it had taken out a second policy, and the agent told the insured that he would endorse the first policy and thereby waive the benefits under the second policy clause. Subsequently, the premises in question burned down. The insurer refused to pay on the first policy because it had not waived the second policy clause. The court held that the insurance carrier was liable, saying "Strictly speaking, this is probably not a waiver of the said conditions, but a case of equitable estoppel." The court also mentioned the theory of ostensible authority conferred on the agent. (At pp. 216, 214.)

In Frasch v. London & Lancashire F. Ins. Co. (1931) 213 Cal. 219 [2 P.2d 147], the insured paid the required premium for the fire insurance policy to the insurer's agent, but the agent absconded with the funds. A fire occurred and the insured made a claim under this policy, but the insurer denied the claim because of nonreceipt of the premium. Upon suit by the insured the court held that the insurer was bound by the conduct of its agent on the theory of ostensible agency. (P. 223.)

In Cronin v. Coyle (1935) 6 Cal.App.2d [44 P.2d 385], an agent issued an insurance policy to a taxicab company, which policy provided for cancellation if the insured took out a second policy. The agent then filed the policy with the appropriate board regulating cab companies. Subsequent to all this, the agent learned that this policy had been issued without authority from the insurer. Then the agent, who also represented a second carrier, obtained a second policy issued by this other insurer. But since the second carrier had not yet been approved by the board, the agent purported to keep the first policy in effect. While both policies were in effect, a passenger riding in the insured's cab was injured. Then the second carrier was board approved and the first policy was cancelled. The passenger sued the insurer under the first policy. The court held that the insurer was liable for the acts of its agent, including the initial issuance without authority, and the subsequent waiver of cancellation in connection with the issuance of the second policy. This case addresses both the theory of ratification and that of ostensible authority.

In Lippert v. Bailey (1966) 241 Cal.App.2d 376 [50 Cal.Rptr. 478], an insurance agent issued a fire insurance policy on an apartment building, but the agent negligently omitted two of the four owners as insureds. Also, while $15,000 personal property coverage had been bargained for, the agent obtained only $5,000 coverage. A fire occurred. The owners of the building sued the carrier and its agent. Prior to trial, the insurer settled, and the trial proceeded against the agent alone. The appellate court noted that the negligence **[187 Cal.App.3d 521]** of the agent was attributable to the insurer and that a legal remedy could have properly been pursued against the insurer.

In Jackson v. Aetna Life & Casualty Co. (1979) 93 Cal.App.3d 838 [155 Cal.Rptr. 905], in a lease of commercial property, the lessee agreed to obtain insurance on the property with the lessor as an additional insured. The lessee obtained an insurance policy through the insurer's duly appointed agent. The agent examined the lease and should have named the lessor as an additional insured, but failed to do so. An injury occurred on this property and this injured person sued the lessor, who cross-complained against the insurer for negligent failure to provide insurance. The appellate court held that where an insurance agent negligently excludes or omits coverage, the intended beneficiary may state a cause of action against the insurer. The court indicated that an insurance company is "quasi-public" in nature, and held the insurer vicariously liable for its agent's negligence.

"Ostensible authority includes (a) the authority given by law to the agent, except where the third party has actual or constructive notice of restrictions; and (b) such authority as the principal, either intentionally or by want of ordinary care, causes or allows a third person to believe the agent to possess. (C.C. 2317, 2318.) [8] And the principal is liable to persons who have in good faith, and without want of ordinary care, relied upon the agent's ostensible authority to their detriment." (1 Witkin, Summary of Cal. Law, supra, § 133, p. 738, italics in original.)

[3e] The above cases deal with situations where an insurer was held liable for the agent's ostensible, if not actual, authority in connection with an expressed agreement or representation. One case deals with an agent's alleged negligence in requesting the insurer issue a policy providing the coverages agreed upon with the insured. None of these cases deal with whether an insurer is liable for the alleged negligence of it's agent/broker in not recommending the appropriate liability coverage.

A second type of situation is where the insurer's breach of fiduciary duty, if any, did not arise under the insurance contract but outside it. (Gibson v. Government Employees Ins. Co., supra, 162 Cal.App.3d 441, 447.) In this situation, while the agent may be liable to the insured, the insurer is not liable to the insured. In Gibson, for approximately the last 20 years prior to the accident, Mr. and Mrs. Gibson had regularly renewed their automobile insurance policy from GEICO and it was in effect on the date of the accident. The policy met the minimum coverage limits and other requirements mandated in the Insurance Code. It featured uninsured motorist coverage, as required, but not underinsured motorist coverage, which was not required **[187 Cal.App.3d 522]** by law. The policy also included medical coverage with a limit of $3,000. Mr. Gibson was struck by a car as he and his wife were crossing the street. The driver was insured, but his policy limits were inadequate to fully compensate the Gibsons. The Gibsons sued GEICO, their own insurance company, alleging the company had a duty to advise them of the availability and potential need of underinsured motorist coverage, and the inadequacy of their $3,000 limit on medical payment coverage. The Gibsons appealed from a dismissal upon the sustaining of GEICO's demurrer, and the appellate court affirmed. The court noted "absent some conduct on the part of the insurer consistent with assuming broader duties, the insurer's fiduciary duties are limited to those arising out of the insurance contract and do not encompass the duties asserted" either to advise the insured of "(1) the availability of coverage in addition to that requested [or] (2) the inadequacy of their policy limits." (Id, at p. 443, italics added.)

The Gibson court reasoned that any possible duty on the part of the insurer to advise the insured could not be based on the covenant of good faith and fair dealing because the covenant "[extends] only to the limits of the insurance coverage afforded by the insurer to the insured, i.e., ... of insurance entered into between

it and its insured." (Id, at p. 446.) Gibson noted the absence of any allegation that the insurer had contracted to provide, or advertised that it would provide, such advice, and therefore the court held that there were no facts extrinsic to the insurance contract upon which such duty could be based. The court rejected the insured's claimed reliance on the insurer's expertise as the basis for such a duty. (Id, at p. 448.)

Gibson also concluded that the duties plaintiffs sought to impose on the insurer could not be based upon the principles of strict fiduciary responsibility because such duties do not apply to conduct extrinsic to the insurance contract. (Id, at pp. 449-450.)

Gibson points out strong public policy considerations weighed against imposition upon the insurer of the duties suggested by the plaintiffs (of the availability of coverage beyond what was requested and advice regarding the inadequacy of policy limits). If such were the rule, insurance companies might have to refer plaintiffs to their competitors who may have a better insurance package available. Insurance companies would cease to be competitive in their sales and would be transformed into an industry dedicated solely to the public good. Under such a rule, insurance seekers would lose their incentive to shop for better prices. Also, insurance companies (not to be confused with brokers) would be transformed into personal financial counselors for the insured. (Id, at p. 451.) **[187 Cal.App.3d 523]**

Gibson also indicates that insureds must remain vigilant regarding changing economic conditions. They must be aware of their own increased insurance coverage needs. Insureds cannot shift their own negligence to insurers. (Id, at p. 452.)

It would seem that the Gibson case closely resembles the case at bar. Thus, applying the reasoning and holding of Gibson, this court rules that Hartford owed no duty to advise Shultz as to the adequacy of its liability coverage limits. Here, as in Gibson, there was no allegation or evidence of representations made by Hartford to either Shultz or Rowan that Hartford would advise Shultz as to the appropriate liability coverage limits for Shultz's needs. On the contrary, both Shultz and Dodd Young testified that no such representations had been made by Hartford. A declaration of Ms. Burns also showed Hartford made no such statements.

In short, as a matter of law, there is no triable issue as to whether Hartford owed a duty of advice to Shultz.

It should be noted that the California Supreme Court denied a petition for hearing on Gibson on February 21, 1985.

C. Did Hartford Ratify Rowan's Alleged Negligence

"An agency may be created, and an authority may be conferred, by a ... subsequent ratification." (Civ. Code, § 2307.) "A ratification can be made ... by accepting or retaining the benefit of the act, with notice thereof." (Civ. Code, § 2310.) "Ratification of part of an indivisible transaction is a ratification of the whole." (Civ. Code, § 2311.) "A principal is responsible for ... wrongs committed by his agent [if] ... he has ... ratified them, ..." (Civ. Code, § 2339.)

In the case of Insurance Co. v. McCain (1878) 96 U.S. 84 [24 L.Ed. 653], the agent accepted a renewal premium on a life insurance policy although he lacked authority to do so. Nevertheless, the agent sent the insurance company a statement showing the premium credited to the insurer's account. More than one month later the insured died. At no time between the date of receipt of the statement and the date of the insured's death did the insurer repudiate the agent's authority. But it refused to pay a claim on the basis of the agent's lack of authority. The beneficiary sued and won, and the United States Supreme Court affirmed, holding that the insurer's silence ratified the agent's wrongful act.

[9] Thus, a principal may become liable for an act he did not originally authorize, if the principal ratifies the act. (1 Witkin, Summary of Cal. Law, supra, § 154, p. 754.) **[187 Cal.App.3d 524]**

[10] Shultz alleges that Hartford possessed full knowledge that Rowan had caused Shultz to carry woefully inadequate insurance, that Hartford was aware of the safety conditions at Shultz's plant, including risks of electrocution, that Hartford better than anyone knew of the potential for a high jury verdict, and that Rowan advised Shultz on insurance coverage matters. From this, Shultz argues that Hartford ratified Rowan's negligence by accepting the insurance premiums paid by Shultz.

However, while Hartford was aware of Shultz's $500,000 policy, a declaration by a Hartford employee (Ms. Burns) indicated that Hartford had no way of knowing whether Shultz had an umbrella or excess coverage with another insurer. Also, there is nothing in the record to show that Hartford knew the $500,000 limits were inadequate or that Shultz had not rejected suggestions to increase its coverage limits.

In short, there is no triable issue raised by Shultz regarding Hartford's ratification. Hartford's receipt and retention of Shultz's premium is not ratification of Rowan's wrongdoing-- Hartford provided a service for the premium--it gave liability coverage up to $500,000.

D. Extrinsic to the Insurance Contract:

[11] The final issue is whether independent of the insurance contract, can it be said that Hartford is liable

[11] The final issue is whether independent of the insurance contract, can it be said that Hartford is liable to Shultz, on a special duty theory, for failure to recommend an increase in liability insurance coverage. In other words, apart from the theories of vicarious liability and ratification, can it be said that Hartford owed Shultz a direct duty to recommend it increase its policy limits.

Shultz alleges that Hartford was periodically responsible for providing renewal quotations and making requested coverage changes for Shultz's general liability policy. Also, that each year Hartford sent an auditor to measure sales, payroll and square footage. That on one occasion Hartford recommended continuance of coverage. Hartford also made safety checks on the Shultz premises and made safety recommendations. On one occasion, Hartford recommended that the limits be increased on property damage (not liability). Also, that Hartford advised Shultz regarding types of property insurance and fidelity bonds and recommended increasing a fidelity bond.

However, no document or testimony was offered to contradict the statements of either Young or Burns that Hartford did not make liability limits recommendations. There was no indication that the audits or loss control inspections had anything to do with liability coverage recommendations, **[187 Cal.App.3d 525]** but rather they dealt with plant safety matters. It was the responsibility of Hartford to give premium quotations because that is its business. In order to determine the appropriate premiums to quote, Hartford had to check Shultz's sales, payroll and square footage. There is no indication that this type of payroll check was for the purpose of providing recommendations pertaining to liability.

In those situations where Hartford gave advice regarding other types of insurance coverage, the matter was discussed with Rowan, not with Shultz, and the advice dealt with property coverage, not general liability coverage limits recommendations. Thus, it appears that Shultz never received advice from Hartford relating to liability coverage limits recommendation. Also, documentary evidence indicates that Hartford did not make liability limits recommendations to any insured.

In short, there is no triable issue as to whether Hartford owed a special duty to Shultz extrinsic to the insurance contract.

Conclusion

The judgment granting Hartford Accident and Indemnity Company a summary judgment is affirmed.

Spencer, P. J., and Devich, J., concurred.

* Reporter's Note: This case was previously entitled "Shultz Steel Company v. Rowan-Wilson, Inc."

RESCISSION OF HEALTH INSURANCE POLICIES AFTER HIPAA

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Introduction

The Health Insurance Portability and Accountability Act ("HIPAA") was intended to expand the availability of group and individual health coverage.[1] HIPAA requires group and individual health insurers to provide coverage to individuals who, prior to its enactment, would not have met underwriting requirements because of their medical histories. In light of HIPAA, the only meaningful protection health insurers have against these substandard risks is the ability to charge higher than standard premiums, assuming that the applicable state insurance law permits such premium increases. This protective mechanism is, of course, highly dependent upon the health insurer obtaining accurate medical histories at the time group and individual risks are underwritten.

In the past, despite differences in the state law of rescission, health insurers could generally rely on the accuracy of medical histories reported on insurance applications. If an application contained meaningful misrepresentations, the group or individual health insurer could generally revoke the policy retroactively – rescind *ab initio*.

Since the effective date of HIPAA, it is no longer true that an insurer may refuse to issue a policy on the grounds that the medical history reported by the applicant renders the risk unacceptable. What remedy, then, does a health insurer have if an applicant makes material misrepresentations of medical history? One possible remedy is the retroactive imposition of a premium increase; however, even if such a retroactive premium increase is permitted under applicable state law, this option, alone, is inadequate because it would promote dishonesty in the disclosure of relevant medical history. If the insurer's only option is to increase premiums retroactively so that the insured pays the amount that would have been required had an accurate medical history been given, apart from the largely theoretical possibility of criminal prosecution, the insured faces no penalty for having attempted to commit a fraud. If the misrepresentation is not uncovered, the insured is rewarded by receiving coverage for a lower premium than would have been charged had complete and accurate medical information been given. As such, a far more meaningful remedy for the insurer would be the ability to rescind the policy and, thus, avoid the risk entirely, which pre-HIPAA was permitted in all states for, at least, fraudulent material misrepresentations. The status of such rescission *ab initio* is unclear in light of HIPAA. As of this writing, there exist no reported decisions which detail an insurer's rescission rights in light of HIPAA.

Rescission of Health Insurance Coverage Under State Law

This article does not purport to address the subtleties and nuances of each state's law applicable to the rescission of health insurance policies. Instead, it sets forth certain general principles of rescission that are applicable in the majority of states and discusses how HIPAA may affect these principles.

In general, an insurance policy, including a health insurance policy, may be rescinded on the basis of material misrepresentation, *i.e.*, a misrepresentation that materially affects the risk assumed, even if the misrepresentation was made without an intent to deceive.[2] In most states, rescission is permitted based upon a material misrepresentation even if benefits are being sought on grounds unrelated to the misrepresented fact.[3] This general rule affirmatively promotes full and complete disclosure of medical history, while the minority rule requiring a causal connection between the loss and the misrepresented fact encourages a lack of forthrightness since it results in coverage in circumstances where the risk would otherwise have been rejected or, at least, a higher premium charged for the coverage. The majority rule is that misrepresentations affecting only the premium charged permit rescission and the avoidance of liability on the policy.[4] Again, permitting rescission and retroactive avoidance of liability in such circumstances promotes full and complete disclosure of adverse medical history by insureds.

Guaranteed Availability and Continuation of Heath Coverage Under HIPAA

HIPAA recognizes three distinct markets for health insurance coverage – the large employer group market, the small employer group market, and the individual market.[5] The availability of health coverage is guaranteed by HIPAA in the

small employer group market and to certain persons in the individual market.[6] While the large employer group market is not extended this same protection, HIPAA significantly impacts on all health insurance issuers in any of the health coverage markets by eliminating their traditional right to reject risks on the basis of "heath status-related factors."[7] Factors which cannot be used as a basis for rejecting a risk include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, and evidence of insurability and disability.[8] The guaranteed availability mandate of HIPAA is less significant for insurers in the individual market because of the applicable HIPAA definition of "eligible individual" with respect to this market. "Eligible individuals," for purposes of the individual market, are generally persons who (i) have had 18 or more months of prior health care coverage and who, most recently, lost coverage under an employer group health plan, (ii) are not eligible for coverage by another group health plan, and (iii) who do not have any other health insurance coverage.[9] HIPAA allows states to adopt their own mandatory issuance rules for individual health insurers, subject to certain minimum requirements, namely, that all "eligible individuals" within the meaning of HIPAA are guaranteed access to coverage.[10] Thus, in those states which have enacted their own legislation, "health status-related factors" within the meaning of HIPAA nonetheless cannot be used to deny coverage to applicants who are "eligible individuals."

HIPAA is also designed to ensure that once health coverage is obtained, the insured may keep the coverage in place indefinitely. As a general rule, an insurer must renew or continue in force health coverage at the option of the plan sponsor or plan (group markets) or the option of the insured individual (individual market).[11]

While HIPAA mandates coverage for many substandard risks, raising concerns about adverse selection, it does not prohibit health insurers from taking into account "health status-related factors" in establishing premium rates. Nonetheless, because HIPAA does not preempt the right of the states to impose rate regulation, the ability of health insurers to protect themselves through premium rates will vary from state to state.

Discontinuation of Coverage Under HIPAA Due to Misrepresentation

Under HIPAA a health insurer may "nonrenew or discontinue" coverage if the plan sponsor or insured individual, as applicable, "performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage."[12] These provisions could be narrowly construed as permitting discontinuance of coverage for misrepresentations in the application for that coverage only for common law fraud.[13] It could be argued that discontinuance of coverage for "intentional misrepresentation of material fact" relates only to misrepresentations that are made in an attempt to obtain benefits after effective coverage is in place, *i.e.*, a misrepresentation "under the terms of coverage." The better construction is that intentional misrepresentation in the application for coverage constitutes grounds for discontinuation. HIPAA does not clearly eliminate the traditional right of insurers to rescind coverage or avoid liability due to material misrepresentations in the application for coverage. The elimination of this right would affirmatively encourage misrepresentation by applicants for health coverage and it should not be concluded, absent the clearest statutory language to the contrary, that HIPAA precludes discontinuation of coverage if the plan or individual has made material misrepresentations in the application for coverage.

In fact, it is at least arguable that rescission of a health policy *ab initio* is not permitted under HIPAA. HIPAA's use of the term "discontinue" (implying an effective policy) and the absence of the term rescission, could be construed as eliminating the right to rescind coverage *ab initio*. This argument is bolstered by the fact that other events which permit an insurer to "discontinue" coverage under HIPAA are prospective or, at most, partially retroactive.[14]

Clearly, the term "discontinue health insurance coverage" need not necessarily be interpreted to preclude retroactive discontinuation through rescission. To interpret HIPAA as permitting only prospective elimination of coverage upon discovery of material misrepresentation or fraud would encourage dishonesty, and presumably, Congress did not intend to condone fraud or intentional misrepresentation. The only remedy that can fully rectify the wrong of a misrepresentation that induced coverage is to permit rescission of that coverage *ab initio*.

HIPAA Preemption and Rescission Under State Law

In general, an action by a health insurer permitted by applicable state law is not invalidated by HIPAA unless that state insurance law would prevent a provision of HIPAA from becoming effective in that state.[15] Because HIPAA does not

expressly preclude rescission as a remedy for material representation, and because HIPAA expressly permits discontinuance of coverage as a consequence of an intentional misrepresentation, state law rescission remedies should not be deemed to prevent the "application of HIPAA."

Further, if Congress had intended to eliminate state law rescission remedies, one would have anticipated an express statutory statement of this intent. In the absence of such an express statement (and the presumption that HIPAA was not enacted so as to permit persons to make misrepresentations on applications for coverage) allowing rescission does not prevent the "application of HIPAA."

What about state laws that permit rescission for unintentional material misrepresentations? In this context, insureds have a much stronger argument that state laws permitting such rescissions prevent the application of HIPAA, and, as such, are preempted. HIPAA only permits nonrenewal or discontinuance of coverage for "fraud or intentional misrepresentation of material fact." While insurers could still argue that HIPAA simply does not address rescission so that the underlying state law is applicable, it is likely that the federal courts would conclude that rescission is only available for fraud or intentional misrepresentation of material fact.

In some circumstances, HIPAA may ultimately be construed as broadening rights to rescind coverage that are not presently recognized by the law of some states. Presumably, the word "material" within the meaning of HIPAA will be construed uniformly throughout the United States and will not be held to turn on how the term is used in the state whose law might otherwise be applicable. The rule adopted in the overwhelming majority of states is that a misrepresentation is "material" if it affects the premium charged for the coverage. If the majority rule is adopted for purposes of HIPAA, then contrary state law should be preempted as a "standard or requirement" which prevents the application of a part of HIPAA, *i.e.*, rescission based on a material misrepresentation, as 'material" is construed within the meaning of HIPAA. Another area of possible preemption might be the laws of the minority of states that require a causal connection between the misrepresented fact and the loss for the misrepresentation to be deemed "material." Cases decided under ERISA, creating a federal common law applicable to insurers who issue group health policies to employee benefit plans, should generally be deemed applicable in construing HIPAA. In this regard, several federal court decisions have rejected a materiality test that requires a casual connection between the misrepresented fact and the loss.[16]

The scope of an insurers right to discontinue health insurance coverage under HIPAA is presently unclear. The extent of this right in light of HIPAA will have to await judicial, statutory or regulatory clarification.

Endnotes

1. In an effort to regulate the provision of health care benefits to all individuals, Congress, in passing HIPAA, amended the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §1001, *et seq.*, the Internal Revenue Code of 1986 (the "Code"), as amended, 26 U.S.C. §1, *et seq.* and the Public Health Services Act ("PHSA"), as amended, 42 U.S.C. §201, *et seq.* The provisions of ERISA generally apply to all group health plans other than church plans or government plans and health insurance issuers that offer health insurance coverage in connection with group health plans. The provisions of the Code apply to all group health plans other than church plans, but not to health insurance issuers. The provisions of the PHSA generally apply to health insurance issuers, and certain state and local government plans. The citations in this article are to ERISA, although parallel provisions exist in both the Code and the PHSA.

2. *E.g.*, *Thompson v Occidental Life Ins. Co. of California*, 9 Cal.3d 904; 109 Cal. Rptr. 473; 513 P.2d 353 (1973), *Continental Assurance Co. v Carroll*, 485 So.2d 406 (Fla. 1986), *Unger v Metropolitan Life Ins. Co.*, 103 Ill. App. 2d; 242 N.E. 2d 907 (1968), *Legel v American Community Mutual Ins. Co.*, 201 Mich. App. 617; 506 N.W. 2d 530 (1993), *Prudential Ins. Co. v Anaya*, 79 N.M. 101; 428 P.2d 640 (1967). *Contra*, requiring an intent to deceive as a condition for rescission, *Marchiori v American Republican Ins. Co.*, 662 A. 2d 932 (Me. 1995), *Union Bankers Ins. Co. v Shelton*, 889 S.W. 2d 278 (Tex. 1994), *Powell v Time Ins. Co.*, 181 W. Va. 289; 382 S.E. 2d 342 (1989).

3. *E.g.*, *National Life & Accident Ins. Co. v Atha*, 69 Ga. App. 825; 26 S.E.2d 675 (1943), *Wickersham v John Hancock Mutual Life Ins. Co.*, 413 Mich. 57; 318 N.W. 2d 456 (1982), *Massachusetts Mutual Life Ins. Co. v Manzo*, 122 N.J. 104; 584 A.2d 190 (1991), *Reisen v Blue Cross Blue Shield of Oregon*, 115 Or. App. 396; 839

P. 2d 729 (1992), *Carroll v Jackson National Life Ins. Co*, 307 S.C. 267; 414 S.E. 2d 777 (1992), *Berger v Minnesota Mutual Life Ins. Co.*, 723 P. 2d 388 (Utah 1986). *Contra*, requiring a causal connection between the misrepresented fact and the loss, *Central National Life Ins. Co. v Peterson*, 23 Ariz. App. 4; 529 P. 2d 1213 (1975).

4. *E.g.*, *Oakes v Blue Cross Blue Shield of Columbus, Inc.*, 170 Ga. App. 335; 317 S.E. 2d 315 (1984), *Hatch v Woodmen Accidents & Life Ins. Co.*, 88 Ill. App. 3d 36; 409 N.E. 2d 540 (1980), *Keys v Pace*, 358 Mich. 74; 99 N.W. 2d 547 (1958) (but see, *contra*, *Zulcosky v Farm Bureau Life Ins. Co. of Michigan*, 206 Mich. App. 95; 520 N.W. 2d 336 (1994)), *Randono v CUNA Mutual Ins. Co.*, 106 Nev. 371; 793 P. 2d 1324 (1990). *See also, contra, Harrington v Aetna Casualty and Surety Co.*, 489 S.W. 2d 171 (Tex. Civ. App. 1973).

5. The large group market consists of employers who employed an average of at least 51 employees during the preceding calendar year and who employed at least 2 employees on the first day of the plan year. 42 U.S.C. § 300gg-91(e)(2) and (3). The small group market consists of employers who employed an average of 2 but not more than 50 employees during the preceding calendar year and who employed at least 2 employees on the first day of the plan year. 42 U.S.C. § 300gg-91(e)(4) and (5). The individual market "means that the market for health insurance coverage offered to individuals other than in connection with a group health plan." 42 U.S.C. § 300gg-91(e)(1).

6. 42 U.S.C. § 300gg-11(a) (small group market); 42 U.S.C. § 300gg-41(a) (individual market).

7. 42 U.S.C. § 300gg-1(a) (group markets); 42 U.S.C. § 300gg-41(a) (individual market).

8. 42 U.S.C.. § 300gg-1(a).

9. 42 U.S.C. § 300gg-41(b).

10. 42 U.S.C. § 300gg-44.

11. 42 U.S.C. § 300gg-12(a) (group markets); 42 U.S.C. § 300gg-42(a) (individual market). There are limited exceptions to this obligation which are discussed, *infra*.

12. 42 U.S.C. § 300gg-12(b)(2) (group markets); 42 U.S.C. § 300gg-42(b)(2) (individual market).

13. Where only an intentional misrepresentation is required, the actor's intent or good faith is immaterial. Fraud, however, requires evidence of an intent to deceive. *See* Couch on Insurance 3d, § 31.81; § 31.82.

14. Discontinuance of coverage is also permitted for (i) nonpayment of premiums; (ii) violation of participation or contribution rules in the case of group insurance, (iii) the insurer's termination of all health coverage within a particular market in any state; (iv) movement of all insured participants (group plans) or the insured individual outside the service area in the case of a network plan and (v) in the case of coverage based on association membership, the cessation of such membership. *See*, 42 U.S.C. § 300gg-12(b) (group markets); 42 U.S.C. § 300gg-42(b) (individual market).

15. 42 U.S.C. § 300gg-23(a)(1) provides that HIPAA "shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part." To similar effect, for individual coverage, *see* 42 U.S.C. § 300gg-62(a).

16. *See*, *e.g.*, *Davies v Centennial Life Ins. Co.*, 128 F.3d 934 (6th Cir. 1997).

HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 2008 UPDATE

APRIL 2008

THE HENRY J. KAISER FAMILY FOUNDATION

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2008 UPDATE

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This primer provides a basic overview of private coverage for health care. It begins by describing what we mean by private health coverage, and continues with discussions of the types of organizations that provide it, its key attributes, and how it is regulated. The paper addresses private health coverage purchased by individuals and employers; it does not address public benefit programs such as Medicare and Medicaid.

1. What is Private Health Coverage?

Private health coverage is a mechanism for people to (1) protect themselves from the potentially extreme financial costs of medical care if they become severely ill, and (2) ensure that they have access to health care when they need it.

Health care can be quite costly, and only the richest among us can afford to pay the costs of treating a serious illness should it arise. Private health coverage products pool the risk of high health care costs across a large number of people, permitting them (or employers on their behalf) to pay a premium based on the average cost of medical care for the group of people. This risk-spreading function helps make the cost of health care reasonably affordable for most people.

In addition, having an "insurance card" enables patients to receive care in a timely way by providing evidence to health care providers that the patient can afford treatment. Providers generally know that when they treat people with health coverage, they are likely to be paid for their services within a reasonable time.

Health coverage is provided by a wide array of public and private sources. Public sources include Medicare, Medicaid, the State Children's Health Insurance Program, federal and state employee health plans, the military, and the Veterans Administration.

Private health coverage is provided primarily through benefit plans sponsored by employers – about 158 million nonelderly people were insured through employer-sponsored health insurance in 2006.[i] People without access to employer-sponsored insurance may obtain health insurance on their own, usually through the individual health insurance market, although in some instances health insurance may be available to individuals through professional associations or similar arrangements. About 14 million nonelderly people bought health insurance directly in 2006.[ii]

> ***Policy**: This is the contract between the health insuring organization and the policyholder. The policyholder may be an individual or an organization, like an employer.*

2. How is Private Health Coverage Delivered?

Types of Organizations That Provide Private Health Coverage

Private health coverage is provided primarily by two different types of entities: state-licensed health insuring organizations and self-funded employee health benefit plans.

State-Licensed Health Insuring Organizations

State-licensed health insuring organizations, as the name implies, are organized and regulated under state law, although federal law adds additional standards and in some cases supersedes state authority. There are three primary types of state-licensed health insuring organizations:

Commercial health insurers. Commercial health insurers (sometimes called indemnity insurers) are generally organized as stock companies (owned by stockholders) or as mutual insurance companies (owned by their policyholders). A prominent example is Aetna, a stock company.

Blue Cross and Blue Shield Plans. Historically, many of these plans were organized as not-for-profit organizations under special state laws by state hospital (Blue Cross) and state medical (Blue Shield) associations. These laws differed significantly across states, sometimes imposing special obligations or regulatory requirements on Blue Cross and Blue Shield plans (e.g., to insure all applicants) and sometimes providing financial advantages such as favorable tax status. Today, some Blue Cross and Blue Shield plans continue to operate under special state laws; others are organized as commercial health insurers. Blue Cross and Blue Shield plans operate and are regulated in a similar manner to commercial insurers, although in a few states Blue Cross and Blue Shield plans continue to have special requirements to accept applicants for health insurance on a more lenient basis than is applied to other types of insurers.

Health Maintenance Organizations (HMOs). HMOs usually are licensed under special state laws that recognize that they tightly integrate health insurance with the provision of health care. HMOs operate as insurers (meaning they spread health care costs across the people enrolled in the HMO) and as health care providers (meaning they directly provide or arrange for the necessary health care for their enrollees). In many states, HMO regulation is shared by agencies that oversee insurance and agencies that oversee heath care providers.[iii] Prominent examples of state-licensed HMOs include Kaiser Permanente and Harvard Pilgrim.

Although states tend to separately license each of these types of entities, it is quite common for several different health insuring organizations to operate together under a common corporate identity. For example, an HMO may have one or more

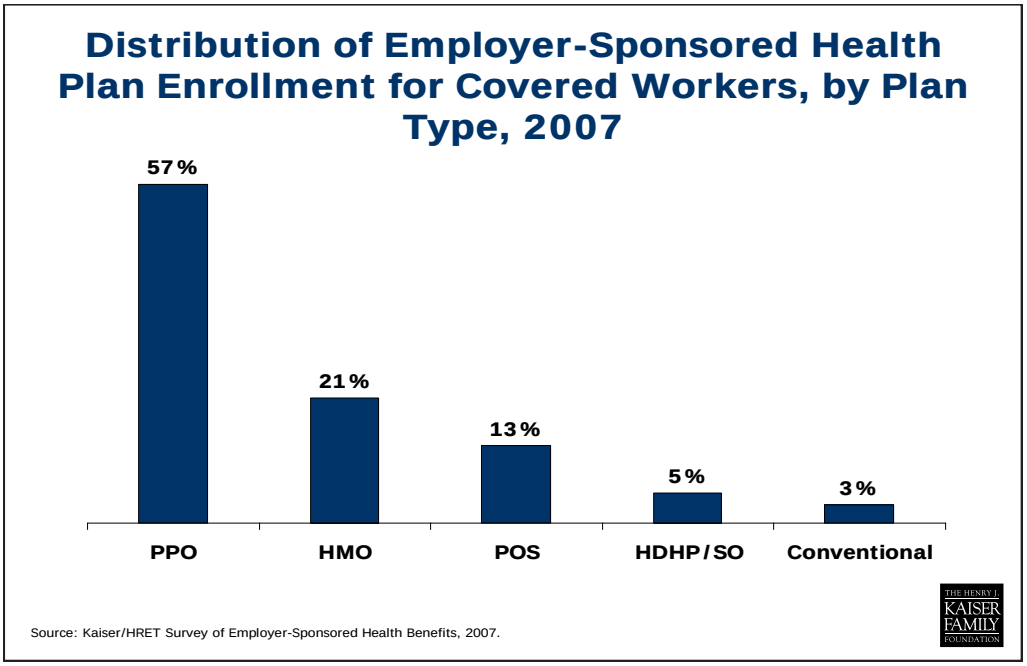
subsidiaries that are separately licensed as commercial health insurers, and may offer its group customers coverage packages that permit members to choose between the different types of coverage.

Self-Funded Employee Health Benefit Plans

Self-funded employee health benefit plans operate under federal law and are health benefit arrangements sponsored by employers, employee organizations, or a combination of the two. Under a self-funded arrangement, the plan sponsor assumes the risk of providing covered services to plan enrollees by paying directly for health care services of the plan's participants. In most cases, the sponsors of self-funded health plans contract with one or more third parties to administer the plans. These contracts are sometimes with entities that specialize in administering benefit plans, called third-party administrators. In other cases, sponsors contract with health insurers or HMOs for administrative services. The administering entity usually will manage the health benefits in the same way as a health insurer or HMO, but will pay for the cost of medical care with funds provided by the sponsor (i.e., no premium is paid).

Types of Private Health Plans

Private health plans include HMOs, Preferred Provider Organizations (PPOs), Point-of-Service Plans (POS), High Deductible Health Plans combined with Health Savings Accounts (HSA) or Health Reimbursement Accounts (HRA), and conventional health plans. For employer-sponsored health plans in 2007, enrollment is highest in PPOs (57%), followed by HMOs (21%), POS plans (13%), Health Savings Accounts/Health Reimbursement Accounts (or HDHP/SOs, 5%), and conventional plans (3%):



How Does Managed Care Fit In?

Formerly, conventional (or, indemnity) health plans were the most common type of health plan. These plans do not use provider networks and require the same cost sharing no matter which physician or hospital the patient goes to. Over the past 20 years, health coverage providers sought to influence the treatment decisions of health care providers and contain costs through a variety of techniques known as "managed care," including financial incentives, development of treatment protocols, prior authorization of certain services, and dissemination of information on provider practice relative to norms or best practices.

As managed care has become increasingly prevalent, the distinctions between different types of heath coverage providers have been shrinking. Commercial health insurers now offer coverage through networks of providers and may establish financial incentives similar to those traditionally used by HMOs. At the same time, HMOs have developed products, called point-of-service products, which permit covered people to elect to receive care outside of the HMO network, typically with higher cost sharing. Although it remains true that HMOs generally are the most tightly managed arrangements and most tightly integrate insurance and the delivery of care, virtually all private health coverage now involves some aspect of managed care.

What is a Preferred Provider Organization?

It is common for people to believe that they are covered by a preferred provider organization (PPO), but these entities generally do not actually provide health coverage. Rather, PPOs are networks composed of physicians and other health care providers that agree to provide services at discounted rates and/or pursuant to certain utilization protocols to people enrolled in health coverage offered by a health coverage provider. Typically enrollees in such an arrangement are given financial incentives – such as lower copayments -- to use network providers.

In some cases, PPOs are freestanding networks of health care providers that contract with a number of different health coverage providers to act as the health coverage provider's network in a particular area. In other cases, a health coverage provider may establish its own PPO network of health care providers in a particular area. Although some states have raised concerns about the level of insurance risk assumed by PPOs under some of their arrangements with health coverage entities, PPOs generally are not treated as health coverage providers in most states.

What are Health Savings Accounts and Health Reimbursement Accounts?

Changes in federal law in recent years have permitted the establishment of new types of savings arrangements for health care. The most common are Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs), which are tax-exempt accounts that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees, and if the employer

contributes to the HSA the contributions are excluded from employee gross income. Individuals can also purchase HSAs from most financial institutions (banks, credit unions, insurance companies, etc.). In order to open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan (HDHP), which can be provided by the employer or purchased from any company that sells health insurance in a state.[1]

HRAs are employer-established benefit plans funded solely by employer contributions which are excluded from employee gross income, with no limits on the amount an employer can contribute. HRAs are often paired with HDHPs, but are not required to do so.

Risk Pooling, Underwriting, and Health Coverage

As discussed above, health coverage providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should result in expected costs for the pool that are reasonably predictable for the insurer and relatively stable over time (i.e., the average level of health risk in the pool should not vary dramatically from time to time, although costs will rise with overall changes in price and utilization).

To accomplish this, health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Said another way, health coverage providers take steps to avoid attracting a disproportionate share of people in poor health into their risk pools, which often is referred to as "adverse selection." For obvious reasons, people who know that they are in poor health will be more likely to seek health insurance than people who are healthier. If a risk pool attracts a disproportionate share of people in poor health, the average cost of people in the pool will rise, and people in better health will be less willing to join the pool (or will leave and seek out a pool that has a lower average cost). A pool that is subject to significant adverse selection will continue to lose its healthier risks, causing its average costs to continually rise. This is referred to as a "death spiral."

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[1] HSAs and HDHPs are subject to certain federal requirements. The maximum contribution allowed from both employer and employee to an HSA in 2008 is $2,900 for self-only coverage and $5,800 for family coverage. In 2008, HDHPs must have a minimum deductible of $1,100 (self-only) and $2,200 (family); the maximum out-of-pocket limit is $5,600 (self-only) and $11,200 (family).

In practice, health coverage providers often have multiple risk pooling arrangements. They may establish separate arrangements for different markets (e.g., individuals who buy insurance on their own, small businesses, and trade associations) and for different benefit plans within markets (e.g., plans with different levels of deductible). In part, this product differentiation protects the health coverage provider because problems in one risk pooling arrangement will not have a direct effect on people participating in another pooling arrangement.

> ***Adverse selection**: People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Adverse selection results when these less healthy people disproportionately enroll in a risk pool.*

Health coverage providers use underwriting to maintain a predictable and stable level of risk within their risk pools and to set terms of coverage for people of different risks within a risk pool. Underwriting is the process of determining whether or not to accept an applicant for coverage and determining what the terms of coverage will be, including the premium. As discussed below, both state and federal laws circumscribe the ability of health coverage providers to reject some applicants for coverage or to vary the terms of coverage.

A primary underwriting decision involves whether or not the health coverage provider will accept an applicant for coverage. In the individual insurance market (where people buy insurance on their own), health coverage providers typically underwrite each person seeking to purchase coverage reviewing the person's health status and claims history. If an applicant is in poor health, a health coverage provider (subject to state and federal law) may decide not to offer coverage. However, in most states, a health coverage provider also may choose to accept the applicant but vary the terms of coverage -- they may offer coverage at a higher than average premium (called a "substandard rate"), exclude benefits for certain health conditions or body parts (called an "exclusionary rider"), or do both. As discussed below, state and federal laws generally require health coverage providers to accept small employers applying for coverage, so the underwriting decisions are more limited to determining the premium and other terms of coverage (though these actions are also limited by law in many states).

To maintain the attractiveness of the risk pool to different segments of the population with different expected costs, health coverage providers typically vary premiums based on factors associated with differences in expected health care costs, such as age, gender, health status, occupation, and geographic location. For example, on average the expected health costs of people over age 50 are more than twice as much as the expected health costs of people under age 20. In cases where the individual is paying the full premium for coverage, health coverage providers will want to charge a higher premium to people who are older to recognize the higher expected costs. If premiums are not varied to account for the differences in expected costs, the pool may attract a disproportionate share of older, more expensive people, raising the average cost in the pool and making coverage in the pool less attractive to younger

people (who would have to pay a premium that exceeded their expected average health care costs). This is another form of adverse selection and would lead to a breakdown of the risk pooling. Other examples of underwriting include health coverage providers charging different premiums to small employers based on the industry of the employer or on the employer's prior health claims.

The most efficient and effective underwriting mechanism for avoiding adverse selection is to provide coverage to already formed large groups of people, such as the employees of a large employer. In such cases, the health coverage provider knows that the individual members of the group did not join it primarily to get insurance, so there is a much lower chance that the group is composed disproportionately of people in poor health. In these cases, the underwriting focuses on the group – its claims history, age distribution, industry, and geographic location – not on individual members of the group. Even in group underwriting situations, however, health coverage providers need to assure that they are not getting only those members of the group who are in poor health. To avoid adverse selection within the group, health coverage providers often limit the opportunity for employees to enroll in the plan (typically through an annual "open enrollment period"), require a minimum percentage of employees to participate in the coverage, and/or require the employer to contribute a minimum percentage of the premium on behalf of workers (to encourage participation).

The advantages of group underwriting break down in certain situations. For example, when a very small employer group (e.g., 2 to 5 employees) seeks coverage, there is a possibility that the need for health care by one member of the group (e.g., a family member of the owner) is the reason that the group is seeking coverage. A health coverage provider in such a case may (if permitted by state law) charge a higher premium based on the higher risk associated with smaller groups (called a "group size factor") or review the health status of each of the members of the group in order to vary the premium for the group. The higher inherent risk in providing coverage to small employers explains in part why a risk pool with 1000 five-employee groups will be less stable (and more expensive to cover) than one employer with 5000 employees.

Health coverage providers also take steps to protect themselves from adverse selection that may not be uncovered in the underwriting process by excluding benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage. For example, if a person seeks benefits for a chronic condition within a few months of enrolling for coverage, the health coverage provider may investigate to determine if the condition was diagnosed (or apparent) within a defined period prior to enrollment. If the health coverage provider determines that the condition was diagnosed (or apparent), it may exclude coverage of the preexisting medical condition for a defined period of time. Treatments for other medical conditions would not be affected by the

> ***Preexisting medical condition**: This is an illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured under a policy.*

exclusion. As discussed below, state and federal law substantially circumscribes the applicability of preexisting condition exclusions.

3. Regulation of Private Health Coverage

This section describes the basic regulatory framework for private health coverage under state and federal laws.

Understanding how private health coverage is regulated is complicated by the overlapping state and federal requirements for health coverage arrangements. States generally regulate the business of insurance, including health insurance. States license entities that offer private health coverage and have established laws that control the legal structure of insurers, their finances, and their obligations to the people that they insure. At the same time, a number of federal laws also regulate private health coverage. The most important of these laws, the Employee Retirement Income Security Act of 1974 (ERISA), establishes standards for employee benefit plans (including benefit plans providing medical care) established or maintained by an employer or an employee organization (i.e., a union). Since the vast majority of Americans with private health coverage receive it through employee benefit plans, understanding the interaction between federal and state laws is essential to understanding how private health coverage operates.

Unfortunately, this interaction is messy. In some cases, ERISA requirements coexist with state law and, in other cases, ERISA requirements preempt state law. And, precisely when ERISA preempts state laws is still the matter of much litigation, even though ERISA was passed over 30 years ago. Important interactions between state and federal law also occur under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This section begins with a general description of how states regulate health insurance and continues with a general description of the applicable provisions of ERISA and HIPAA and their interaction with state law and state oversight of state-licensed health insuring organizations.

State Regulation of Health Insurance

The regulation of insurance has traditionally been a state responsibility. In 1945, Congress enacted the McCarran-Ferguson Act,[iv] which clarified federal intent that states have the primary role in regulating the business of insurance.[2]

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[2] The McCarran-Ferguson Act was enacted in response to the U.S. Supreme Court's decision in *United States* v. *South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944), which held that insurers that conducted a substantial part of their business across state lines were engaged in interstate commerce and thereby were subject to federal antitrust laws. State and industry concern over the effect of the decision on state authority over insurance lead Congress to pass the McCarran-Ferguson Act to restore the primary role of states in regulating the business of insurance. See *United States Department of Treasury v. Fabe*, 508 U.S. 491, 499 (1993).

State regulation of health and other insurance starts with the licensing of entities that sell insurance within the state. The licensing process reviews the finances, management, and business practices of the insuring entity to evaluate whether it can provide the coverage that is promised to policyholders. States establish requirements for state-licensed health insuring organizations in a number of areas to protect the people that they cover. States also license the insurance producers (e.g., agents, brokers) who sell health insurance within the state.

> ***Minimum capital requirements**: These are requirements of state law that set a minimum amount of net worth that an insuring organization must have in order to operate. This minimum amount must be unencumbered – i.e., it must be available to pay for claims. The amount varies with the type of insurance that is being sold by the insurer (e.g., life, health, auto, workers compensation). Relatively recent state laws establishing "risk-based" capital requirements relate minimum capital requirements to insurers' risk exposure and business practices. For example, an HMO may have lower minimum capital requirements than an indemnity health insurer because the HMO has additional tools to manage risk.*

The discussion below describes the types of insurance laws that states have typically enacted, though the content and extent of regulation in these areas varies among the states, sometimes significantly.

Financial Standards

State financial standards include requirements for minimum capital, investment practices, and the establishment of claims and other reserves. States require state-licensed health insuring organizations to submit quarterly and annual financial statements, and also perform periodic on-site financial examinations to ensure that state-licensed health insuring organizations remain financially viable.

Market Conduct

State market conduct standards include requirements relating to claims practices, underwriting practices, advertising, marketing (including licensing of insurance producers), rescissions of coverage, and timely payment of claims. States generally have laws giving them authority to address unfair trade and unfair claims practices, and perform periodic market conduct examinations of state-licensed health insuring organizations to review business practices.

> ***Guaranty fund**: This is a funding mechanism established under state law to pay the claims of insurers that become insolvent. The funds to pay claims generally are provided by assessing other insurers that provide coverage in the state.*

Policy Forms

Policy forms are the pieces of paper that establish the contractual relationship between the health insuring organization and the purchaser. State standards for policy forms address the content of the form -- including required and prohibited contract provisions and standard definitions and terminology -- as well as how they are issued to purchasers. In some cases, states review or approve policy forms, although these practices vary by type of purchaser and by state.[v] States most often review or approve policies that are offered directly to consumers or to small employers; larger purchasers are presumed to be sophisticated buyers that need less protection.

> ***Policy form**: This is a representative contract of the policies that health insuring organizations offer to policyholders. Health insuring organizations will have different policy forms representing different configurations of benefits and different types of customers (e.g., individuals or small groups). In some states, health insuring organizations have to file the policy forms that they offer to certain types of customers with the insurance department.*

Access to Coverage and Required Benefits

State standards relating to access address when, and on what terms, state-licensed health insuring organizations must accept an applicant for coverage. Most states have laws that require state-licensed health insuring organizations to provide coverage to small employers that want it, with some limitation on the rates that can be charged (e.g., restrictions on how premiums can vary based on age and health status). Fewer states apply these types of rules to the individual insurance market, where people buy coverage on their own rather than through an employer. Federal law also includes requirements for access to coverage, as discussed under HIPAA below.

> ***Guaranteed issue or guaranteed availability of coverage**: This is a requirement that insurers accept specified applicants for coverage, generally without regard to their health status or previous claims experience. For example, health insuring organizations generally are required by state and federal law to issue coverage to small employers that apply. Separate provisions of law generally address the extent to which health insuring organizations can vary premiums based on health status, claims experience, or other factors.*

All states also have laws that require state-licensed health insuring organizations selling health coverage to offer or include coverage for certain benefits or services (known as “mandated benefits”), including items such as mental health services, substance abuse treatment, and breast reconstruction following mastectomy. The number and type of these mandates varies considerably across states. Federal law also includes certain mandated benefits, as discussed under HIPAA below.

State standards also address the ability of state-licensed health insuring organizations to offer restricted coverage to people with preexisting health problems. As discussed above, health coverage providers generally exclude benefits for a defined period of time for treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage. States set standards for how these limitations can be structured, and generally limit the application of such exclusions under group policies when people are switching from one health coverage to another (often called "portability" protection). Federal law also ensures this type of portability, as discussed under HIPAA below.

Premiums

> ***Loss ratio**: This is the ratio of benefits paid to premiums. Loss ratios can be calculated for a particular policy form, for a line of business (e.g., small group health insurance), or a health insuring organization's overall business. Minimum loss ratios for established by law or regulation typically apply to a policy form.*

State standards for premiums address the cost of insurance to consumers, both initially and when coverage is renewed. The degree of regulation varies by type of purchaser and by state. For health coverage offered directly to individuals, many states establish minimum loss ratios (the percentage of premium that must be paid out in claims rather than for administrative costs or profits) and also reserve the right to review or approve the rates submitted by state-licensed health insuring organizations.[vi] State standards generally require that rate variations (e.g., variations due to age, gender, location) be actuarially fair (meaning that they are based on true variations in health costs). Some states further limit the rights of insurers to vary premiums for individual policyholders by age or health status (often referred to as "rate band" or "community rating"). Health coverage sold to small employers also is regulated, but the regulation tends to focus more on limiting the extent to which the rates offered to a small employer can reflect the claims experience or health status of workers in the group.

> ***Rate bands**: These are laws that restrict the difference between the lowest and highest premium that a health insuring organization may charge for the same coverage. For example, a rate band may specify that the highest rate a health insuring organization may charge for a policy may be not more than 150 percent of the lowest rate charged for the same policy. The rate bands may limit all factors by which rates vary (e.g., age, gender), or may apply only to specified factors, such as health status or claims experience.*
>
> ***Community rating**: This is a rating method under which all policyholders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums for coverage based on specified demographic characteristics (e.g., age, gender, location) but cannot vary premiums based on the health status or claims history of policyholders.*

Renewability

Health coverage is generally provided for a limited period (typically one year), and state requirements address the extent to which a purchaser has a right to renew the policy for another year without being reevaluated for coverage. Federal law also is important in this area, and is discussed under HIPAA, below.

> ***Guaranteed renewability**: This is a provision of an insurance policy or law which guarantees a policyholder the right to renew their policy when the term of coverage expires. The health insuring organization generally is permitted to change the premium rates at renewal.*

State standards also address the ability of individuals covered under group policies to continue coverage if the group policyholder cancels the coverage or the person is no longer part of the group. Standards in some states permit these people to continue coverage or to convert to individual insurance in some instances. The requirements for terms of coverage and rates vary substantially across states. Federal law (often referred to as "COBRA" continuation) provides similar protection to individuals with employer-sponsored coverage, as discussed under ERISA, below.

HMOs, Managed Care, and Network Arrangements

States for many years have had separate standards for HMOs, recognizing their dual roles as providers and insurers of health care. State HMO standards, in addition to addressing typical insurance topics such as finances, claims administration, policy forms, and minimum benefits, also establish standards that affect HMOs as entities that directly deliver health care and closely manage the health care use of those they insure. Such state standards include requirements relating to the establishment of utilization review and quality assurance programs, the establishment of enrollee grievance processes, and the contents of contracts with participating health care providers.

As the use of managed care has proliferated among non-HMO state-licensed health insuring organizations (e.g., insurers offering PPO-type coverage), and as managed care practices have become more controversial with the general public, states have extended HMO-type standards to other entities offering managed care and have generally increased their regulatory scrutiny in this area. Standards relating to network adequacy (e.g., the number, location, and types of physicians), utilization review practices, credentialing of participating health care providers, and quality assessment and improvement have recently been adopted in a number of states.

Complaints, Remedies, and Appeals

States also have laws and regulations that assist people who do not receive the benefits that they believe are covered under their health plans. States receive consumer complaints, and in some cases are able to act as intermediaries to resolve specific conflicts between consumers and health coverage providers. The receipt of a

large number of complaints about a particular health coverage provider also may alert regulators to more pervasive market conduct abuses and trigger a broader review of marketing or claims practices.

State law also generally permits people who feel aggrieved by a state-licensed health coverage provider to seek redress through a lawsuit. Such suits may be brought under the contract for coverage, tort, or in some cases under special state insurance laws (such as unfair claims practices laws). For example, HMOs and other managed care arrangements may be sued under state medical malpractice laws if their delivery of health care does not meet ordinary standards of care. Under state law, a person covered by a health insurance policy also generally can sue the insurer if benefits are not delivered as promised and the failure to deliver the benefits was negligent and the proximate cause of the person's injury. In some cases where the aggrieved person is covered under an employee benefit plan, however, ERISA preempts the person's right to bring certain types of lawsuits. This interaction between state and federal law is discussed in more detail under ERISA, below.

In the last few years, most states have adopted standards that provide for an independent, external party to review certain benefit decisions made by state-licensed health coverage providers. For example, these states permit a covered person to appeal a decision by a health coverage provider that denies a benefit because it was not medically necessary or because it was experimental. The types of claims that are subject to review, who the reviewers are, and the procedures for requesting a review vary substantially across the states. There also is a question as to whether ERISA preempts state external appeal laws as they apply to benefit decisions for people covered under an employee benefit plan (as discussed under ERISA, below).

Federal Laws Governing Health Insurance

Although the business of insurance is primarily regulated by the states, a number of federal laws contain requirements that apply to private health coverage, including ERISA, HIPAA, the Americans with Disabilities Act, the Internal Revenue Code, the Civil Rights Act, the Social Security Act (relating to private coverage that supplements Medicare), and the Gramm-Leach-Bliley Act (relating to financial services and bank holding companies). The discussion below focuses on two of these laws, ERISA and HIPAA, because of the significant impact that they have on the structure of private health coverage. Other Federal laws that affect private health coverage are then discussed.

ERISA (Employee Retirement Income Security Act)

ERISA[vii] was enacted in 1974 to protect workers from the loss of benefits provided through the workplace. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization (such as a labor union), or both (referred to here generally as "plan

sponsors"). Employee benefit plans that provide medical benefits (and other non-pension benefits) are referred to as "employee welfare benefit plans."

ERISA does not require employers or other plan sponsors to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan when a plan is established. Thus, employers remain essentially free to decide if they want to offer health benefits at all and, if so, what level of benefits and the amount of coverage they will provide.

The important requirements for employee welfare benefit plans include:

Written document. ERISA requires that an employee benefit plan be established and maintained pursuant to a written document, which must provide for at least one "named fiduciary" who has authority to manage and administer the plan.

> ***Fiduciary**: This generally refers to a person who manages funds or benefits for another. A fiduciary acts in a position of trust and generally is required to act in the best interests of the beneficiary. Under ERISA, a fiduciary is a person who exercises discretion or control in the management of an employee benefit plan or in the management or disposition of the assets of an employee benefit plan.*

Disclosure requirements. ERISA requires the administrator of an employee welfare benefit plan to provide a summary plan description (SPD) to people covered under the plan (called participants and beneficiaries). The SPD must clearly inform participants and beneficiaries of their benefits and obligations under the plan and of their rights under ERISA. The SPD must include information about how to file a claim for benefits and how a denial of a claim can be appealed.

Reporting requirements. ERISA requires administrators of certain employee benefit plans to file annual reports describing the operations of the plan. Reports are filed with the Internal Revenue Service, which forwards the information to the Department of Labor. Certain types of employee welfare benefits plans (e.g., those with fewer than 100 participants and are self-funded, fully insured, or both) are not required to file a report.

Fiduciary requirements. ERISA establishes standards of fair dealing for "fiduciaries" who exercise discretion or control in the management of an employee benefit plan or in the management or disposition of the assets of an employee benefit plan. ERISA fiduciaries may be corporate entities or individuals and may include, for example, plan trustees, plan administrators, or members of a plan's investment committee. ERISA requires that employee benefit plans have at least one "named fiduciary" who is responsible for

administration and operation of the plan. The plan documents may designate additional fiduciaries.

ERISA requires plan fiduciaries to carry out their responsibilities "solely in the interest of (plan) participants and beneficiaries and for the exclusive purpose of providing benefits . . . and defraying reasonable expenses of administering the plan."[viii] ERISA also requires plan fiduciaries to act with the same skill, care, prudence, and diligence that a prudent person would use in like circumstances, and to carry out their responsibilities in accord with the lawful provisions of the plan documents.

Claims for benefits. ERISA requires employee benefit plans to maintain procedures for claiming benefits under the plan and to inform participants and beneficiaries of the procedures. Employee benefit plans must also have a procedure permitting participants and beneficiaries to appeal a denial of benefits to a fiduciary. Department of Labor regulations made substantial changes to requirements for these procedures, including minimum standards for claims procedures, processes for appeal of denied claims, timeframes for plans to make decisions on claims for benefits and on appeals of denials of claims, and greater disclosure of information by insurers to claimants, effective for plan years after July 2002.[ix]

Remedies and enforcement. ERISA contains civil enforcement provisions that permit participants and beneficiaries to bring actions to obtain benefits due to them under an employee benefit plan, for redress of fiduciary breaches, to stop practices that violate ERISA or the provisions of the employee benefit plan, or for other appropriate equitable relief. Courts may award reasonable costs and attorney fees to participants and beneficiaries who prevail. ERISA does not, however, provide a remedy to recover economic or non-economic (e.g., pain and suffering) damages that may result from improper claims denials, fiduciary breaches, or other improper acts. ERISA also contains other civil and criminal penalties for violations of its provisions.

Continuation coverage. As amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), ERISA requires plan sponsors that employ 20 or more employees to offer continuation coverage to qualified beneficiaries (including dependents) who lose health coverage under an employee benefit plan for certain specified reasons (e.g., death of an employee, termination of employment, divorce, or legal separation). ERISA requires the plan sponsor to notify individuals of their right to continuation coverage and addresses the benefits that must be offered, the period that qualifying individuals are eligible for continuation coverage, and premium that they must pay.

ERISA Interaction With State Law

How ERISA interacts with state law is quite complex and has generated numerous court cases which, in the absence of clarifying federal legislation, have determined whether federal or state law pertains to employee benefit plans. As a general matter, ERISA preempts state laws that would regulate the operation of employee benefit plans, affecting several aspects of the regulation of these plans.

ERISA contains an express provision that preempts state laws that "relate to" an employee benefit plan.[x] In applying the term "relates to," courts have looked to whether the state law in question has a "connection with or reference to" an employee benefit plan.[xi] [3] For example, state laws that prohibited garnishment of benefits provided under an employee benefit plan or that required employers to maintain existing health coverage for employees who are eligible for workers compensation benefits have been found to be preempted by ERISA.[xii] State laws of general applicability, however, are not preempted merely because they impose some burdens on an ERISA plan. For example, a state law that imposes a surcharge on hospitals bills was found not to be preempted as applied to hospitals owned by an employee benefit plan.[xiii]

The ERISA preemption provision has an exception that saves from preemption those state laws that regulate insurance. This "saving" provision permits states to continue to apply their insurance laws to insurers, including state-licensed health insuring organizations, even when they provide coverage to or under an employee benefit plan. State insurance laws can be saved because, in the case of plans that buy insurance as opposed to self funding, the state laws regulate the insurance products sold to the ERISA plans, rather than the plans themselves.

The saving clause thus allows states to set standards for ERISA-governed employer-sponsored health benefits in those situations in which employers buy health insurance rather than buying just the administrative services of a health benefits services company for their self-funded plans. For example, state laws that mandate the inclusion of certain benefits in health insurance contracts are saved from preemption, even though application of the law affects the benefits provided under an employee benefit plan.[xiv] Similarly, a state insurance law that prohibits insurers from automatically denying a claim for benefits because it is not filed in a timely manner is saved from preemption because the law regulates insurance, even though the application of the law affects the administration of an employee benefit plan.[xv] A state law requiring managed care plans to permit all willing providers to participate in their networks is saved from preemption by applying the standards of whether the state law is specifically directed toward the insurance industry and whether is substantially affect the risk-pooling

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[3] The U.S. Supreme Court expressed concern about the unhelpful nature of the preemption language in ERISA, and has stated that in looking at whether a state law is preempted it "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurer. Co.,* 514 U.S. 645, 656 (1995).

arrangement between the insurer and the insured.[xvi] State laws that simply apply to insurers, however, but which do not primarily regulate the business of insurance, are not saved from preemption.

Although the ERISA preemption provision saves state laws that regulate insurance, ERISA prohibits states from "deeming" employee benefit plans to be insurers. This provision prohibits states from treating employee benefit plans (i.e., self-funded employee plans) as insurers and attempting to regulate them directly under their insurance laws.[xvii]

As a practical matter under ERISA, states can continue to regulate the insurance activities of state-licensed health insuring organizations that provide health coverage to an employee benefit plan established by an employer or other plan sponsor. States generally cannot, however, regulate the content or activities of self-funded employee benefit plans. States also cannot indirectly regulate the practices of employee benefit plans by trying to regulate how third parties, including state-licensed health insuring organizations, provide administrative services to self-funded employee benefit plans. As an example, states can require insurance companies and HMOs to include coverage for specified benefits (e.g., mental health services) in the policies they sell. Any employer or individual purchasing insurance coverage would therefore have to purchase a policy that included those benefits. States cannot, however, require self-funded employer plans to offer any specified benefits.

Another area of ERISA preemption involves the civil remedies available to participants and beneficiaries relating to a claim for benefits. As discussed above, ERISA provides a limited set of civil remedies to participants and beneficiaries. The courts have determined that these remedies are the exclusive remedies available to participants and beneficiaries to contest a denial of benefits under an employee benefit plan. State laws that provide for causes of action against the administrator or another fiduciary of an employee benefit plan (e.g., for breach of contract or tort) are preempted if they could have been brought under the civil enforcement provisions of ERISA.[xviii] The Supreme Court has determined that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."[xix] [xx]

HIPAA (Health Insurance Portability and Accountability Act)

A second federal law that established important regulatory requirements for private health coverage is HIPAA, enacted in 1996. HIPAA was motivated by concern that people face lapses in coverage when they change or lose their jobs. As discussed above, health coverage providers often exclude benefits for preexisting health conditions for new enrollees. HIPAA also addressed other concerns of federal policymakers about private health coverage.

HIPAA and related standards address several areas, including: portability, access to coverage, renewability, nondiscrimination, and mandated benefits. The standards established by HIPAA vary by market segment (e.g., large group, small group, or individual coverage) and by type of coverage provider. HIPAA creates separate but similar standards for state-licensed health insuring organizations and employee welfare benefit (i.e., ERISA) plans. Generally, the provisions applicable to employee welfare benefit plans and plan sponsors are incorporated into ERISA and into the Internal Revenue Code, and the provisions applicable to state-licensed health insuring organizations are incorporated into the Public Health Service Act. In addition, the HIPAA standards that create individual rights (e.g., portability) and that are applicable to state-licensed health insuring organizations providing health coverage to employee benefit plans also are incorporated into ERISA and the Internal Revenue Code. Three federal agencies – the U.S. Departments of Labor, Health and Human Services, and Treasury -- coordinate rulemaking under HIPAA.[xxi]

Preexisting condition exclusions and portability. As discussed above, some private health coverage excludes benefits for treatment of preexisting medical conditions for defined period of time after initial enrollment. HIPAA requires state-licensed health insuring organizations providing group coverage and employee welfare benefit plans providing health benefits to limit preexisting condition exclusion periods to no more than 12 months (18 months for late enrollees unless they enroll under special circumstances). The preexisting condition exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before the enrollment date. For eligible individuals leaving group coverage for another group plan, any preexisting condition exclusion period must be reduced by the number of days that a newly enrolling person was previously covered by public or private health coverage; the time between lapse of the previous coverage and enrollment in the new coverage must be shorter than 63 days.

Access to coverage. HIPAA requires state-licensed health insuring organizations to make all of their small group products available to any qualifying small employer that applies, regardless of their claims experience or of the health status of their employees. Under HIPAA, a small employer is defined as having 2 to 50 employees. HIPAA does not have standards for the premium that can be charged to small employers seeking coverage, although, as discussed above, most states have laws that limit rate variation in the small group market.

HIPAA also requires state-licensed health insuring organizations to accept certain people leaving group health coverage for coverage in the individual market regardless of their health status and without any exclusion period for preexisting medical conditions. To be eligible, the person must not be eligible for other public or private group health coverage, must have been previously covered for a period of at least 18 months, must apply for the individual coverage within 63 days of leaving the group coverage, and must have exhausted any federal or state continuation rights under their group policy. States are provided substantial

flexibility in determining the mechanism for making coverage available to eligible people. For example, in most states, eligible people are guaranteed access to coverage in the state's high-risk pool; private insurers are not required to sell coverage to them. HIPAA generally does not regulate the premiums that people can be charged for the coverage that is offered under HIPAA.[xxii]

Renewability. HIPAA requires state-licensed health insuring organizations and certain employee benefit plans that provide benefits to multiple employers to guarantee that the coverage can be renewed at the end of the period of coverage. This protection generally means that group (either small or large) or individual coverage cannot be terminated by the health coverage provider except in cases such as nonpayment of premium and fraud. HIPAA, however, does not have standards for the premiums that may be charged at renewal.

Nondiscrimination. HIPAA prohibits state-licensed health insuring organizations providing group coverage and employee welfare benefit plans providing health benefits from considering the health status of a member of the group in determining the member's eligibility for coverage, premium contribution, or cost-sharing requirements. Final 2006 rules clarified the exception for wellness programs (programs of health promotion or disease prevention), specifying the circumstances under which wellness programs can discriminate based on health status-related factors.[xxiii] A more recent clarification provided that supplemental coverage (including benefits under a wellness program, such as a reduced premium for nonsmokers) cannot discriminate on the basis of health factors unless specified criteria are met.[xxiv]

HIPAA was structured in a way that reasonably clearly delineates the state and federal roles in enforcing its standards. As described above, HIPAA standards applicable to employee welfare benefit plans and plan sponsors are incorporated into ERISA and the Internal Revenue Code, and are enforced by the U.S. Departments of Labor and Treasury. Standards applicable to state-licensed health insuring organizations generally are incorporated into the Public Health Services Act, and are under the jurisdiction of the U.S. Department of Health and Human Services (DHHS).[4] HIPAA provides however, that if a state's law establishes standards for state-licensed health insuring organizations that are at least as stringent as the HIPAA standard, the state is the primary enforcer of the standard, with DHHS having authority to enforce the standard if the state does not. Where a state's laws do not contain a standard at least as stringent as the HIPAA standard, enforcement falls to DHHS.

[4] As discussed above, standards for some HIPAA provisions applicable to state-licensed health insuring organizations providing coverage to employee benefit plans also are incorporated in ERISA, and individuals may bring actions under ERISA to enforce those standards.

Although HIPAA establishes generally clear federal and state enforcement responsibilities, in practice there have been some difficulties. The test for when a state assumes enforcement responsibility is conducted separately for each different standard under HIPAA, which can lead to a patchwork of federal and state enforcement responsibilities.[xxv] This is most problematic for federally-mandated benefits.

Other Federal Laws That Affect Private Health Coverage

Other federal laws require health coverage providers to cover certain benefits as part of their benefit arrangements. Although enacted separately from HIPAA, the following benefit requirements are incorporated into the same legal framework as the HIPAA standards, and include the following: (1) the Women's Health and Cancer Rights Act requires group health coverage providers that provide coverage for mastectomies to also cover breast reconstruction surgery following a mastectomy;[xxvi] (2) the Newborns' and Mothers' Health Protection Act prohibits group health coverage providers from restricting hospital stays following childbirth to less than 48 hours (or 96 hours following delivery by cesarean section),[xxvii] and (3) the Mental Health Parity Act restricts the ability of group health plans sponsored by employers with more than 50 employees to impose annual and lifetime dollar limits for mental health benefits that are more stringent than for medical and surgical benefits.[xxviii] The Pregnancy Discrimination Act amends the Civil Rights Act to require that any health insurance an employer provides must cover expenses for pregnancy-related conditions on the same basis as costs for other medical conditions.[xxix] The Americans with Disabilities Act also amends the Civil Rights Act to prohibit discrimination solely on the basis of disability; employers are prohibited from such discrimination in many job-related aspects including employee compensation; however, the Act's requirements for insurers and their insurance products are less clear, allowing insurers to classify, underwrite, or administer health risks based on sound actuarial principles or experience.[xxx]

4. Conclusion

Health coverage is subject to significant requirements at both the state and federal level. While new laws and regulations have created important protections for consumers, they have also produced overlapping and sometimes duplicative or conflicting state and federal rules.

Continued interest by policymakers in expanding access to health care and to health care coverage may lead policymakers to revisit current regulatory standards. For example, proposals to provide federal tax credits for people purchasing individual health insurance are likely to prompt discussion of how to permit people in poorer health to have access to private individual coverage so that they can make use of the tax credit. As some state policymakers have discovered in addressing this issue, it will be a challenge to find ways to expand access to those in poorer health without undermining the stability of risk pools in this market.

As federal policy issues increasingly focus on regulation or expanded use of the private health insurance market, there will be greater need for policymakers to understand how this market functions and how state and federal rules interact.

This primer was written by Gary Claxton and updated by Janet Lundy of the Kaiser Family Foundation's Health Care Marketplace Project.

Endnotes

[i] Kaiser Family Foundation, *The Uninsured—A Primer*, October 2007, Table 3, p. 32, *http://www.kff.org/uninsured/upload/7451-03.pdf*.
[ii] Ibid.
[iii] National Association of Insurance Commissioners, "Departmental Regulation of HMOs" in *Compendium of State Laws on Insurance Topics*, 2000.
[iv] 15 U.S.C. 1011-1015.
[v] National Association of Insurance Commissioners, "Filing Requirements Health Insurance Laws Forms and Rates" in *Compendium of State Laws on Insurance Topics*, 2000.
[vi] Ibid.
[vii] 29 U.S.C. 1001 *et seq.*
[viii] 29 U.S.C. 1104(a).
[ix] 29 C.F.R. 2560.503-1 (also see *Federal Register*, Vol. 65, No. 225, November 21, 2000, pp. 70246-70271, and *Federal Register*, Vol. 66, No. 131, July 9, 2001, pp. 35886-35888).
[x] 29 U.S.C. 1144.
[xi] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983).
[xii] District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125 (1992).
[xiii] De Buono v. NYSA-ILA Medical and Clinical Services Fund, 520 U.S. 806 (1997).
[xiv] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).
[xv] Unum Life Insurer. Co. of Am. V. Ward, 526 U.S. 358 (1999).
[xvi] Kentucky Assn. of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003).
[xvii] Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1984).
[xviii] Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).
[xix] Cicio v. Does, 385 F.3d 156 (2004), at 158, quoting Aetna Health Inc. v. Davila, 542 U.S. 200 (2004).
[xx] The Supreme Court has determined that state insurance laws that allow participants in insured plans to appeal to external review bodies to get an independent opinion regarding a claim that was denied are considered not to create additional remedies beyond those allowed by ERISA and therefore are not preempted by ERISA (Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002). Participants seeking such independent reviews would still have rely on the remedies under ERISA if a plan did not comply with a reviewer's external review determination.
[xxi] The HIPAA provisions incorporated into ERISA may be found at 29 U.S.C. 1181 et seq.; the provisions incorporated into the Internal Revenue Code may be found at 26 U.S.C. 9801 et seq.; the provisions incorporated into the Public Health Service (PHS) Act may be found at 42 U.S.C. 300gg et seq. Regulations issued by the Departments of Labor, the Treasury, and Health and Human Services on group market provisions are contained in 29 C.F.R Part 2590, 26 C.F.R Part 54, and 45 C.F.R Parts 144 and 146; reforms provided in the PHS Act for the individual market are contained in 45 C.F.R Parts 144 and 148. For the most recent regulations on portability, see *Federal Register*, Vol. 69, No. 250 (December 30, 2004), 78720-78799, *http://www.dol.gov/ebsa/regs/fedreg/final/2004028112.pdf*; for the most recent rules on nondiscrimination and wellness programs, see *Federal Register*, Vol. 71, No. 239 (December 13, 2006), 75014-75055, *http://www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf*.
[xxii] General Accounting Office, *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, and Regulators,* GAO/HEHS-98-67 (February 1998) and *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100 (May 1999)10-16.
[xxiii] *Federal Register*, Vol. 71, No. 239 (December 13, 2006), 75014-75055, *http://www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf*.
[xxiv] U.S. Department of Labor, Employee Benefits Security Administration, Field Assistance Bulletin No. 2007-04, "Supplemental Health Insurance Coverage as Excepted Benefits Under HIPAA and Related Legislation," (December 7, 2007), *http://www.dol.gov/ebsa/pdf/fab2007-4.pdf*.
[xxv] *See* General Accounting Office, *Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States,* GAO/HEHS-00-85 (March 2000) and *Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve*, GAO-01-652R (May 7, 2001.
[xxvi] The Women's Health and Cancer Rights Act of 1998 (Title IX of P.L. 105-277).
[xxvii] The Newborns' and Mothers' Health Protection Act of 1996 (Title VI of P.L. 104-204).
[xxviii] The Mental Health Parity Act of 1996 (Title VII of P.L. 104-204, most recently extended by P.L. 109-432).
[xxix] The Pregnancy Discrimination Act of 1978 (P.L. 95-555).
[xxx] The Americans with Disabilities Act of 1990 (P.L. 101-336). See J. Mathis, Bazelon Center for Mental Health Law, "The ADA's Application to Insurance Coverage," June 2004, *http://uacf4hope.org/index2.php?option=com_content&do_pdf=1&id=257*.

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INSURANCE CODE
SECTION 10900-10902.6

10900. As used in this chapter:
(a) "Benefit plan design" means a specific health coverage policy issued by a carrier to individuals, to trustees of associations that cover individuals. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health services that has significant incentives for the covered individuals to use the system.
(b) "Carrier" means any disability insurance company or any other entity that writes, issues, or administers health benefit plans, as defined in subdivision (a) of Section 10198.6, that cover individuals, regardless of the situs of the contract or master policyholder.
(c) "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, Champus supplement, 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)(l) of the Public Health Service Act, as amended by Public Law 104-191.
(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504(e)).
(d) "Dependent" means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health benefit plan covering the eligible person.
(e) "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 an employer-sponsored health benefit 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 such coverage.
(f) "In force business" means an existing health benefit plan issued by a carrier to a federally eligible defined individual.
(g) "New business" means a health benefit plan issued to an eligible individual that is not the carrier's in force business.
(h) "Preexisting condition provision" means a policy 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, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

Federal 63 day limit 300 gg c 2 a

10901. Every carrier offering health benefit plans to individuals shall comply with the provisions of this chapter and the rules adopted thereunder.

10901.1. Nothing in this chapter 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, (b) an association, trust, multiple employer welfare arrangement, or other organization or person presenting information regarding a health benefit plan to persons who may be interested in subscribing or enrolling in the plan.

10901.2. (a) Commencing January 1, 2001, a carrier shall fairly and affirmatively offer, market, and sell the health benefit plan designs described in subdivision (d) of Section 10785 that are sold to individuals or to associations that include individuals to all federally eligible defined individuals in each geographic region in which the carrier provides coverage for health care services. Each carrier shall make available to each federally eligible defined individual the identified health benefit plan designs which the plan offers and sells to individuals or to associations that include individuals.

(b) A carrier may not reject an application from a federally eligible defined individual for a benefit plan design under the following circumstances:

(1) The federally eligible defined individual as defined by subdivision (e) of Section 10900 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 carrier, work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

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

(d) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to a solicitor for the sale of a health benefit plan design 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. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary for the reasons listed in this subdivision.

(e) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to individuals in this state, the third-party administrator shall be subject to this chapter.

10901.3. (a) (1) After the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the following amounts:

(A) For health benefit plans 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 qualified individuals who are between the ages of 60 and 64, 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 benefit plans identified in subdivision (d) of Section 10785 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 qualified individuals who are between the ages of 60 and 64, 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 carrier may adjust the premium based on family size, not to exceed the following amounts:

(A) For health benefit 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 benefit plans identified in subdivision (d) of Section 10785 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.
(b) 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.
(c) During the first 30 days after the effective date of the health benefit plan, the individual shall have the option of changing coverage to a different health benefit plan design offered by the same carrier. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new health benefit plan shall become effective no later than the first day of the following month. If an enrolled individual notified the carrier of the change after the 15th day of a month, coverage under the health benefit plan shall become effective no later than the first day of the second month following notification.

10901.4. A carrier 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 health benefit plan 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.

10901.7. (a) The commissioner may require a carrier to discontinue the offering of health benefit plans or the acceptance of applications from any individual upon a determination by the commissioner that the plan carrier does not have sufficient financial viability, organization, and administrative capacity to assure the delivery of health care services to its enrollees.
(b) The commissioner's determination shall follow an evaluation that includes a certification by the commissioner that the acceptance of an application or applications would place the carrier in a financially impaired condition.
(c) A carrier that has not offered coverage or accepted applications pursuant to this chapter shall not offer coverage or accept applications for any individual until the commissioner has determined that the carrier has ceased to be financially impaired.

10901.8. All health benefit plans offered to a federally eligible defined individual shall be renewable with respect to the individual and dependents at the option of the enrolled individual except in cases of:
(a) Nonpayment of the required premiums.
(b) Fraud or misrepresentation by the enrolled individual.
(c) The carrier ceases to provide or arrange for the provision of health care services for individual health benefit 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 commissioner and to the contractholder.
(2) Individual health benefit 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 carrier that remains in force, any carrier that ceases to offer for sale new individual health benefit plan contracts shall continue to be governed by this article with respect to business conducted under this chapter.
(3) A carrier that ceases to write new individual business in this state after the effective date of this chapter shall be prohibited from offering for sale new individual health benefit plan contracts in this state for a period of three years from the date of the notice to the commissioner.
(d) When a carrier withdraws a health benefit plan design from the individual market, provided that a carrier makes available to eligible individuals all health plan benefit designs that it makes available to new individual business, and provided that premium for the new health benefit plan complies with the renewal increase requirements set forth in Section 10901.9.

10901.9. Commencing January 1, 2001, premiums for health benefit plans offered, delivered, amended, or renewed by carriers 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:

(1) For health benefit plans identified in subdivision (d) of Section 10785 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 qualified individuals who are between the ages of 60 to 64, 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.

(2) For health benefit plans identified in subdivision (d) of Section 10785 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 qualified individuals who are between the ages of 60 to 64, 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:

(1) For health benefit plans identified in subdivision (d) of Section 10785 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 qualified individuals who are between the ages of 60 and 64, 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.

(2) For health benefit plans identified in subdivision (d) of Section 10785 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 qualified individuals who are between the ages of 60 and 64, 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.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 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 benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(2) For a contract that a carrier 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.

10902. Carriers shall apply premiums consistently with respect to all federally eligible defined individuals who apply for coverage.

10902.1. In connection with the offering for sale of any health benefit plan designed to an individual, each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all individual contracts.

10902.2. Nothing in this chapter shall be construed to require a health benefit plan to offer a contract to an individual if the carrier does not otherwise offer contracts to individuals.

10902.3. (a) At least 20 business days prior to renewing or amending a health benefit plan contract subject to this chapter, or at least 20 business days prior to the initial offering of a health benefit plan subject to this chapter, a carrier shall file a statement with the commissioner in the same manner as required for small employers as outlined in Section 10717. The statement shall include a statement certifying that the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. Any action by the commissioner, as permitted under Section 10717, to

disapprove, suspend, or postpone the plan's use of a carrier's health benefit plan design shall be in writing, specifying the reasons the health benefit plan does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the carrier shall file an amendment in the same manner as required for small employers as outlined in Section 10717, and shall include a statement certifying the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. All other changes to a health benefit plan previously filed with the commissioner pursuant to subdivision (a) shall be filed as an amendment in the same manner as required for small employers as outlined in Section 10717.

10902.4. Carriers and health care service plans that offer contracts to individuals may elect to establish a mechanism or method to share in the financing of high-risk individuals. This mechanism or method shall be established through a committee of all carriers and health care service plans offering coverage to individuals by July 1, 2002, and shall be implemented by January 1, 2003. If carriers and health care service plans wish to establish a risk-sharing mechanism but cannot agree on the terms and conditions of such an agreement, the Managed Risk Medical Insurance Board shall develop a risk-sharing mechanism or method by January 1, 2003, and it shall be implemented by July 1, 2003.

10902.5. The commissioner may issue regulations that are necessary to carry out the purposes of this chapter. Any rules and regulations adopted pursuant to this chapter 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 commissioner.

10902.6. This chapter shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

INSURANCE CODE
SECTION 10785

10785. (a) A disability insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan as defined in subdivision (a) of Section 10198.6 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 disability insurer that covers hospital, medical, or surgical expenses 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 disability insurer shall offer the following health benefit plans 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 insurer in compliance with federal law. An insurer that offers only one health benefit plan to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this chapter if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this chapter.

(e) (1) In the case of a disability insurer that offers health benefit plans in the individual market through a network plan, the insurer 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 covered by the health benefit plan, deny coverage to individuals if the insurer has demonstrated to the commissioner that the insured will not have the capacity to deliver services adequately to additional individual insureds because of its obligations to existing group policyholders, group contractholders and insureds, and individual insureds, and that the insurer 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 disability insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer health benefit plans through a network in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A disability insurer may deny health insurance coverage in the individual market to a federally eligible defined individual if the insurer has demonstrated to the commissioner both of the following:

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

(B) The insurer 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 disability insurer, 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 insurer has demonstrated to the commissioner that the insurer 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 benefits plans offered by a disability insurer in the individual market in the same manner as it applies to an insurer in connection with a group

health benefit plan policy or group health benefit plan contract.

(h) A disability insurer 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 insurer 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.

(i) Every disability insurer 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 disability insurer 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 policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

§ 300gg. Increased portability through limitation on preexisting condition exclusions

(a) Limitation on preexisting condition exclusion period; crediting for periods of previous coverage

Subject to subsection (d) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1) of this section) applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term "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 for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1) of this section in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f) of this section.

(4) Waiting period

The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this subchapter, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C. 1395c et seq., 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C. 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C. 1396s].

(E) Chapter 55 of title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504 (e) of title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg–91 (c) of this title).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4) of this section, any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2) of this section) shall not be taken into account in determining the continuous period under subparagraph (A).

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group health insurance, may elect to apply subsection (a)(3) of this section based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) Issuer notice

In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer—

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) of this section or in such other manner as may be specified in regulations.

(d) Exceptions

(1) Exclusion not applicable to certain newborns

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy

A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage

(1) Requirement for certification of period of creditable coverage

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits

In the case of an election described in subsection (c)(3)(B) of this section by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods

(1) Individuals losing other coverage

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph

(C)(ii).

(2) For dependent beneficiaries

(A) In general

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion

(1) In general

A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) "Affiliation period" defined

For purposes of this subchapter, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

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COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 310-519-1335 fax: 310-519-1359

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Steve Shorr Insurance

1027 W. 11th Street # 3

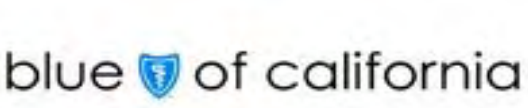
San Pedro, CA 90731

Please make your check payable to: Blue Shield of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 310-519-1335

Thank you for choosing...



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APPLICATION FOR BLUE SHIELD INDIVIDUAL AND FAMILY HEALTH PLANS

Application must be typed or completed in blue or black ink. Please make sure you answer all questions as completely and accurately as possible and initial any changes/corrections you may have to make. Fully completing the application will help avoid a delay in processing or possible return of the application. Submit ALL pages, 1 through 12, as your complete application. Call Blue Shield at (800) 431-2809 or contact your agent for help filling out the application or for the address of where to send the application.

MARKET CODE (PRODUCER USE ONLY)

REASON FOR APPLICATION ☐ New enrollment ☐ Plan Transfer ☐ Add family member to existing coverage

PART 1 – APPLICANT INFORMATION: Indicating the younger spouse/domestic partner as the primary applicant may reduce your monthly dues/payments.

Applicant's Social Security Number	First name	MI
___ ___ ___ - ___ ___ - ___ ___ ___ ___	Last name	

☐ Male ☐ Female	Married: ☐ Yes ☐ No Domestic Partner: ☐ Yes ☐ No	Date of Birth (Mo/Day/Yr) _____/_____/_____	Height (ft. in.)	Weight (lbs.)

Choose health plan (check one box only):

Shield Spectrum PPOs	Vital Shield*	Shield Savings	Active Start plans*
☐ 5000* ☐ 5500	☐ 900 ☐ 2900	☐ 1800/3600*	☐ 25
Access+ ☐ HMO ☐ e HMO	Vital Shield Plus*	☐ 3500*	☐ 25 Generic Rx
Balance plans* ☐ 1000 ☐ 1700 ☐ 2500	☐ 400 ☐ 400 Generic Rx	☐ 4000/8000*	☐ 35
Essential plans* ☐ 1750 ☐ 3000 ☐ 4500	☐ 900 ☐ 900 Generic Rx	☐ 5200*	☐ 35 Generic Rx
	☐ 2900 ☐ 2900 Generic Rx		

HMO only (visit blueshieldca.com to find a provider): Personal Physician Name: _____	Provider #: _____	Med.Group/IPA #: _____ ☐ Check if Current Patient

If applying for Guaranteed Issue ONLY, complete Parts 1-3, 8-11 only. See Part 11 for more information on Guaranteed Issue plans.

☐ Please check here if not interested in a Guaranteed Issue plan.

Payment options: ☐ Easy$Pay (complete page 12) ☐ Credit Card (complete page 12) ☐ Monthly Direct Billing ☐ Quarterly Direct Billing

Applicant's business phone # ( )	Applicant's home phone # ( )	Applicant's fax # ( )

Other name(s) under which you've received care	Existing subscriber #

Have you been a resident of California for the past six months? ☐ Yes ☐ No If no, where was your last residence? _____
If no, medical records documenting a complete physical exam by a California physician, within the last six months, may be required.

Home Address (no P.O. Box)		
City	State	ZIP Code
County of residence		
Billing Address (if different from above)		
City	State	ZIP Code
Mailing Address (if different from home address)		
City	State	ZIP Code

Applicant's Occupation	Employer and employer's address	City	State	ZIP Code
Spouse/Domestic Partner's Occupation	Employer and employer's address	City	State	ZIP Code

To help us serve you better in the future, please indicate your language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other:

Please check your preferred method of contact: ☐ Home telephone ☐ Work telephone ☐ E-Mail ☐ Standard mail	Applicant's E-Mail Address
If you have been a Blue Shield member, indicate prior Blue Shield #:	Date cancelled (MO/DAY/YR) _____/_____/_____
Do you want your effective date to coordinate with the termination date of your short-term health insurance? ☐ Yes ☐ No ☐ N/A Short-term health termination date _____/_____/_____	Requested effective date (see Part 10, Item 4 for instructions) _____/_____/_____

*Underwritten by Blue Shield of California Life & Health Insurance Company.

ONE page Pre Application - Underwriting

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Applicant's Social Security Number
____ ____ ____ - ____ ____ - ____ ____ ____ ____

PART 2 – SUPPLEMENTAL PLAN CHOICES

You may also purchase a dental plan and/or life insurance to supplement your medical coverage. **PLEASE NOTE:** Guaranteed Issue plans are not eligible for life insurance coverage options.

Dental plan options (check one): ☐ Dental HMO (DHMO) ☐ Dental PPO (DPPO) ☐ Value Smile PPO ☐ No dental plan
If Dental HMO (visit **blueshieldca.com** to find a dental provider or for questions call (800) 431-2809):
Dental Provider name: ________________________ Dental Provider #: ________________

Life Insurance options* (check one): Applicants under the age of one year are not eligible for life insurance. These options apply only to the primary applicant.
Child applicants can apply for up to a $30,000 Life Insurance option and Spouse/domestic partner can apply for up to a $100,000 Life Insurance option in Part 3 of this application.
☐ $10,000 (ages 1-64) ☐ $30,000 (ages 1-64) ☐ $60,000 (ages 19-64) ☐ $90,000 (ages 19-49) ☐ $100,000 (ages 19-49) ☐ No Life Insurance
Beneficiary information applies only to the primary applicant. If you have not indicated a beneficiary, and the policy is issued, death benefits will be paid in accordance with the policy. The percentage indicated must total 100%.
Beneficiary: ________________ Relationship________ Age______ City/St________________ (%)______
Beneficiary: ________________ Relationship________ Age______ City/St________________ (%)______

Bridge Plan* (hospital insurance indemnity rider) ☐ (available for Shield Savings 3500, 4000/8000, and 5200)

* Underwritten by Blue Shield of California Life & Health Insurance Company.

PART 3 – DEPENDENT INFORMATION – List all family members you wish to cover. Dependent children must be under age 19, or under age 23 if full-time students and not married or in a domestic partnership. Please note: if you consider a separate medical plan for your dependents, your dependents are eligible to select any dental or life insurance plan listed below. Dependents will be considered the primary applicant for each new plan selected.

For HMO only, select a Personal Physician for each family member from the Blue Shield HMO Physician and Hospital Network for your service area. For questions, call **(800) 424-6521**.
For Dental HMO: select a Dental Provider from the Dental HMO Dental Provider Directory. For questions regarding your Dental Provider selection, call **(800) 431-2809**.
Visit **blueshieldca.com** to find a Personal Physician or Dental Provider.

Relation	Sex	First name	MI	Last name	Social Security Number	Date of Birth	Height (ft.in.)	Weight (lbs.)
☐ Spouse ☐ Domestic partner	☐ M ☐ F				__ __ __ - __ __ - __ __ __ __	____/____/____		

HMO plans only: Personal physician name: Provider #: Med.group/IPA #: Check if current patient ☐

Consider my spouse/domestic partner for a separate plan ☐ **Choose plan (check 1 box only):** **Access+:** ☐ Value HMO ☐ HMO **Balance plan:** ☐ 1000 ☐ 1700 ☐ 2500
Essential plan: ☐ 1750 ☐ 3000 ☐ 4500 **Vital Shield:** ☐ 900 ☐ 2900 **Vital Shield Plus:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx
PPO Plan: ☐ 5000 ☐ 5500 **Shield Savings:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Active Start:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx
Bridge Plan: ☐ (available for Shield Savings 3500, 4000, and 5200)
Dental Coverage: ☐ HMO ☐ PPO ☐ Value Smile PPO ☐ No dental plan **Dental HMO only**: Dental provider #: ________ Dental provider name: ________________
Optional Life Insurance: ☐ $10,000 ☐ $30,000 (ages 1–64) ☐ $60,000 (ages 19–64) ☐ $90,000 (ages 19-49) ☐ $100,000 (ages 19-49)
Beneficiary ________________________

Relation	First name	MI	Last name	Social Security Number	Date of Birth	Height (ft.in.)	Weight (lbs.)
☐ Son ☐ Daughter				__ __ __ - __ __ - __ __ __ __	____/____/____		

HMO plans only: Personal physician name: Provider #: Med.group/IPA #: Check if current patient ☐

Consider my child for a separate plan ☐ **Choose plan (check 1 box only):** **Access+:** ☐ Value HMO ☐ HMO **Balance plan:** ☐ 1000 ☐ 1700 ☐ 2500
Essential plan: ☐ 1750 ☐ 3000 ☐ 4500 **Vital Shield:** ☐ 900 ☐ 2900 **Vital Shield Plus:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx
PPO Plan: ☐ 5000 ☐ 5500 **Shield Savings:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Active Start:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx
Bridge Plan: ☐ (available for Shield Savings 3500, 4000, and 5200)
Dental Coverage: ☐ HMO ☐ PPO ☐ Value Smile PPO ☐ No dental plan **Dental HMO only**: Dental provider #: ________ Dental provider name: ________________
Optional Life Insurance: ☐ $10,000 ☐ $30,000 Beneficiary ________________________

Relation	First name	MI	Last name	Social Security Number	Date of Birth	Height (ft.in.)	Weight (lbs.)
☐ Son ☐ Daughter				__ __ __ - __ __ - __ __ __ __	____/____/____		

HMO plans only: Personal physician name: Provider #: Med.group/IPA #: Check if current patient ☐

Consider my child for a separate plan ☐ **Choose plan (check 1 box only):** **Access+:** ☐ Value HMO ☐ HMO **Balance plan:** ☐ 1000 ☐ 1700 ☐ 2500
Essential plan: ☐ 1750 ☐ 3000 ☐ 4500 **Vital Shield:** ☐ 900 ☐ 2900 **Vital Shield Plus:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx
PPO Plan: ☐ 5000 ☐ 5500 **Shield Savings:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Active Start:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx
Bridge Plan: ☐ (available for Shield Savings 3500, 4000, and 5200)
Dental Coverage: ☐ HMO ☐ PPO ☐ Value Smile PPO ☐ No dental plan **Dental HMO only**: Dental provider #: ________ Dental provider name: ________________
Optional Life Insurance: ☐ $10,000 ☐ $30,000 Beneficiary ________________________

Relation	First name	MI	Last name	Social Security Number	Date of Birth	Height (ft.in.)	Weight (lbs.)
☐ Son ☐ Daughter				__ __ __ - __ __ - __ __ __ __	____/____/____		

HMO plans only: Personal physician name: Provider #: Med.group/IPA #: Check if current patient ☐

Consider my child for a separate plan ☐ **Choose plan (check 1 box only):** **Access+:** ☐ Value HMO ☐ HMO **Balance plan:** ☐ 1000 ☐ 1700 ☐ 2500
Essential plan: ☐ 1750 ☐ 3000 ☐ 4500 **Vital Shield:** ☐ 900 ☐ 2900 **Vital Shield Plus:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx
PPO Plan: ☐ 5000 ☐ 5500 **Shield Savings:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Active Start:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx
Bridge Plan: ☐ (available for Shield Savings 3500, 4000, and 5200)
Dental Coverage: ☐ HMO ☐ PPO ☐ Value Smile PPO ☐ No dental plan **Dental HMO only**: Dental provider #: ________ Dental provider name: ________________
Optional Life Insurance: ☐ $10,000 ☐ $30,000 Beneficiary ________________________

Certification for students age 19 or older (must be under age 23). I certify that my dependent listed below is currently enrolled as a full-time student (does not apply to children of legal guardians). If you have more than two dependents age 19 or older who are full-time students, please attach an additional sheet with the required information and check here. ☐

Name	Hours/week	Units	School	Address
Name	Hours/week	Units	School	Address

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Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 4 – MEDICAL HISTORY – Please answer ALL questions. Remember to initial any changes/corrections you may have to make as you complete the questionnaire.

Have you or any applying family member in the past 10 years sought any professional consultation or received any treatment (including prescription medications) from a licensed health practitioner for any of the following?

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 6.	**YES**	**NO**
1. *Brain or nervous system* – such as: migraine headache; seizure disorder; loss of consciousness; epilepsy; paralysis; muscular dystrophy; multiple sclerosis; stroke; cerebral palsy; mental retardation?	☐	☐
2. *Cardiovascular system* – such as: heart or valve problems; coronary artery disease; heart attack; heart murmur; pericarditis; mitral valve prolapse; heart valve regurgitation; rheumatic fever; palpitations; high blood pressure; shortness of breath; chest pains; elevated cholesterol and/or triglycerides?	☐	☐
3. *Circulatory system* – such as: varicose veins; peripheral vascular disease; phlebitis; blood clots; stroke; disease or disorder of the blood (except HIV infection); anemia; enlarged lymph nodes?	☐	☐
4. *Respiratory tract* – such as: asthma; reactive airway disease; bronchitis; allergies; sinusitis; disease, disorder or injury of the lungs or respiratory system; emphysema; tuberculosis; spitting or coughing up blood; shortness of breath; pneumonia; cystic fibrosis; pulmonary fibrosis; chronic obstructive pulmonary disease; sleep apnea? **If asthma or allergies (circle frequency): daily, weekly, monthly, seasonal Severity (circle one): mild, moderate, severe, other**	☐	☐
5. A. *Musculo-skeletal system* – such as: pain, injury, sprain, or other problems of the neck, spine, or back; sciatica; herniated or bulging disc(s); curvature of the spine; scoliosis; pain, injury, or other problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis; temporo-mandibular joint syndrome (TMJ); Lyme disease; broken bones or retained hardware; dislocation of joints; bunions; hammertoe; carpal tunnel syndrome; physically handicapped; polio; amputations? **B. If any chiropractic treatment has been received, please explain reason for treatment:** _____ **Number of chiropractic treatments within the past 6 months:** _____	☐	☐
6. *Metabolic system* – such as: diabetes; gout; thyroid or adrenal disorders; hormone or growth hormone deficiencies; immune system disorders (except HIV infection) such as: lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), treatment for AIDS/ARC with AZT, HIVID or Pentamidine therapy?	☐	☐
7. *Cancer (malignancy)* – such as: leukemia; Hodgkin's; malignant melanoma; tumor/cyst; lymphoma? **Type:** _____ **If Yes, circle treatment type: chemotherapy, radiation therapy, other?**	☐	☐
8. *Congenital abnormalities, birth defects* – such as: Down's Syndrome; cerebral palsy; cleft lip or palate; clubfoot; developmental delay; or other neurological or physical abnormalities?	☐	☐
9. Alcoholism, drug dependency or substance abuse **Type:** _____	☐	☐
10. Counseling or treatment for symptoms of depression; manic depression; anxiety; panic attacks; nervousness; mental or emotional disorders; schizophrenia; behavior problems; hyperactivity; attention deficit disorder; eating disorders; bulimia; anorexia; alcohol or substance abuse; or for any other reason? **Are you currently in counseling? If yes, reason for counseling and frequency of treatment** _____	☐	☐

Have you or any applying family member in the past 5 years sought any professional consultation or received any treatment (including prescription medications) from a licensed health practitioner pertaining to any of the following?

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 6.	**YES**	**NO**
11. *Male reproductive system* – such as: prostate problems; impotency; male breast problems; gynecomastia; infections; herpes; syphilis; gonorrhea; or other venereal disease (except HIV infection); or is either the applicant, spouse or domestic partner whether or not listed on the application, being treated or been treated for infertility within the last 24 months?	☐	☐
12. A. *Female reproductive system* – such as: breast problems; breast implants; adhesions; abnormal bleeding; amenorrhea; miscarriage and/or abortion; endometriosis; fibroid tumors; abnormal Pap test; problems of the ovaries, uterus and associated female organs; in-vitro fertilization; infections, genital warts, herpes, syphilis, or other venereal disease (except HIV infection); or is either the applicant, spouse or domestic partner whether or not listed on the application, being treated or been treated for infertility within the last 24 months? **Type of implants (circle one): saline or silicone**	☐	☐
B. Does any female applicant between the ages of 12-55 menstruate?	☐	☐
1. If yes, list the names of family member(s): _____; _____; _____		
2. Has it been more than 40 days since her/their last menstrual period? _____		
3. If Yes, list the names of family member(s): _____; _____; _____		
4. Please explain: _____		
13. *Digestive system* – such as: disease or disorder of the mouth, tongue, esophagus or stomach; ulcer; gall bladder disorder; liver disease; cirrhosis; jaundice; ascites; pancreatitis; colon, intestinal or rectal problems; colitis; chronic diarrhea; hemorrhoids; hernia; weight or eating problems; hepatitis? **If hepatitis, type(s): A, B, C, other**	☐	☐
14. *Urinary tract* – such as: renal colic; gravel or stones; urethra, bladder, ureter or kidney problems; urinary tract infections; stricture; pyelonephritis?	☐	☐
15. *Skin conditions* – such as: skin cancer; melanoma; psoriasis; keratosis; acne; herpes; warts; birthmarks; severe burns?	☐	☐
16. *Diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing* – such as: any infections of eyes, ears, nose or throat; crossed eyes; glaucoma; cataracts; detached retina; polyps; deviated nasal septum; excessive snoring; problems with tonsils or adenoids; sleep apnea?	☐	☐
17. *Abnormal laboratory results* – such as blood work; x-rays; EKG; nerve conduction; blood flow studies; MRI, CT, PET or other scans(s) (except HIV antibody detection tests)?	☐	☐
18. Prosthesis, implant, or retained hardware? **Type:** _____	☐	☐

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Applicant's Social Security Number
____ ____ ____ - ____ ____ - ____ ____ ____ ____

PART 4 – MEDICAL HISTORY *(continued)* – Please answer ALL questions. Remember to initial any changes/corrections you may have to make as you complete the questionnaire.

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 6.	**YES**	**NO**
19. Have you or any applying family member taken or been written a prescription for medication(s) in the last 12 months? If yes, please fill out Part 5 of this application.	☐	☐
20. In the past 5 years, have you or any applying family member:		
A. Been an inpatient or outpatient in a hospital, surgical center, sanitarium, or other medical facility, including an emergency room, or had surgery, including angioplasty, cosmetic/reconstructive, bypass or transplant surgery?	☐	☐
B. Had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner?	☐	☐
C. Been advised to have, or been referred for, a medical exam, further testing, treatment or surgery which has not yet been performed by a physician, dentist, or other licensed health practitioner?	☐	☐
D. Had any application for health or life insurance revoked, declined, deferred, postponed, or restricted in any way?	☐	☐
Family member: ______________________ Date:_____/____/____		
Please explain: ______________________		
21. Are you or any applying family member presently a member of a support group? **Type:** ______________ **How Long:**__________	☐	☐
22. *Males only:* Are you expecting a child with anyone, even if the birth mother is not listed on the application?	☐	☐
23. *Males and females:* Is either the applicant, spouse, domestic partner or dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy?	☐	☐
24. Have or do you or any applying family member:		
A. Requested or received a pension, benefits or payment because of any injury, sickness, disability of workers' compensation?	☐	☐
B. Smoke(d) cigarettes? **Family member:** ______________ **How many packs per day:** ________	☐	☐
For how many years: ________ **Have you/they stopped?** ________ **If yes, when?**______________		
C. Drink alcoholic beverages? **Family member:** ______________ **Number of drinks per week:** ________	☐	☐
For how many years: ________ **Have you/they stopped?** ________ **If yes, when?** ______________		

PART 5 – CURRENT OR RECENT PRESCRIPTION MEDICATIONS

If you answered "YES" to question 19 in Part 4, please provide the details of the current and previous medications. If additional space is necessary to provide complete information, please attach an additional sheet of paper. Be sure to identify the family member, include all information requested and **sign and date every attachment**. Check here for attachment. ☐

Name of family member			Dates from: _____/_____/_____ to: _____/_____/_____		
Medication	Reason for Rx			Dosage	Frequency
Physician Name	Phone number		Medical group		Physician specialty
Address	Ste #	City		State	ZIP
Name of family member			Dates from: _____/_____/_____ to: _____/_____/_____		
Medication	Reason for Rx			Dosage	Frequency
Physician Name	Phone number		Medical group		Physician specialty
Address	Ste #	City		State	ZIP
Name of family member			Dates from: _____/_____/_____ to: _____/_____/_____		
Medication	Reason for Rx			Dosage	Frequency
Physician Name	Phone number		Medical group		Physician specialty
Address	Ste #	City		State	ZIP

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___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 6 – MEDICAL CONDITION DETAILS – If you answered "YES" to any of questions 1–24 with the exception of 19, 20D, 24B and 24C in Part 4, give full details below for each condition.

If additional space is necessary to provide complete information, please attach an additional sheet of paper. Be sure to identify the family member, the section and the question number, as appropriate, include all information requested in Part 6 and **sign and date every attachment**. Check here for attachment. ☐

List question number	Family member name and name used on doctor's records:	Diagnosis:	Treatment:	
	First:		Dates of treatment:	
	Last:		Began: ____ /____ (MO/YR) Ended: ____ /____ (MO/YR)	
	Does the condition still exist? ☐ Yes ☐ No		Condition's present status:	
	Medical ID card # (if available)		Hospitalized? ☐ Yes ☐ No Dates:	
			ER visits? ☐ Yes ☐ No Dates:	
	Full name and address of every physician, clinic or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.			
	Name:	Phone number: ( )	Medical group	
	Address:			Ste #
	City		State	ZIP
List question number	Family member name and name used on doctor's records:	Diagnosis:	Treatment:	
	First:		Dates of treatment:	
	Last:		Began: ____ /____ (MO/YR) Ended: ____ /____ (MO/YR)	
	Does the condition still exist? ☐ Yes ☐ No		Condition's present status:	
	Medical ID card # (if available)		Hospitalized? ☐ Yes ☐ No Dates:	
			ER visits? ☐ Yes ☐ No Dates:	
	Full name and address of every physician, clinic or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.			
	Name:	Phone number: ( )	Medical group	
	Address:			Ste #
	City		State	ZIP
List question number	Family member name and name used on doctor's records:	Diagnosis:	Treatment:	
	First:		Dates of treatment:	
	Last:		Began: ____ /____ (MO/YR) Ended: ____ /____ (MO/YR)	
	Does the condition still exist? ☐ Yes ☐ No		Condition's present status:	
	Medical ID card # (if available)		Hospitalized? ☐ Yes ☐ No Dates:	
			ER visits? ☐ Yes ☐ No Dates:	
	Full name and address of every physician, clinic or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.			
	Name:	Phone number: ( )	Medical group	
	Address:			Ste #
	City		State	ZIP
List question number	Family member name and name used on doctor's records:	Diagnosis:	Treatment:	
	First:		Dates of treatment:	
	Last:		Began: ____ /____ (MO/YR) Ended: ____ /____ (MO/YR)	
	Does the condition still exist? ☐ Yes ☐ No		Condition's present status:	
	Medical ID card # (if available)		Hospitalized? ☐ Yes ☐ No Dates:	
			ER visits? ☐ Yes ☐ No Dates:	
	Full name and address of every physician, clinic or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.			
	Name:	Phone number: ( )	Medical group	
	Address:			Ste #
	City		State	ZIP

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___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 7 – LIST YOUR HEALTH PRACTITIONER VISITS

Have you and/or any applying family member visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health practitioner in the past 5 years? If Yes, enter the details below. If No, check here ☐ and go to Part 8.
Note: Exams for children under 5 years of age are required. Medical Records will be requested for ALL children age seven (7) months and younger.

Name of applicant	Date of visit: ____/____/_____	Reason for exam		Results	Present status
Physician name		Phone number		Medical group	Physician specialty
Address		Ste #	City	State	ZIP
Name of spouse/domestic partner	Date of visit: ____/____/_____	Reason for exam		Results	Present status
Physician name		Phone number		Medical group	Physician specialty
Address		Ste #	City	State	ZIP
Name of dependent	Date of visit: ____/____/_____	Reason for exam		Results	Present status
Physician name		Phone number		Medical group	Physician specialty
Address		Ste #	City	State	ZIP
Name of dependent	Date of visit: ____/____/_____	Reason for exam		Results	Present status
Physician name		Phone number		Medical group	Physician specialty
Address		Ste #	City	State	ZIP

PART 8 – PRIOR MEDICAL COVERAGE – **Please answer each question.**

1. Did you or any applying family member have other health coverage (insurance) within the last 63 days? ☐ YES ☐ NO

   If **NO**, go to Part 9
   If **YES**, complete the following:

	Type of Coverage	Effective date:	Cancel date:	Health plan carrier or COBRA administrator:
2. Applicant _____	☐ Group ☐ COBRA ☐ Individual ☐ Other	____/____/____	____/____/____	_____
Spouse/Domestic Partner/Dependent _____	☐ Group ☐ COBRA ☐ Individual ☐ Other	____/____/____	____/____/____	_____

3. If you are applying for a plan other than an HMO, did you have a prior health plan that covered any of the conditions checked yes in Part 4? ☐ **Yes** ☐ **No**
   If that plan terminated within 63 days of the Blue Shield receipt date of this application, please check here ☐ and submit a certificate of creditable coverage from your previous health carrier. If your application is approved, we will apply your prior creditable coverage to reduce any waiting period on your pre-existing condition exclusion with this plan. See the Summary of Benefits booklet for more on pre-existing conditions. You can call Blue Shield at **(800) 431-2809** for assistance obtaining a certificate.

4. If you are applying for an HMO Plan, please note that pregnancy is a Waivered Condition. Benefits for pregnancy and maternity services are not covered during the six (6)-month period beginning as of the effective date of coverage if you received pregnancy-related medical advice, diagnosis, care or treatment, including prescription drugs, from a licensed health practitioner during the six months immediately preceding the effective date of coverage, with the exception of services required to treat involuntary complications of pregnancy. However, if you have prior creditable coverage, and you apply for coverage within 63 days after termination of the prior coverage, Blue Shield will credit the length of time you were covered on your previous health plan toward the six-month period. See the Summary of Benefits booklet for more on waivered conditions. You can call Blue Shield at **(800) 431-2809** for assistance obtaining a certificate.

STOP!! WANT TO EXPEDITE THIS APPLICATION? WANT TO AVOID POSSIBLE ERRORS WHICH CAUSE DELAYS IN ACCEPTANCE? TALK TO YOUR AGENT ABOUT COMPLETING THIS FORM ONLINE!

ENROLL IN AUTOMATIC PAYMENT AND STOP WORRYING ABOUT PAYING YOUR BILL ON TIME! HAVE YOUR DUES/PREMIUM DEBITED DIRECTLY FROM YOUR CHECKING ACCOUNT OR SAVINGS ACCOUNT OR CHARGED DIRECTLY TO YOUR CREDIT CARD.

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Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

DON'T FORGET – YOUR SIGNATURE AND TODAY'S DATE ARE REQUIRED AT THE END OF PART 9 AND 10 OF THIS APPLICATION

PART 9 – AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this form you are authorizing the release of your and/or your dependents' health care information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, Blue Shield) for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing this form you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or evaluating any claim for benefits. The healthcare information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under the federal health information privacy laws.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your and/or your dependents' eligibility for coverage and enrollment determinations upon receipt of this signed authorization.

You are entitled to a copy of this Authorization after you sign it.

Expiration: This authorization will remain valid: 1) for thirty (30) months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

Applicant/Parent (or legal guardian) — Today's date

X_____ _____/_____/_____

Applicant's spouse/domestic partner — Today's date

X_____ _____/_____/_____

Applicant age 18 and over — Today's date

X_____ _____/_____/_____

Applicant age 18 and over — Today's date

X_____ _____/_____/_____

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Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 10 – AUTHORIZATIONS, TERMS & CONDITIONS

Please read the following terms and conditions carefully. **Your authorization and signature are required below.**

1. **Application for Coverage**: It is important to know that Blue Shield of California or Blue Shield of California Life & Health Insurance Company (as applicable) has the right to decline your application for coverage. **Note:** I understand that Blue Shield may use any medical information in reviewing my application, including any medical condition which occurs after the signature and submission of the application and before a decision by Underwriting is made.
2. **First Month's Dues/Premiums**: Attach a personal check or money order to this application in an amount equal to one month's Dues/Premiums. Find your estimated monthly dues/premiums in the rate book provided to you. Failure to submit full payment of Dues/Premiums may delay processing and the effective date of coverage. Please note that cashing of your check does not constitute approval of your application with Blue Shield or Blue Shield Life. If your application is not approved, this amount will be refunded to you.
3. **Dues/Premiums**: Dues/Premiums are to be paid by the first day of the billing period. Coverage will be terminated for failure to pay Dues/Premiums in a timely manner as set forth in the Health Service Agreement/Policy.
4. **Effective Date of Coverage**: If your application is approved, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date, or is unable to issue coverage before your requested date, coverage will begin as soon as possible. If additional Dues/Premiums are owed, payment must be received within the time specified in the notice from Blue Shield to avoid changing the effective date. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Entire Agreement**: If approved, this application (including the health questionnaire), together with the evidence of coverage and health services agreement/policy for individuals and families, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage. Your agent cannot approve this application for coverage or change any terms or conditions of coverage.
6. **Parents/Guardians**: If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 10. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for Dues/Premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach the court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):

   ☐ Parent or legal guardian only:_____ (name) or,

   ☐ My designee_____ (include name and relationship) or,

   ☐ Qualified Medical Child Support Order designee_____ (include name and relationship).

   ☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.
7. **Authorization for Spouse/Domestic Partner to Make Changes**: If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make additions or changes to the application/contract/policy on your behalf. ☐ Yes. ☐ No. **Note**: You may discontinue this authorization at any time by sending a written request to Blue Shield.
8. **Response to Requested Information:** You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or information, may be cause to rescind or cancel your coverage.
9. **HIV Testing Prohibited: California law prohibits an HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.**

ALL APPLICANTS AGE 18 AND OLDER MUST SIGN AND DATE THIS APPLICATION. KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS.

I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. I understand and agree to each of them. I alone am responsible for the accuracy and completeness of the information provided on this application. I understand that neither I, nor any family members, will be eligible for coverage if any information is false or incomplete. I also understand that if coverage is issued, it may be cancelled or rescinded upon such a finding.

Signature of applicant (or legal guardian)	Today's date (required)	Print name (and relationship if applicant is a minor)
X_____	_____/_____/_____	_____
Signature of applicant's spouse/domestic partner (if applying)	**Today's date (required)**	**Print name**
X_____	_____/_____/_____	_____
Signature of family member age 18 and over (if applying)	**Today's date (required)**	**Print name**
X_____	_____/_____/_____	_____
Signature of family member age 18 and over (if applying)	**Today's date (required)**	**Print name**
X_____	_____/_____/_____	_____

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___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 11 — STATEMENT OF GUARANTEED ISSUE ELIGIBILITY

If you have a pre-existing condition and are concerned about obtaining health care coverage, Blue Shield offers an alternative that you may want to consider.

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. Depending on your responses to the statements below, you may be eligible for guaranteed issue in accordance with HIPAA, and Blue Shield will automatically accept your application for one of its guaranteed issue plans. Each person on the application must meet HIPAA eligibility requirements to qualify for a guaranteed issue plan.

If you are applying for coverage on behalf of any dependents who are not eligible for guaranteed issue, their coverage will be subject to medical underwriting, except for children who were enrolled under any prior creditable coverage within 30 days of the birth or placement for adoption. A dependent child who is 18 years of age or younger or a dependent spouse applying for guaranteed issue must complete a separate Statement of Guaranteed Issue Eligibility (Blue Shield will accept copies of the Statement of Guaranteed Issue Eligibility). For additional applications or current guaranteed issue rates, please contact your Blue Shield agent or call Blue Shield at **(800) 431-2809**.

STATEMENT OF GUARANTEED ISSUE ELIGIBILITY & CHECKLIST

Please complete the following questionnaire if you are interested in a Guaranteed Issue policy so that your eligibility for Guaranteed Issue coverage may be verified.

☐ Yes ☐ No 1. I have had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without a lapse in coverage of more than 63 days (excluding employer-imposed waiting periods).

☐ Yes ☐ No 2. My most recent coverage was through an employer-sponsored health plan (COBRA and Cal-COBRA are considered employer-sponsored coverage).

☐ Yes ☐ No 3. I accepted and exhausted any available COBRA and/or Cal-COBRA coverage. (If COBRA/Cal-COBRA were not available, check "yes").

COBRA/Cal-COBRA coverage dates ___/___/_____ through ___/___/_____

COBRA Administrator _____ Telephone _____

Insurance Carrier _____ Telephone _____

If your most recent coverage was employer-sponsored and you were not eligible for COBRA and/or Cal-COBRA coverage, please explain: _____

☐ Yes ☐ No 4. I am currently eligible for coverage under a group or employer sponsored health plan, Medicare or Medicaid.

☐ Yes ☐ No 5. My most recent coverage terminated because of nonpayment of dues/premium or fraud.

If your answers to statements 1, 2 & 3 are "yes," and your answers to statements 4 & 5 are "no," please complete the remaining sections below to apply for a guaranteed issue plan.

GUARANTEED ISSUE COVERAGE OPTIONS (PLEASE SELECT ONE)

A. If you know that you will not qualify for coverage, or do not want to apply for an underwritten plan, check this box:

☐ Issue the Guaranteed Issue Plan only. Since I have chosen this option, I understand that I will not be considered for an underwritten plan.

B. If you are applying for both Guaranteed Issue and an underwritten plan, select one of the following:

☐ Guaranteed Issue coverage at the earliest effective date, so that I am covered during the underwriting process of the individual plan. (I understand that if my application for the underwritten plan is approved, I will automatically be transferred to the underwritten plan. If it is not approved, I will continue to receive Guaranteed Issue.)

☐ Issue the Guaranteed Issue plan only if I am not approved for the underwritten plan. (I understand that I will not have any coverage until my application for the underwritten plan is processed and either approved or declined.)

GUARANTEED ISSUE PLAN OPTIONS (PLEASE SELECT ONE)

☐ Access+ HMO
☐ Shield Savings 4000*
☐ Shield Spectrum PPO 5500
☐ Shield Spectrum PPO 5000*
☐ Access+ Value HMO

By signing this statement I verify that I have read and understood the eligibility conditions listed above and that all of the information is true and correct.

Signature of applicant or legal guardian	Today's date (required)	Print name
X _____	_____/_____/_____	_____

*Underwritten by Blue Shield of California Life & Health Insurance Company.

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One page pre underwriting forms

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___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 12 — PRODUCER INFORMATION — Must be completed by Producer.

1. Did you complete this application? ☐ Yes ☐ No

2. If yes, did you ask each question in this application exactly as set forth? ☐ Yes ☐ No

3. Are the answers recorded exactly as given to you? ☐ Yes ☐ No, attach explanation.

4. Did you see the applicant? ☐ Yes ☐ No

5. Are you aware of any information not disclosed in this application of health, which may have a bearing on this risk?
☐ Yes, attach explanation ☐ No

6. Review and select one of the following:

☐ I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice of any kind from me.

☐ I assisted the applicant in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

7. Do you want the service agreement/policy sent directly to the subscriber? ☐ Yes ☐ No

Producer number:	Telephone number:	Fax number:
8914s ____ ____ ____ ____ ____ ____ ____ ____ ____	(310-519-1335 ☐ Update	(310-519-1359 ☐ Update

Producer name: Steve Shorr

Email Address: SteveS@SteveShorr.com ☐ Update

Producer address: 1027 W. 11th Street # 3

☐ Update

City San Pedro | State CA | ZIP Code 90731

Super producer name:	Super producer number
	____ ____ ____ ____ ____ ____ ____ ____ ____

Today's date (required) **Producer signature (required)** **Print name**

____/____/_____ X_____ _____

NOTICE: Please ensure each part of the application is complete. In the event of missing or incomplete information Blue Shield may contact your applicant directly to obtain complete information. IFP Applications can be faxed toll-free 24 hours a day, 7 days a week, to **(888) 386-3420**.

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Application Checklist

Before you send in your application for processing, we suggest you go through this checklist. Make sure each box is checked off so that your application is processed as quickly as possible.

Make sure you and each applying family member have:

- ☐ Answered every question, even if you are not sure it applies to you.
- ☐ Printed clearly in blue or black ink.
- ☐ Selected a Personal Physician only if you are applying for Access+ HMO or Access+ Value HMO; selected a Dental provider only if you are applying for Dental HMO.
- ☐ Indicated your payment option in Part 1 of the application. If you chose credit card payments or Easy$Pay, you must complete the authorization form on the reverse side of this page and send it in when you submit your application to Blue Shield.
- ☐ Stapled a personal check or money order to your application in an amount equal to the dues/premiums for the first month of coverage.
- ☐ Signed Part 9 and 10 of the application. Signatures by all applicants (age 18 and over) are required.
- ☐ Returned the application within 30 days of your date and signature.

General Information

You are eligible for any Individual & Family Health Plan if you: are a California resident, are ineligible for Medicare, and are not age 65 or over.

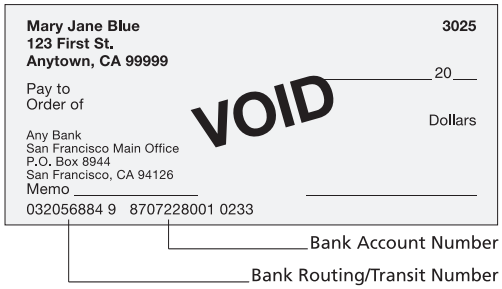
If your application is approved, you may be eligible to receive Access+ HMO or Access+ Value HMO benefits on the first of the month following Blue Shield's approval date, and on any day of the month, except for the 29th, 30th or 31st of the month following Blue Shield's approval date for any IFP PPO Plan.

Your spouse or Domestic Partner (under age 65) and unmarried dependent children (under age 19, or under age 23 if a full-time student), are eligible to apply for dependent coverage. If your children are under 19, you may also apply for separate child plans, which may cost you less overall. Call Blue Shield at **(800) 351-2465** or talk to your agent to find out which option is best for you.

Process to Authorize Blue Shield to Release Personal Information to Others: If you would like to authorize your spouse, domestic partner or a third party to access your personal health information, please complete the form titled *Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party*. To obtain this form go to **blueshieldca.com** or call **(800) 431-2809**.

Billing Information

- Using the rate book provided to you, calculate your rates or talk to your agent to get estimated rates. You may receive rates higher than your agent quoted you based on Underwriting determination.
- For the first month's dues/premium staple a personal check or money order to your application in an amount equal to the dues/premiums for for one month, payable to Blue Shield. If paying first month's dues/premium by credit card please fill out the required information on Page 12.



Payment Options

Subsequent dues/premiums must be paid in advance. Blue Shield offers four payment methods. Please select a billing option below:

1. Easy$Pay Monthly Payment – monthly payments are handled automatically, via electronic transfer from your checking or savings account.
2. Credit Card Payment – monthly/ quarterly (select frequency on following page) payments are handled automatically, via electronic charging to your credit card.
3. Monthly (30 days) direct billing
4. Quarterly (90 days) direct billing

Easy$Pay and Credit Card Payment Options

To sign up for Automatic Payments: Complete the authorization form on the next page and return it with your application. If you have selected Easy$Pay as your payment option please staple a deposit slip or blank check marked "VOID" to your authorization form **in addition to your initial dues/premiums check**. If you prefer not to attach a voided check or deposit slip, you must provide the routing/ transit number of your financial institution.

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If paying first month's dues/premium by credit card please fill out the required information below.

Automatic Payment Authorization Form

I AM: ☐ A new Automatic Payment applicant	☐ A current Automatic Payment user reporting a change (requires 30-day notice)
METHOD OF AUTOMATIC PAYMENT:	☐ Easy$Pay (complete Parts A and C only): Checking Account Savings Account (circle one) ☐ Credit Card* (complete Parts B and C only)

PART A (Complete for checking/savings account debits only.)

Payment Date (choose one): HMO and Dental HMO Subscribers must use 1st of month. ☐ 1st of month, or ☐ 15th of month

Bank routing/transfer number	Bank account number	
Name of Financial Institution		
Name(s) on Bank account		
Branch Address		
City	State	ZIP Code
Branch Telephone Number		

PART B (Complete for credit card charges only. Visa or MasterCard only.) ☐ Payment for first month's dues/premium only

Payment Date (choose one): ☐ Monthly ☐ Quarterly

Credit card number	Card Type: ☐ Visa ☐ MasterCard	Expiration Date (MM/YYYY)	
Cardholder First Name			MI
Last Name			
Cardholder Billing Address			
City	State	ZIP Code	

PART C (All Automatic Payment applicants must complete.)

Name of subscriber	Subscriber's daytime phone number ( )
Mailing Address Street	
City	State ZIP Code

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company as applicable, to initiate debits/charges (and/or corrections to previous debits/charges) from my account with the financial institution identified by me on this form for payment of my Blue Shield dues/premium, as well as for the dues/premium of the following covered individuals (my dependents):

_____ _____ _____ - _____ _____ - _____ _____ _____ _____
Social Security Number

_____ _____ _____ - _____ _____ - _____ _____ _____ _____
Spouse/Domestic Partner Social Security Number

_____ _____ _____ - _____ _____ - _____ _____ _____ _____
Dependent Social Security Number

_____ _____ _____ - _____ _____ - _____ _____ _____ _____
Dependent Social Security Number

I also authorize that financial institution to reduce/charge my account by the amount of those debits/charges (and/or corrections to previous debits/charges) on the agreed upon schedule. This authorization will remain in effect until I provide notice revoking the authorization, at least 10 days before my account is to be debited/charged.

Authorized Signature(s) – as it/they appear in the financial institution's records. If the account is listed as a joint account, both account holders must sign. If the holder of the account is not an individual, the one signing on behalf of a company/ partnership/etc. must identify him/herself and his/her relationship to the company/partnership.

Signature	Date
Print name	Relationship
Signature	Date
Print name	Relationship

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* You will be charged the amount owed for dues/premium until you choose to cancel your automatic payment schedule. If you chose to cancel your automatic payment, or if changes are made to the account being charged, please contact IFP Customer Service at **(800) 431-2809**. Credit card charges may occur 1 to 2 days prior to payment date.