INSURANCE CODE
SECTION 10198.6-10198.10

10198.6. For purposes of this article:

(a) "Health benefit plan" means any group or individual policy or contract that provides medical, hospital, or surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, 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.

(b) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, or the Medi-Cal program was the reason for declining enrollment provided that, if the individual was covered under another employer health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, legal separation, or divorce; or the individual has lost or will lose coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program.

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

(2) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4) The carrier cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of "COBRA" set forth in subdivision (e) of Section 10116.5 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program and requests enrollment within 60 days of termination of that coverage.

(c) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, 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.

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(d) "Creditable coverage" means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, 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 private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, 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 federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(3) The Medicaid Program pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (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. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the federal Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(c)).

(e) "Affiliation period" means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

(f) "Waivered condition" means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

10198.61. (a) For purposes of this article, "health benefit plan" does not include policies or certificates of specified disease or hospital confinement indemnity provided that the carrier offering those policies or certificates complies with the following:

(1) The carrier files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in paragraph (2).

(2) The certification required in paragraph (1) shall contain the following:

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance, health care service plans, or major medical expense insurance, (ii) the disclosure forms as described in Section 10603 contains the following statement prominently on the first page: "This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance," and (iii) are not being offered, marketed, or sold in a manner that would make the purchase of the policies contingent upon the sale of any product sold under Sections 10700 and 10718, or under Section 1357 of the Health and Safety Code.

(B) A summary description of each policy or certificate described in this section, including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender, or other factors, charged for the policies and certificates in this state.

(3) In the case of a policy or certificate described in this section and that is offered for the first time in this state on or after January 1, 1997, the carrier files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

(b) As used in this section, "policies or certificates of specified disease" and "policies or certificates of hospital confinement indemnity" mean policies or certificates of insurance sold to an insured to supplement other health insurance coverage as specified in this section. An insurer issuing a "policy or certificate of specified disease" or a "policy or certificate of hospital confinement indemnity" shall require that the person to be insured is covered by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

10198.7. (a) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer,

nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No health benefit plan that covers one or two individuals and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a health benefit plan for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) Notwithstanding subdivision (b), a health benefit plan for individual coverage that is a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

(d) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) A carrier that does not utilize a preexisting condition provision in health plans that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No carrier may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any person, all health benefit plans shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A health benefit plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan,

including any affiliation or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated or, an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period.

(g) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(h) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act, 42 U.S.C. Sec. 300gg(e).

(i) A group health benefit plan may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

(j) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

10198.8. This article applies to all health benefit plans that provide hospital, medical, or surgical benefits to residents of this state regardless of the situs of the contract or group master policyholder.

10198.9. (a) Except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a disability insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 10198.7.

(b) For purposes of this section, "health benefit plan" shall have the same meaning as in Section 10198.6 and subdivision (a) of Section 10198.61.

(c) For purposes of this section, "eligible employee" shall have the same meaning as in Section 10700 except that it shall apply to any health benefit plan covering two or more eligible employees.

10198.10. This article shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

See new rules under Health Care Reform