

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:

- 1 **SECTION 1.** *Section 1357.51 of the Health and Safety Code*
- 2 *is amended to read:*
- 3 1357.51. (a) No plan contract that covers three or more
- 4 enrollees shall exclude coverage for any individual on the basis
- 5 of a preexisting condition provision for a period greater than six
- 6 months following the individual’s effective date of coverage.
- 7 Preexisting condition provisions contained in plan contracts may
- 8 relate only to conditions for which medical advice, diagnosis, care,
- 9 or treatment, including use of prescription drugs, was recommended

1 or received from a licensed health practitioner during the six
2 months immediately preceding the effective date of coverage.

3 (b) No plan contract that covers one or two individuals shall
4 exclude coverage on the basis of a preexisting condition provision
5 for a period greater than 12 months following the individual's
6 effective date of coverage, nor shall the plan limit or exclude
7 coverage for a specific enrollee by type of illness, treatment,
8 medical condition, or accident, except for satisfaction of a
9 preexisting condition clause pursuant to this article. Preexisting
10 condition provisions contained in plan contracts may relate only
11 to conditions for which medical advice, diagnosis, care, or
12 treatment, including use of prescription drugs, was recommended
13 or received from a licensed health practitioner during the 12 months
14 immediately preceding the effective date of coverage.

15 (c) (1) Notwithstanding subdivision (a), a plan contract for
16 group coverage shall not impose any preexisting condition
17 provision upon any child under 19 years of age. *A plan contract*
18 *for group coverage issued, amended, or renewed on or after*
19 *January 1, 2014, shall not impose any preexisting condition*
20 *provision upon any individual.*

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

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

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

1 No plan may exclude coverage on the basis of a waived condition
2 for a period greater than 12 months following the individual's
3 effective date of coverage. A waived condition provision
4 contained in plan contracts may relate only to conditions for which
5 medical advice, diagnosis, care, or treatment, including use of
6 prescription drugs, was recommended or received from a licensed
7 health practitioner during the 12 months immediately preceding
8 the effective date of coverage.

9 (f) In determining whether a preexisting condition provision, a
10 waived condition provision, or a waiting or affiliation period
11 applies to any enrollee, a plan shall credit the time the enrollee
12 was covered under creditable coverage, provided that the enrollee
13 becomes eligible for coverage under the succeeding plan contract
14 within 62 days of termination of prior coverage, exclusive of any
15 waiting or affiliation period, and applies for coverage under the
16 succeeding plan within the applicable enrollment period. A plan
17 shall also credit any time that an eligible employee must wait
18 before enrolling in the plan, including any postenrollment or
19 employer-imposed waiting or affiliation period.

20 However, if a person's employment has ended, the availability
21 of health coverage offered through employment or sponsored by
22 an employer has terminated, or an employer's contribution toward
23 health coverage has terminated, a plan shall credit the time the
24 person was covered under creditable coverage if the person
25 becomes eligible for health coverage offered through employment
26 or sponsored by an employer within 180 days, exclusive of any
27 waiting or affiliation period, and applies for coverage under the
28 succeeding plan contract within the applicable enrollment period.

29 (g) No plan shall exclude late enrollees from coverage for more
30 than 12 months from the date of the late enrollee's application for
31 coverage. No plan shall require any premium or other periodic
32 charge to be paid by or on behalf of a late enrollee during the period
33 of exclusion from coverage permitted by this subdivision.

34 (h) A health care service plan issuing group coverage may not
35 impose a preexisting condition exclusion upon a condition relating
36 to benefits for pregnancy or maternity care.

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

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

4
5 Article 11.7. ~~Individual~~-Child Access to Health Care Coverage

6
7 SEC. 3. *Section 1399.829 of the Health and Safety Code is*
8 *amended to read:*

9 1399.829. (a) A health care service plan may use the following
10 characteristics of an eligible child for purposes of establishing the
11 rate of the plan contract for that child, where consistent with federal
12 regulations under PPACA: age, geographic region, and family
13 composition, plus the health care service plan contract selected by
14 the child or the responsible party for the child.

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

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

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

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

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

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

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

3
4 “Please consider your options carefully before failing to maintain
5 or renew coverage for a child for whom you are responsible. If
6 you attempt to obtain new individual coverage for that child, the
7 premium for the same coverage may be higher than the premium
8 you pay now.”

9
10 (d) A child who applied for coverage between September 23,
11 2010, and the end of the initial open enrollment period shall be
12 deemed to have maintained coverage during that period.

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

16 ~~(f)~~

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

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

21 *1399.836. This article shall remain in effect only until January*
22 *1, 2014, and as of that date is repealed, unless a later enacted*
23 *statute, that is enacted before January 1, 2014, deletes or extends*
24 *that date.*

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

28

29 *Article 11.8. Individual Access to Health Care Coverage*

30

31 *1399.845. For purposes of this article, the following definitions*
32 *shall apply:*

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

35 (b) “Exchange” means the California Health Benefit Exchange
36 created by Section 100500 of the Government Code.

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

39 (d) “Health benefit plan” means any individual or group health
40 insurance policy or health care service plan contract that provides

1 *medical, hospital, and surgical benefits. The term does not include*
2 *accident only, credit, disability income, coverage of Medicare*
3 *services pursuant to contracts with the United States government,*
4 *Medicare supplement, long-term care insurance, dental, vision,*
5 *coverage issued as a supplement to liability insurance, insurance*
6 *arising out of a workers' compensation or similar law, automobile*
7 *medical payment insurance, or insurance under which benefits*
8 *are payable with or without regard to fault and that is statutorily*
9 *required to be contained in any liability insurance policy or*
10 *equivalent self-insurance.*

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

16 *(f) "Preexisting condition provision" means a contract provision*
17 *that excludes coverage for charges or expenses incurred during*
18 *a specified period following the enrollee's effective date of*
19 *coverage, as to a condition for which medical advice, diagnosis,*
20 *care, or treatment was recommended or received during a specified*
21 *period immediately preceding the effective date of coverage.*

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

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

26 *1399.847. Every health care service plan offering individual*
27 *health benefit plans shall, in addition to complying with the*
28 *provisions of this chapter and rules adopted thereunder, comply*
29 *with the provisions of this article.*

30 *1399.849. (a) (1) On and after January 1, 2014, a plan shall*
31 *fairly and affirmatively offer, market, and sell all of the plan's*
32 *health benefit plans that are sold in the individual market to all*
33 *individuals in each service area in which the plan provides or*
34 *arranges for the provision of health care services. A plan shall*
35 *limit enrollment to open enrollment periods and special enrollment*
36 *periods as provided in subdivisions (c) and (d).*

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

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

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

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

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

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

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

19 *(B) "Loss of minimum essential coverage" includes loss of that*
20 *coverage due to the circumstances described in Section*
21 *54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of*
22 *Federal Regulations. "Loss of minimum essential coverage" does*
23 *not include loss of that coverage due to the individual's failure to*
24 *pay premiums on a timely basis or situations allowing for a*
25 *rescission, subject to Section 1389.21.*

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

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

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

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

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

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

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

10 *(2) With respect to an individual health benefit plan offered*
11 *outside the Exchange for which an individual applies during the*
12 *initial open enrollment period described in subdivision (c), when*
13 *the subscriber submits a premium payment, based on the quoted*
14 *premium charges, and that payment is delivered or postmarked,*
15 *whichever occurs earlier, by December 15, 2013, coverage under*
16 *the individual health benefit plan shall become effective no later*
17 *than January 1, 2014, except that coverage for an individual under*
18 *19 years of age shall, at the option of the subscriber, become*
19 *effective as required under Section 1399.826. When that payment*
20 *is delivered or postmarked within the first 15 days of any*
21 *subsequent month, coverage shall become effective no later than*
22 *the first day of the following month. When that payment is delivered*
23 *or postmarked between December 16, 2013, and December 31,*
24 *2013, inclusive, or after the 15th day of any subsequent month,*
25 *coverage shall become effective no later than the first day of the*
26 *second month following delivery or postmark of the payment.*

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

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

5 (A) *When the individual submits a premium payment, based on*
6 *the quoted premium charges, and that payment is delivered or*
7 *postmarked, whichever occurs earlier, within the first 15 days of*
8 *the month, coverage under the plan shall become effective no later*
9 *than the first day of the following month.*

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

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

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

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

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

29 (1) *Health status.*

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

31 (3) *Claims experience.*

32 (4) *Receipt of health care.*

33 (5) *Medical history.*

34 (6) *Genetic information.*

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

37 (8) *Disability.*

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

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

6 (i) This section shall not apply to a grandfathered health plan.
 7 1399.851. (a) Commencing January 1, 2014, no health care
 8 service plan or solicitor shall, directly or indirectly, engage in the
 9 following activities:

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

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

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

32 (c) This section shall not apply to a grandfathered health plan.
 33 1399.853. (a) All individual health benefit plans shall conform
 34 to the requirements of Sections 1365, 1366.3, 1367.001, and
 35 1373.6, and shall be renewable at the option of the enrollee except
 36 as permitted to be canceled, rescinded, or not renewed pursuant
 37 to Section 1365.

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

1 *governed by this article with respect to business conducted under*
2 *this article.*

3 *1399.855. (a) With respect to individual health benefit plans*
4 *issued, amended, or renewed on or after January 1, 2014, a health*
5 *care service plan may use only the following characteristics of an*
6 *individual, and any dependent thereof, for purposes of establishing*
7 *the rate of the individual health benefit plan covering the individual*
8 *and the eligible dependents thereof, along with the health benefit*
9 *plan selected by the individual:*

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

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

26 *(3) Family size, as described in PPACA.*

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

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

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

32 *1399.857. A health care service plan shall not be required to*
33 *offer an individual health benefit plan or accept applications for*
34 *the plan pursuant to this article in the case of any of the following:*

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

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

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

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

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

17 1399.859. The director may require a health care service plan
 18 to discontinue the offering of individual health benefit plans or
 19 acceptance of applications from any individual upon a
 20 determination by the director that the plan does not have sufficient
 21 financial viability or organizational and administrative capacity
 22 to ensure the delivery of health care services to its enrollees. In
 23 determining whether the conditions of this section have been met,
 24 the director shall consider, but not be limited to, the plan's
 25 compliance with the requirements of Section 1367, Article 6
 26 (commencing with Section 1375.1), and the rules adopted under
 27 those provisions.

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

30 10198.7. (a) No health benefit plan that covers three or more
 31 persons and that is issued, renewed, or written by any insurer,
 32 nonprofit hospital service plan, self-insured employee welfare
 33 benefit plan, fraternal benefits society, or any other entity shall
 34 exclude coverage for any individual on the basis of a preexisting
 35 condition provision for a period greater than six months following
 36 the individual's effective date of coverage, nor shall limit or
 37 exclude coverage for a specific insured person by type of illness,
 38 treatment, medical condition, or accident except for satisfaction
 39 of a preexisting clause pursuant to this article. Preexisting condition
 40 provisions contained in health benefit plans may relate only to

1 conditions for which medical advice, diagnosis, care, or treatment,
2 including use of prescription drugs, was recommended or received
3 from a licensed health practitioner during the six months
4 immediately preceding the effective date of coverage.

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

19 (c) (1) Notwithstanding subdivision (a), a health benefit plan
20 for group coverage shall not impose any preexisting condition
21 provision upon any child under 19 years of age. *A health benefit*
22 *plan for group coverage issued, amended, or renewed on or after*
23 *January 1, 2014, shall not impose any preexisting condition*
24 *provision upon any individual.*

25 (2) Notwithstanding subdivision (b), a health benefit plan for
26 individual coverage that is *not* a grandfathered plan within the
27 meaning of Section 1251 of the federal Patient Protection and
28 Affordable Care Act (Public Law 111-148) shall not impose any
29 preexisting condition provision upon any child under 19 years of
30 age. *A health benefit plan for individual coverage that is issued,*
31 *amended, or renewed on or after January 1, 2014, and that is not*
32 *a grandfathered health plan within the meaning of Section 1251*
33 *of the federal Patient Protection and Affordable Care Act (Public*
34 *Law 111-148) shall not impose any preexisting condition provision*
35 *upon any individual.*

36 (d) A carrier that does not utilize a preexisting condition
37 provision may impose a waiting or affiliation period not to exceed
38 60 days, before the coverage issued subject to this article shall
39 become effective. During the waiting or affiliation period, the

1 carrier is not required to provide health care services and no
2 premium shall be charged to the subscriber or enrollee.

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

14 (f) In determining whether a preexisting condition provision, a
15 waived condition provision, or a waiting or affiliation period
16 applies to any person, all health benefit plans shall credit the time
17 the person was covered under creditable coverage, provided the
18 person becomes eligible for coverage under the succeeding health
19 benefit plan within 62 days of termination of prior coverage,
20 exclusive of any waiting or affiliation period, and applies for
21 coverage under the succeeding plan within the applicable
22 enrollment period. A health benefit plan shall also credit any time
23 an eligible employee must wait before enrolling in the health
24 benefit plan, including any affiliation or employer-imposed waiting
25 period. However, if a person's employment has ended, the
26 availability of health coverage offered through employment or
27 sponsored by an employer has terminated or, an employer's
28 contribution toward health coverage has terminated, a carrier shall
29 credit the time the person was covered under creditable coverage
30 if the person becomes eligible for health coverage offered through
31 employment or sponsored by an employer within 180 days,
32 exclusive of any waiting or affiliation period, and applies for
33 coverage under the succeeding plan within the applicable
34 enrollment period.

35 (g) No health benefit plan that covers three or more persons and
36 that is issued, renewed, or written by any insurer, nonprofit hospital
37 service plan, self-insured employee welfare benefit plan, fraternal
38 benefits society, or any other entity may exclude late enrollees
39 from coverage for more than 12 months from the date of the late
40 enrollee's application for coverage. No insurer, nonprofit hospital

1 service plan, self-insured employee welfare benefit plan, fraternal
2 benefits society, or any other entity shall require any premium or
3 other periodic charge to be paid by or on behalf of a late enrollee
4 during the period of exclusion from coverage permitted by this
5 subdivision.

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

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

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

17 *SEC. 7. The heading of Chapter 9.7 (commencing with Section*
18 *10950) of Part 2 of Division 2 of the Insurance Code is amended*
19 *to read:*

20

21 CHAPTER 9.7. ~~INDIVIDUAL~~ CHILD ACCESS TO HEALTH
22 INSURANCE
23

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

26 10954. (a) A carrier may use the following characteristics of
27 an eligible child for purposes of establishing the rate of the health
28 benefit plan for that child, where consistent with federal regulations
29 under PPACA: age, geographic region, and family composition,
30 plus the health benefit plan selected by the child or the responsible
31 party for a child.

32 (b) From the effective date of this chapter to December 31,
33 2013, inclusive, rates for a child applying for coverage shall be
34 subject to the following limitations:

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

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

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

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

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

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

19
20 “Please consider your options carefully before failing to maintain
21 or renew coverage for a child for whom you are responsible. If
22 you attempt to obtain new individual coverage for that child, the
23 premium for the same coverage may be higher than the premium
24 you pay now.”

25
26 (d) A child who applied for coverage between September 23,
27 2010, and the end of the initial enrollment period shall be deemed
28 to have maintained coverage during that period.

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

32 (f)
33 (e) Carriers may require documentation from applicants relating
34 to their coverage history.

35 *SEC. 9. Section 10961 is added to the Insurance Code, to read:*
36 *10961. This chapter shall remain in effect only until January*
37 *1, 2014, and as of that date is repealed, unless a later enacted*
38 *statute, that is enacted before January 1, 2014, deletes or extends*
39 *that date.*

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

3
4 *CHAPTER 9.8. INDIVIDUAL ACCESS TO HEALTH INSURANCE*

5
6 *10965. For purposes of this chapter, the following definitions*
7 *shall apply:*

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

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

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

14 *(d) "Health benefit plan" means any individual or group health*
15 *insurance policy or health care service plan contract that provides*
16 *medical, hospital, and surgical benefits. The term does not include*
17 *accident only, credit, disability income, coverage of Medicare*
18 *services pursuant to contracts with the United States government,*
19 *Medicare supplement, long-term care insurance, dental, vision,*
20 *coverage issued as a supplement to liability insurance, insurance*
21 *arising out of a workers' compensation or similar law, automobile*
22 *medical payment insurance, or insurance under which benefits*
23 *are payable with or without regard to fault and that is statutorily*
24 *required to be contained in any liability insurance policy or*
25 *equivalent self-insurance.*

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

31 *(f) "Preexisting condition provision" means a policy provision*
32 *that excludes coverage for charges or expenses incurred during*
33 *a specified period following the insured's effective date of*
34 *coverage, as to a condition for which medical advice, diagnosis,*
35 *care, or treatment was recommended or received during a specified*
36 *period immediately preceding the effective date of coverage.*

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

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

1 10965.1. Every health insurer offering individual health benefit
2 plans shall, in addition to complying with the provisions of this
3 part and rules adopted thereunder, comply with the provisions of
4 this chapter.

5 10965.3. (a) (1) On and after January 1, 2014, a health
6 insurer shall fairly and affirmatively offer, market, and sell all of
7 the insurer's health benefit plans that are sold in the individual
8 market to all individuals in each service area in which the insurer
9 provides or arranges for the provision of health care services. An
10 insurer shall limit enrollment to open enrollment periods and
11 special enrollment periods as provided in subdivisions (c) and (d).

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

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

20 (c) A health insurer shall provide an initial open enrollment
21 period from October 1, 2013, to March 31, 2014, inclusive, and
22 annual enrollment periods for plan years on or after January 1,
23 2015, from October 15 to December 7, inclusive, of the preceding
24 calendar year.

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

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

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

33 (B) "Loss of minimum essential coverage" includes loss of that
34 coverage due to the circumstances described in Section
35 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of
36 Federal Regulations. "Loss of minimum essential coverage" does
37 not include loss of that coverage due to the individual's failure to
38 pay premiums on a timely basis or situations allowing for a
39 rescission, subject to Section 10384.17.

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

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

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

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

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

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

24 (2) *With respect to an individual health benefit plan offered*
25 *outside the Exchange for which an individual applies during the*
26 *initial open enrollment period described in subdivision (c), when*
27 *the individual submits a premium payment, based on the quoted*
28 *premium charges, and that payment is delivered or postmarked,*
29 *whichever occurs earlier, by December 15, 2013, coverage under*
30 *the individual health benefit plan shall become effective no later*
31 *than January 1, 2014, except that coverage for an individual under*
32 *19 years of age shall, at the option of the policyholder, become*
33 *effective as required under Section 10951. When that payment is*
34 *delivered or postmarked within the first 15 days of any subsequent*
35 *month, coverage shall become effective no later than the first day*
36 *of the following month. When that payment is delivered or*
37 *postmarked between December 16, 2013, and December 31, 2013,*
38 *inclusive, or after the 15th day of any subsequent month, coverage*
39 *shall become effective no later than the first day of the second*
40 *month following delivery or postmark of the payment.*

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

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

19 (A) *When the individual submits a premium payment, based on*
20 *the quoted premium charges, and that payment is delivered or*
21 *postmarked, whichever occurs earlier, within the first 15 days of*
22 *the month, coverage under the plan shall become effective no later*
23 *than the first day of the following month.*

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

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

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

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

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

4 (1) *Health status.*

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

6 (3) *Claims experience.*

7 (4) *Receipt of health care.*

8 (5) *Medical history.*

9 (6) *Genetic information.*

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

12 (8) *Disability.*

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

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

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

21 10965.5. (a) *Commencing January 1, 2014, no health insurer*
22 *or agent or broker shall, directly or indirectly, engage in the*
23 *following activities:*

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

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

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

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

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

8 10965.7. (a) All individual health benefit plans shall conform
 9 to the requirements of Sections 10112.1, 10127.18, 10273.4, and
 10 12682.1, and shall be renewable at the option of the insured except
 11 as permitted to be canceled, rescinded, or not renewed pursuant
 12 to Section 10273.4.

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

17 10965.9. (a) With respect to individual health benefit plans
 18 issued, amended, or renewed on or after January 1, 2014, a health
 19 insurer may use only the following characteristics of an individual,
 20 and any dependent thereof, for purposes of establishing the rate
 21 of the individual health benefit plan covering the individual and
 22 the eligible dependents thereof, along with the health benefit plan
 23 selected by the individual:

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

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

40 (3) Family size, as described in PPACA.

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

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

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

6 10965.11. *A health insurer shall not be required to offer an*
7 *individual health benefit plan or accept applications for the plan*
8 *pursuant to this chapter in the case of any of the following:*

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

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

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

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

30 10965.13. *The commissioner may require a health insurer to*
31 *discontinue the offering of individual health benefit plans or*
32 *acceptance of applications from any individual upon a*
33 *determination by the commissioner that the insurer does not have*
34 *sufficient financial viability or organizational and administrative*
35 *capacity to ensure the delivery of health care services to its*
36 *insureds. In determining whether the conditions of this section*
37 *have been met, the commissioner shall consider, but not be limited*
38 *to, the insurer's compliance with the requirements of this part and*
39 *the rules adopted under those provisions.*

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

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

12 ~~10961. (a) To the extent required by federal law, commencing~~
13 ~~on and after January 1, 2014, every health insurer shall comply~~
14 ~~with the following provisions related to the offer, sale, issuance,~~
15 ~~and renewal of individual health benefit plans, consistent with~~
16 ~~federal law and implementing rules, regulations, and federal~~
17 ~~guidance:~~

18 ~~(1) Guaranteed availability of coverage pursuant to Section~~
19 ~~2702 of the Public Health Service Act (42 U.S.C. Sec. 300gg-1).~~

20 ~~(2) Guaranteed renewability of coverage pursuant to Section~~
21 ~~2703 of the Public Health Service Act (42 U.S.C. Sec. 300gg-2).~~

22 ~~(3) The portability and nondiscrimination provisions in Sections~~
23 ~~2701, 2704, and 2705 of the Public Health Service Act (42 U.S.C.~~
24 ~~Secs. 300gg, 300gg-3, and 300gg-4).~~

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

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

34 ~~(d) The commissioner may, in consultation with the Department~~
35 ~~of Managed Health Care, adopt regulations implementing this~~
36 ~~section, pursuant to the Administrative Procedure Act (Chapter~~
37 ~~3.5 (commencing with Section 11340) of Part 1 of Division 3 of~~
38 ~~Title 2 of the Government Code).~~

O