AMENDED IN ASSEMBLY APRIL 9, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1461

Introduced by Assembly Member Monning
(Principal coauthor: Senator Hernandez)

January 9, 2012

An act to *amend Sections 1357.51 and 1399.829 of, to amend the heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of, to add Section 1399.836 to, to add Article 11.8 (commencing with Section 1399.845) to Chapter 2.2 of Division 2 of, and to repeal Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 10198.7 and 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, to add Section 10961 to, to* add ~~Section 10961 to~~ *Chapter 9.8 (commencing with Section 10965) to Part 2 of Division 2 of, and to repeal Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of,* the Insurance Code, relating to health ~~insurance~~ *care coverage*.

LEGISLATIVE COUNSEL'S DIGEST

AB 1461, as amended, Monning. ~~Health insurance.~~ *Individual health care coverage.*

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA) enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA

prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate charge by a health insurance issuer offering small group or individual coverage to vary only by family composition, rating area, age, and tobacco use, as specified, and prohibits discrimination against individuals based on health status.

Existing law*, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also* provides for the ~~licensing and~~ regulation of health insurers by the Insurance Commissioner. ~~Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. The California Health Benefit Exchange is governed by a board and the board is required to facilitate enrollment of qualified individuals in qualified health plans.~~ *Existing law requires plans and insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements.*

This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, from imposing any preexisting condition provision upon any individual, except as specified. The bill would require a plan or insurer, on and after January 1, 2014, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals in each service area in which the plan provides or arranges for the provision of health care services, but would require plans and insurers to limit enrollment to specified open enrollment and special enrollment periods. Commencing January 1, 2014, the bill would prohibit a plan or insurer from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified, and would authorize plans and insurers to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans. The bill would enact other related provisions and make related conforming changes.

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state.

Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing federal law, the federal Patient Protection and Affordable Care Act, commencing on and after January 1, 2014, requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and requires the issuer to renew that coverage. Existing federal law, commencing on and after January 1, 2014, prohibits discriminatory premium rates charged by a health insurance issuer for health insurance coverage offered in the individual or small group market, as specified, and also prohibits discrimination against individuals based on health status. Existing federal law, commencing on and after January 1, 2014, except as otherwise specified, prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage.~~

~~This bill would, consistent with federal law, commencing on and after January 1, 2014, require a health insurer to comply with these federal requirements. The bill would require the commissioner to consult and coordinate with the department and the Exchange in carrying out these provisions. The bill would also authorize the commissioner, in consultation with the department, to adopt regulations to carry out these provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 1357.51 of the Health and Safety Code is amended to read:

1357.51. (a) No plan contract that covers three or more enrollees 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. Preexisting condition provisions contained in plan contracts 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 plan contract that covers one or two individuals 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 the plan limit or exclude coverage for a specific enrollee 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 plan contracts 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 plan contract for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age. *A plan contract for group coverage issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.*

(2) Notwithstanding subdivision (b), a plan contract for individual coverage that is not a grandfathered health plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (P.L. 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age. *A plan contract for individual coverage that is issued, amended, or renewed on or after January 1, 2014, and that is not a grandfathered health 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 individual.*

(d) A plan 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 plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) A plan that does not utilize a preexisting condition provision in plan contracts that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions.

No plan 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 plan contracts 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 enrollee, a plan shall credit the time the enrollee was covered under creditable coverage, provided that the enrollee becomes eligible for coverage under the succeeding plan contract 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 plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting or affiliation 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 plan 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 contract within the applicable enrollment period.

(g) No plan shall exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No plan 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) A health care service plan issuing group coverage may not impose a preexisting condition exclusion upon a condition relating to benefits for pregnancy or maternity care.

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

SEC. 2. The heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of the Health and Safety Code is amended to read:

Article 11.7. ~~Individual~~ *Child* Access to Health Care Coverage

SEC. 3. Section 1399.829 of the Health and Safety Code is amended to read:

1399.829. (a) A health care service plan may use the following characteristics of an eligible child for purposes of establishing the rate of the plan contract for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health care service plan contract selected by the child or the responsible party for the child.

(b) From the effective date of this article to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with any health care service plan or health insurer for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health care service plan contract issued, sold, or renewed prior to December 31, 2013, the health plan shall

provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial open enrollment period shall be deemed to have maintained coverage during that period.

~~(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.~~

~~(f)~~

(e) Health care service plans may require documentation from applicants relating to their coverage history.

SEC. 4. Section 1399.836 is added to the Health and Safety Code, to read:

1399.836. 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.

SEC. 5. Article 11.8 (commencing with Section 1399.845) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.8. Individual Access to Health Care Coverage

1399.845. For purposes of this article, the following definitions shall apply:

(a) "Dependent" means the spouse or child of an individual, subject to applicable terms of the health benefit plan.

(b) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(c) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(d) "Health benefit plan" means any individual or group health insurance policy or health care service plan contract that provides

medical, hospital, and 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.

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

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee'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.

(g) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of PPACA.

(h) "Rating period" means the period for which premium rates established by a plan are in effect.

1399.847. Every health care service plan offering individual health benefit plans shall, in addition to complying with the provisions of this chapter and rules adopted thereunder, comply with the provisions of this article.

1399.849. (a) (1) On and after January 1, 2014, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment to open enrollment periods and special enrollment periods as provided in subdivisions (c) and (d).

(2) A plan that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraph (1) with respect to an individual health benefit plan offered through

the Exchange in those geographic regions in which the plan offers health benefit plans through the Exchange.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) A plan shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.

(d) Subject to subdivision (e), a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(1) He or she loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

(A) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(B) "Loss of minimum essential coverage" includes loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations. "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to Section 1389.21.

(2) He or she gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.

(3) He or she becomes a resident of California.

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

(5) With respect to individual health benefit plans offered through the Exchange, the individual meets any of the requirements listed in Section 155.420(d)(3) of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 63 days from the date of a triggering event identified in subdivision (d) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange,

an individual shall have 63 days from the date of a triggering event to select a plan offered through the Exchange.

(f) (1) With respect to individual health benefit plans offered outside the Exchange, after an individual submits a completed application form for a plan, the health care service plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 1399.855. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the initial open enrollment period described in subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014, except that coverage for an individual under 19 years of age shall, at the option of the subscriber, become effective as required under Section 1399.826. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the 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 under the plan shall become effective no later than the first day of the following month.

(B) When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(C) Notwithstanding subparagraph (A) or (B), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(D) Notwithstanding subparagraph (A) or (B), in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the following month.

(5) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage selected pursuant to this section shall be the same as the applicable date specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(g) On or after January 1, 2014, a health care service plan shall not condition the issuance or offering of an individual health benefit plan on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

(h) A health care service plan offering coverage in the individual market shall not reject the request of a subscriber during an open enrollment period to include a dependent of the subscriber as a dependent on an existing individual health benefit plan that provides dependent coverage.

(i) This section shall not apply to a grandfathered health plan.

1399.851. (a) Commencing January 1, 2014, no health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct an individual to refrain from filing an application for individual coverage with a plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the individual.

(2) Encourage or direct an individual to seek individual coverage from another plan or health insurer or the California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the individual.

(b) Commencing January 1, 2014, a health care service plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

(c) This section shall not apply to a grandfathered health plan.

1399.853. (a) All individual health benefit plans shall conform to the requirements of Sections 1365, 1366.3, 1367.001, and 1373.6, and shall be renewable at the option of the enrollee except as permitted to be canceled, rescinded, or not renewed pursuant to Section 1365.

(b) Any plan that ceases to offer for sale new individual health benefit plans pursuant to Section 1365 shall continue to be

governed by this article with respect to business conducted under this article.

1399.855. (a) With respect to individual health benefit plans issued, amended, or renewed on or after January 1, 2014, a health care service plan may use only the following characteristics of an individual, and any dependent thereof, for purposes of establishing the rate of the individual health benefit plan covering the individual and the eligible dependents thereof, along with the health benefit plan selected by the individual:

(1) Age, as described in regulations adopted by the department in conjunction with the Department of Insurance that do not prevent the application of PPACA. Rates based on age shall be determined based on the individual's birthday and shall not vary by more than three to one for adults.

(2) Geographic region. With respect to the 2014 plan year, the geographic regions for purposes of rating shall be the same as those used by a health benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code). For subsequent plan years, the geographic regions for purposes of rating shall be determined by the Exchange in consultation with the department, the Department of Insurance, and other private and public purchasers of health care coverage.

(3) Family size, as described in PPACA.

(b) The rate for a health benefit plan subject to this section shall not vary by any factor not described in this section.

(c) The rating period for rates subject to this section shall be no less than 12 months.

(d) This section shall not apply to a grandfathered health plan.

1399.857. A health care service plan shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to this article in the case of any of the following:

(a) To an individual who does not work or reside within the plan's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to ensure that health care services will be

available and accessible to the individual because of its obligations to existing enrollees.

(2) A health care service plan that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a health benefit plan in the area in which the plan is not offering coverage to individuals to new employer groups until the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan.

(3) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired.

1399.859. The director may require a health care service plan to discontinue the offering of individual health benefit plans or acceptance of applications from any individual upon a determination by the director that the plan does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375.1), and the rules adopted under those provisions.

SEC. 6. Section 10198.7 of the Insurance Code is amended to read:

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. *A health benefit plan for group coverage issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.*

(2) Notwithstanding subdivision (b), a health benefit plan for individual coverage that is *not* 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. *A health benefit plan for individual coverage that is issued, amended, or renewed on or after January 1, 2014, and that is not a grandfathered health 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 individual.*

(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.

SEC. 7. The heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of the Insurance Code is amended to read:

CHAPTER 9.7. ~~INDIVIDUAL~~ *CHILD* ACCESS TO HEALTH INSURANCE

SEC. 8. Section 10954 of the Insurance Code is amended to read:

10954. (a) A carrier may use the following characteristics of an eligible child for purposes of establishing the rate of the health benefit plan for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health benefit plan selected by the child or the responsible party for a child.

(b) From the effective date of this chapter to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with

any carrier or health care service plan for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a carrier may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a carrier may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health benefit plan issued, sold, or renewed prior to December 31, 2013, the carrier shall provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial enrollment period shall be deemed to have maintained coverage during that period.

~~(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.~~

~~(f)~~

(e) Carriers may require documentation from applicants relating to their coverage history.

SEC. 9. Section 10961 is added to the Insurance Code, to read:

10961. This chapter 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.

SEC. 10. Chapter 9.8 (commencing with Section 10965) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.8. INDIVIDUAL ACCESS TO HEALTH INSURANCE

10965. For purposes of this chapter, the following definitions shall apply:

(a) "Dependent" means the spouse or child of an individual, subject to applicable terms of the health benefit plan.

(b) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(c) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(d) "Health benefit plan" means any individual or group health insurance policy or health care service plan contract that provides medical, hospital, and 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.

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

(f) "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.

(g) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of PPACA.

(h) "Rating period" means the period for which premium rates established by an insurer are in effect.

10965.1. Every health insurer offering individual health benefit plans shall, in addition to complying with the provisions of this part and rules adopted thereunder, comply with the provisions of this chapter.

10965.3. (a) (1) On and after January 1, 2014, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market to all individuals in each service area in which the insurer provides or arranges for the provision of health care services. An insurer shall limit enrollment to open enrollment periods and special enrollment periods as provided in subdivisions (c) and (d).

(2) A health insurer that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraph (1) with respect to an individual health benefit plan offered through the Exchange in those geographic regions in which the insurer offers health benefit plans through the Exchange.

(b) An individual health benefit plan issued, amended, or renewed shall not impose any preexisting condition provision upon any individual.

(c) A health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.

(d) Subject to subdivision (e), a health insurer shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(1) He or she loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

(A) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(B) "Loss of minimum essential coverage" includes loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations. "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to Section 10384.17.

(2) He or she gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.

(3) He or she becomes a California resident.

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

(5) With respect to individual health benefit plans offered through the Exchange, the individual meets any of the requirements listed in Section 155.420(d)(3) of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 63 days from the date of a triggering event identified in subdivision (d) to apply for coverage from a health benefit plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 63 days from the date of a triggering event to select a plan offered through the Exchange.

(f) (1) With respect to individual health benefit plans offered outside the Exchange, after an individual submits a completed application form for a plan, the insurer shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 10965.9. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the initial open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014, except that coverage for an individual under 19 years of age shall, at the option of the policyholder, become effective as required under Section 10951. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the 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 under the plan shall become effective no later than the first day of the following month.

(B) When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(C) Notwithstanding subparagraph (A) or (B), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(D) Notwithstanding subparagraph (A) or (B), in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the following month.

(5) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage selected pursuant to this section shall be the same as the applicable date specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(g) On or after January 1, 2014, a health insurer shall not condition the issuance or offering of an individual health benefit plan on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

(h) A health insurer offering coverage in the individual market shall not reject the request of a policyholder during an open enrollment period to include a dependent of the policyholder as a dependent on an existing individual health benefit plan that provides dependent coverage.

(i) This section shall not apply to a grandfathered health plan.

10965.5. (a) Commencing January 1, 2014, no health insurer or agent or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct an individual to refrain from filing an application for individual coverage with an insurer because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the insurer's approved service area, of the individual.

(2) Encourage or direct an individual to seek individual coverage from another health care service plan or health insurer or the California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the insurer's approved service area, of the individual.

(b) Commencing January 1, 2014, a health insurer shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a broker or agent that provides for or results in the compensation paid to a broker or agent for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic

location of the individual. This subdivision does not apply to a compensation arrangement that provides compensation to a broker or agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

(c) This section shall not apply to a grandfathered health plan.

10965.7. (a) All individual health benefit plans shall conform to the requirements of Sections 10112.1, 10127.18, 10273.4, and 12682.1, and shall be renewable at the option of the insured except as permitted to be canceled, rescinded, or not renewed pursuant to Section 10273.4.

(b) Any insurer that ceases to offer for sale new individual health benefit plans pursuant to Section 10273.4 shall continue to be governed by this chapter with respect to business conducted under this chapter.

10965.9. (a) With respect to individual health benefit plans issued, amended, or renewed on or after January 1, 2014, a health insurer may use only the following characteristics of an individual, and any dependent thereof, for purposes of establishing the rate of the individual health benefit plan covering the individual and the eligible dependents thereof, along with the health benefit plan selected by the individual:

(1) Age, as described in regulations adopted by the department in conjunction with the Department of Managed Health Care that do not prevent the application of PPACA. Rates based on age shall be determined based on the individual's birthday and shall not vary by more than three to one for adults.

(2) Geographic region. With respect to the 2014 plan year, the geographic regions for purposes of rating shall be the same as those used by a health benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code). For subsequent plan years, the geographic regions for purposes of rating shall be determined by the Exchange in consultation with the department, the Department of Managed Health Care, and other private and public purchasers of health care coverage.

(3) Family size, as described in PPACA.

(b) The rate for a health benefit plan subject to this section shall not vary by any factor not described in this section.

(c) The rating period for rates subject to this section shall be no less than 12 months.

(d) This section shall not apply to a grandfathered health plan.

10965.11. A health insurer shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to this chapter in the case of any of the following:

(a) To an individual who does not work or reside within the insurer's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the insurer reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual because of its obligations to existing insureds.

(2) A health insurer that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a health benefit plan in the area in which the insurer is not offering coverage to individuals to new employer groups until the insurer notifies the commissioner that it has the ability to deliver services to individuals, and certifies to the commissioner that from the date of the notice it will enroll all individuals requesting coverage in that area from the insurer.

(3) Nothing in this chapter shall be construed to limit the commissioner's authority to develop and implement a plan of rehabilitation for a health insurer whose financial viability or organizational and administrative capacity has become impaired.

10965.13. The commissioner may require a health insurer to discontinue the offering of individual health benefit plans or acceptance of applications from any individual upon a determination by the commissioner that the insurer does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its insureds. In determining whether the conditions of this section have been met, the commissioner shall consider, but not be limited to, the insurer's compliance with the requirements of this part and the rules adopted under those provisions.

SEC. 11. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. Section 10961 is added to the Insurance Code, to read:~~

~~10961. (a) To the extent required by federal law, commencing on and after January 1, 2014, every health insurer shall comply with the following provisions related to the offer, sale, issuance, and renewal of individual health benefit plans, consistent with federal law and implementing rules, regulations, and federal guidance:~~

~~(1) Guaranteed availability of coverage pursuant to Section 2702 of the Public Health Service Act (42 U.S.C. Sec. 300gg-1).~~

~~(2) Guaranteed renewability of coverage pursuant to Section 2703 of the Public Health Service Act (42 U.S.C. Sec. 300gg-2).~~

~~(3) The portability and nondiscrimination provisions in Sections 2701, 2704, and 2705 of the Public Health Service Act (42 U.S.C. Secs. 300gg, 300gg-3, and 300gg-4).~~

~~(b) The commissioner shall consult and coordinate with the Department of Managed Health Care in the implementation and enforcement of this section to ensure uniform and consistent rules, regulations, guidance, and enforcement for health benefit plans sold to individuals in this state.~~

~~(c) In implementing this section, the commissioner shall, in addition to the requirements in subdivision (b), consult and coordinate with the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.~~

~~(d) The commissioner may, in consultation with the Department of Managed Health Care, adopt regulations implementing this section, pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).~~

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