

AMENDED IN SENATE AUGUST 24, 2012

AMENDED IN SENATE AUGUST 21, 2012

AMENDED IN ASSEMBLY APRIL 9, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1461**

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

January 9, 2012

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An act to amend Sections 1363 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 amend, renumber, and add Section 1389.1 of, to amend and repeal Sections 1389.5 and 1399.816 of, to amend, repeal, and add Sections 1389.25, 1389.4, 1389.7, 1399.805, and 1399.811 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 Section 1399.816 of, the Health and Safety Code, and to amend Sections 10291.5 and 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, to amend and repeal Sections 10119.1 and 10902.4 of, to amend, repeal, and add Sections 10113.9, 10113.95, 10119.2, 10901.3, and 10901.9 of, to add Section 10960.5 to, to add Chapter 9.9 (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, *Section 10965.3 of the Insurance Code*, relating to health care coverage.

## LEGISLATIVE COUNSEL'S DIGEST

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

(1) 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 regulation of health insurers by the Insurance Commissioner.~~ 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 require a plan ~~or insurer~~, on and after October 1, 2013, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services, with coverage effective on or after January 1, 2014, as specified, but would require plans ~~and insurers~~ to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these health benefit plans from imposing any preexisting condition upon any individual. 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 whether the plan covers an individual or family for purposes of establishing rates for individual health benefit plans, as specified. The

bill would require a health care service plan ~~or health insurer~~ to issue a specified notice at least 60 days prior to the renewal date of an individual grandfathered health plan to all subscribers ~~and policyholders~~ of the plan. ~~The bill would enact other related provisions and make related conforming changes. The bill would make certain of these provisions inoperative if the corresponding provisions of PPACA are repealed and would make other 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.

(2) PPACA requires health insurance issuers to provide a summary of benefits and coverage explanation pursuant to specified standards to applicants and enrollees or policyholders.

Existing law requires health care service plans to use disclosure forms that contain specified information regarding the contracts ~~or policies~~ issued by the plan ~~or insurer~~, including the benefits and coverage of the contract ~~or policy~~, and the exceptions, reductions, and limitations that apply to the contract ~~or policy~~. Existing law requires health care service plans that offer individual or small group coverage to also provide a uniform health plan benefits and coverage matrix containing the plan's major provisions, as specified.

This bill would authorize the Department of Managed Health Care, ~~until January 1, 2015~~, to waive or modify those requirements for purposes of compliance with PPACA, ~~as specified through issuance of all-plan letters until January 1, 2015.~~

~~(3) Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual insurance policies to fairly and affirmatively offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. Existing law prohibits the premium for those policies and contracts from exceeding the premium paid by a subscriber of the California Major Risk Medical Insurance Program who is of the same age and resides in the same geographic region as the federally eligible defined individual, as specified.~~

~~This bill would prohibit the premium for those policies and contracts from exceeding the premium for a specified plan offered in the individual market through the California Health Benefit Exchange in the rating area in which the individual resides.~~

(3) *The bill would provide that it shall become operative only if SB 961 of the 2011–12 Regular Session is also enacted.*

(4) 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.

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

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

1 SECTION 1. Section 1363 of the Health and Safety Code is  
2 amended to read:

3 1363. (a) The director shall require the use by each plan of  
4 disclosure forms or materials containing information regarding  
5 the benefits, services, and terms of the plan contract as the director  
6 may require, so as to afford the public, subscribers, and enrollees  
7 with a full and fair disclosure of the provisions of the plan in  
8 readily understood language and in a clearly organized manner.  
9 The director may require that the materials be presented in a  
10 reasonably uniform manner so as to facilitate comparisons between  
11 plan contracts of the same or other types of plans. Nothing  
12 contained in this chapter shall preclude the director from permitting  
13 the disclosure form to be included with the evidence of coverage  
14 or plan contract.

15 The disclosure form shall provide for at least the following  
16 information, in concise and specific terms, relative to the plan,  
17 together with additional information as may be required by the  
18 director, in connection with the plan or plan contract:

19 (1) The principal benefits and coverage of the plan, including  
20 coverage for acute care and subacute care.

21 (2) The exceptions, reductions, and limitations that apply to the  
22 plan.

23 (3) The full premium cost of the plan.

24 (4) Any copayment, coinsurance, or deductible requirements  
25 that may be incurred by the member or the member’s family in  
26 obtaining coverage under the plan.

1 (5) The terms under which the plan may be renewed by the plan  
2 member, including any reservation by the plan of any right to  
3 change premiums.

4 (6) A statement that the disclosure form is a summary only, and  
5 that the plan contract itself should be consulted to determine  
6 governing contractual provisions. The first page of the disclosure  
7 form shall contain a notice that conforms with all of the following  
8 conditions:

9 (A) (i) States that the evidence of coverage discloses the terms  
10 and conditions of coverage.

11 (ii) States, with respect to individual plan contracts, small group  
12 plan contracts, and any other group plan contracts for which health  
13 care services are not negotiated, that the applicant has a right to  
14 view the evidence of coverage prior to enrollment, and, if the  
15 evidence of coverage is not combined with the disclosure form,  
16 the notice shall specify where the evidence of coverage can be  
17 obtained prior to enrollment.

18 (B) Includes a statement that the disclosure and the evidence of  
19 coverage should be read completely and carefully and that  
20 individuals with special health care needs should read carefully  
21 those sections that apply to them.

22 (C) Includes the plan's telephone number or numbers that may  
23 be used by an applicant to receive additional information about  
24 the benefits of the plan or a statement where the telephone number  
25 or numbers are located in the disclosure form.

26 (D) For individual contracts, and small group plan contracts as  
27 defined in Article 3.1 (commencing with Section 1357), the  
28 disclosure form shall state where the health plan benefits and  
29 coverage matrix is located.

30 (E) Is printed in type no smaller than that used for the remainder  
31 of the disclosure form and is displayed prominently on the page.

32 (7) A statement as to when benefits shall cease in the event of  
33 nonpayment of the prepaid or periodic charge and the effect of  
34 nonpayment upon an enrollee who is hospitalized or undergoing  
35 treatment for an ongoing condition.

36 (8) To the extent that the plan permits a free choice of provider  
37 to its subscribers and enrollees, the statement shall disclose the  
38 nature and extent of choice permitted and the financial liability  
39 that is, or may be, incurred by the subscriber, enrollee, or a third  
40 party by reason of the exercise of that choice.

1 (9) A summary of the provisions required by subdivision (g) of  
2 Section 1373, if applicable.

3 (10) If the plan utilizes arbitration to settle disputes, a statement  
4 of that fact.

5 (11) A summary of, and a notice of the availability of, the  
6 process the plan uses to authorize, modify, or deny health care  
7 services under the benefits provided by the plan, pursuant to  
8 Sections 1363.5 and 1367.01.

9 (12) A description of any limitations on the patient's choice of  
10 primary care physician, specialty care physician, or nonphysician  
11 health care practitioner, based on service area and limitations on  
12 the patient's choice of acute care hospital care, subacute or  
13 transitional inpatient care, or skilled nursing facility.

14 (13) General authorization requirements for referral by a primary  
15 care physician to a specialty care physician or a nonphysician  
16 health care practitioner.

17 (14) Conditions and procedures for disenrollment.

18 (15) A description as to how an enrollee may request continuity  
19 of care as required by Section 1373.96 and request a second opinion  
20 pursuant to Section 1383.15.

21 (16) Information concerning the right of an enrollee to request  
22 an independent review in accordance with Article 5.55  
23 (commencing with Section 1374.30).

24 (17) A notice as required by Section 1364.5.

25 (b) (1) As of July 1, 1999, the director shall require each plan  
26 offering a contract to an individual or small group to provide with  
27 the disclosure form for individual and small group plan contracts  
28 a uniform health plan benefits and coverage matrix containing the  
29 plan's major provisions in order to facilitate comparisons between  
30 plan contracts. The uniform matrix shall include the following  
31 category descriptions together with the corresponding copayments  
32 and limitations in the following sequence:

33 (A) Deductibles.

34 (B) Lifetime maximums.

35 (C) Professional services.

36 (D) Outpatient services.

37 (E) Hospitalization services.

38 (F) Emergency health coverage.

39 (G) Ambulance services.

40 (H) Prescription drug coverage.

- 1 (I) Durable medical equipment.
- 2 (J) Mental health services.
- 3 (K) Chemical dependency services.
- 4 (L) Home health services.
- 5 (M) Other.

6 (2) The following statement shall be placed at the top of the  
7 matrix in all capital letters in at least 10-point boldface type:

8  
9 THIS MATRIX IS INTENDED TO BE USED TO HELP YOU  
10 COMPARE COVERAGE BENEFITS AND IS A SUMMARY  
11 ONLY. THE EVIDENCE OF COVERAGE AND PLAN  
12 CONTRACT SHOULD BE CONSULTED FOR A DETAILED  
13 DESCRIPTION OF COVERAGE BENEFITS AND  
14 LIMITATIONS.

15  
16 (c) Nothing in this section shall prevent a plan from using  
17 appropriate footnotes or disclaimers to reasonably and fairly  
18 describe coverage arrangements in order to clarify any part of the  
19 matrix that may be unclear.

20 (d) All plans, solicitors, and representatives of a plan shall, when  
21 presenting any plan contract for examination or sale to an  
22 individual prospective plan member, provide the individual with  
23 a properly completed disclosure form, as prescribed by the director  
24 pursuant to this section for each plan so examined or sold.

25 (e) In the case of group contracts, the completed disclosure form  
26 and evidence of coverage shall be presented to the contractholder  
27 upon delivery of the completed health care service plan agreement.

28 (f) Group contractholders shall disseminate copies of the  
29 completed disclosure form to all persons eligible to be a subscriber  
30 under the group contract at the time those persons are offered the  
31 plan. If the individual group members are offered a choice of plans,  
32 separate disclosure forms shall be supplied for each plan available.  
33 Each group contractholder shall also disseminate or cause to be  
34 disseminated copies of the evidence of coverage to all applicants,  
35 upon request, prior to enrollment and to all subscribers enrolled  
36 under the group contract.

37 (g) In the case of conflicts between the group contract and the  
38 evidence of coverage, the provisions of the evidence of coverage  
39 shall be binding upon the plan notwithstanding any provisions in

1 the group contract that may be less favorable to subscribers or  
2 enrollees.

3 (h) In addition to the other disclosures required by this section,  
4 every health care service plan and any agent or employee of the  
5 plan shall, when presenting a plan for examination or sale to any  
6 individual purchaser or the representative of a group consisting of  
7 25 or fewer individuals, disclose in writing the ratio of premium  
8 costs to health services paid for plan contracts with individuals  
9 and with groups of the same or similar size for the plan’s preceding  
10 fiscal year. A plan may report that information by geographic area,  
11 provided the plan identifies the geographic area and reports  
12 information applicable to that geographic area.

13 (i) Subdivision (b) shall not apply to any coverage provided by  
14 a plan for the Medi-Cal program or the Medicare program pursuant  
15 to Title XVIII and Title XIX of the Social Security Act.

16 (j) The department may waive or modify the requirements of  
17 this section for the purpose of resolving duplication or conflict  
18 with federal requirements for uniform benefit disclosure in effect  
19 pursuant to Section 2715 of the federal Public Health Service Act  
20 and the regulations adopted thereunder. The department shall  
21 implement this subdivision in a manner that preserves disclosure  
22 requirements of this section that exceed or are not in direct conflict  
23 with federal requirements. ~~The department shall consult and~~  
24 ~~coordinate with the Department of Insurance in implementing any~~  
25 ~~regulations pursuant to this subdivision in order to provide~~  
26 ~~consumers with comparable product information and uniform~~  
27 ~~benefit summaries for all health care coverage in this state,~~  
28 ~~consistent with the intent of federal law and this section. The~~  
29 ~~Notwithstanding the Administrative Procedure Act (Chapter 3.5~~  
30 ~~(commencing with Section 11340) of Part 1 of Division 3 of Title~~  
31 ~~2 of the Government Code), the department shall implement this~~  
32 section through issuance of all-plan letters until January 1, 2015.

33 ~~SEC. 2. Section 1389.1 of the Health and Safety Code is~~  
34 ~~amended and renumbered to read:~~

35 ~~1389.11. (a) The director shall not approve any plan contract~~  
36 ~~unless the director finds that the application conforms to the~~  
37 ~~following requirements, as applicable:~~

38 ~~(1) All applications for coverage, except that which is guaranteed~~  
39 ~~issue, which include health-related questions shall contain clear~~



1 and unambiguous questions designed to ascertain the health  
2 condition or history of the applicant.

3 (2) The application questions related to an applicant’s health in  
4 applications described in paragraph (1) shall be based on medical  
5 information that is reasonable and necessary for medical  
6 underwriting purposes. The application shall include a prominently  
7 displayed notice that shall read:

8 “California law prohibits an HIV test from being required or  
9 used by health care service plans as a condition of obtaining  
10 coverage.”

11 (3) All applications for coverage subject to Article 11.8  
12 (commencing with Section 1399.845) shall comply with paragraph  
13 (2) of subdivision (g) of Section 1399.849.

14 (b) Nothing in this section shall authorize the director to  
15 establish or require a single or standard application form for  
16 application questions.

17 SEC. 3. Section 1389.1 is added to the Health and Safety Code,  
18 to read:

19 1389.1. (a) For purposes of this article, the following  
20 definitions shall apply:

21 (1) “PPACA” means the federal Patient Protection and  
22 Affordable Care Act (Public Law 111-148), as amended by the  
23 federal Health Care and Education Reconciliation Act of 2010  
24 (Public Law 111-152), and any rules, regulations, or guidance  
25 issued pursuant to that law.

26 (2) “Grandfathered health plan” has the same meaning as that  
27 term is defined in Section 1251 of PPACA.

28 (b) This section shall become operative on November 1, 2013.

29 SEC. 4. Section 1389.25 of the Health and Safety Code is  
30 amended to read:

31 1389.25. (a) (1) This section shall apply only to a full-service  
32 health care service plan offering health coverage in the individual  
33 market in California and shall not apply to a specialized health  
34 care service plan, a health care service plan contract in the  
35 Medi-Cal program (Chapter 7 (commencing with Section 14000)  
36 of Part 3 of Division 9 of the Welfare and Institutions Code), a  
37 health care service plan conversion contract offered pursuant to  
38 Section 1373.6, a health care service plan contract in the Healthy  
39 Families Program (Part 6.2 (commencing with Section 12693) of  
40 Division 2 of the Insurance Code), or a health care service plan

1 contract offered to a federally eligible defined individual under  
2 Article 4.6 (commencing with Section 1366.35):

3 (2) A local initiative, as defined in subdivision (v) of Section  
4 53810 of Title 22 of the California Code of Regulations, that is  
5 awarded a contract by the State Department of Health Care Services  
6 pursuant to subdivision (b) of Section 53800 of Title 22 of the  
7 California Code of Regulations, shall not be subject to this section  
8 unless the plan offers coverage in the individual market to persons  
9 not covered by Medi-Cal or the Healthy Families Program.

10 (b) (1) A health care service plan that declines to offer coverage  
11 or denies enrollment for an individual or his or her dependents  
12 applying for individual coverage or that offers individual coverage  
13 at a rate that is higher than the standard rate, shall, at the time of  
14 the denial or offer of coverage, provide the individual applicant  
15 with the specific reason or reasons for the decision in writing in  
16 clear, easily understandable language.

17 (2) No change in the premium rate or coverage for an individual  
18 plan contract shall become effective unless the plan has delivered  
19 a written notice of the change at least 60 days prior to the effective  
20 date of the contract renewal or the date on which the rate or  
21 coverage changes. A notice of an increase in the premium rate  
22 shall include the reasons for the rate increase.

23 (3) The written notice required pursuant to paragraph (2) shall  
24 be delivered to the individual contractholder at his or her last  
25 address known to the plan, at least 60 days prior to the effective  
26 date of the change. The notice shall state in italics and in 12-point  
27 type the actual dollar amount of the premium rate increase and the  
28 specific percentage by which the current premium will be  
29 increased. The notice shall describe in plain, understandable  
30 English any changes in the plan design or any changes in benefits,  
31 including a reduction in benefits or changes to waivers, exclusions,  
32 or conditions, and highlight this information by printing it in italics.  
33 The notice shall specify in a minimum of 10-point bold typeface,  
34 the reason for a premium rate change or a change to the plan design  
35 or benefits.

36 (4) If a plan rejects an applicant or the dependents of an  
37 applicant for coverage or offers individual coverage at a rate that  
38 is higher than the standard rate, the plan shall inform the applicant  
39 about the state's high-risk health insurance pool, the California  
40 Major Risk Medical Insurance Program (MRMIP) (Part 6.5

1 (~~commencing with Section 12700~~) of Division 2 of the Insurance  
2 Code), and the federal temporary high risk pool established  
3 pursuant to Part 6.6 (~~commencing with Section 12739.5~~) of  
4 Division 2 of the Insurance Code. The information provided to the  
5 applicant by the plan shall be in accordance with standards  
6 developed by the department, in consultation with the Managed  
7 Risk Medical Insurance Board, and shall specifically include the  
8 toll-free telephone number and Internet Web site address for  
9 MRMIP and the federal temporary high risk pool. The requirement  
10 to notify applicants of the availability of MRMIP and the federal  
11 temporary high risk pool shall not apply when a health plan rejects  
12 an applicant for Medicare supplement coverage.

13 (e) ~~A notice provided pursuant to this section is a private and~~  
14 ~~confidential communication and, at the time of application, the~~  
15 ~~plan shall give the individual applicant the opportunity to designate~~  
16 ~~the address for receipt of the written notice in order to protect the~~  
17 ~~confidentiality of any personal or privileged information.~~

18 (d) ~~This section shall become inoperative on November 1, 2013,~~  
19 ~~and, as of January 1, 2014, is repealed, unless a later enacted~~  
20 ~~statute, that becomes operative on or before January 1, 2014,~~  
21 ~~deletes or extends the dates on which it becomes inoperative and~~  
22 ~~is repealed.~~

23 ~~SEC. 5. Section 1389.25 is added to the Health and Safety~~  
24 ~~Code, to read:~~

25 ~~1389.25. (a) (1) This section shall apply only to a full-service~~  
26 ~~health care service plan contract in the individual market in~~  
27 ~~California and shall not apply to a specialized health care service~~  
28 ~~plan contract, a health care service plan contract in the Medi-Cal~~  
29 ~~program (Chapter 7 (commencing with Section 14000) of Part 3~~  
30 ~~of Division 9 of the Welfare and Institutions Code), a health care~~  
31 ~~service plan conversion contract offered pursuant to Section 1373.6,~~  
32 ~~a health care service plan contract in the Healthy Families Program~~  
33 ~~(Part 6.2 (commencing with Section 12693) of Division 2 of the~~  
34 ~~Insurance Code) or the Access for Infants and Mothers Program~~  
35 ~~(Part 6.3 (commencing with Section 12695) of Division 2 of the~~  
36 ~~Insurance Code), a health care service plan contract offered under~~  
37 ~~Part 6.4 (commencing with Section 12699.50) of Division 2 of the~~  
38 ~~Insurance Code, or a health care service plan contract offered to~~  
39 ~~a federally eligible defined individual under Article 4.6~~  
40 ~~(commencing with Section 1366.35).~~

1     ~~(2) A local initiative, as defined in subdivision (v) of Section~~  
2     ~~53810 of Title 22 of the California Code of Regulations, that is~~  
3     ~~awarded a contract by the State Department of Health Care Services~~  
4     ~~pursuant to subdivision (b) of Section 53800 of Title 22 of the~~  
5     ~~California Code of Regulations, shall not be subject to this section~~  
6     ~~unless the plan offers coverage in the individual market to persons~~  
7     ~~not covered by Medi-Cal or the Healthy Families Program.~~

8     ~~(b) (1) No change in the premium rate or coverage for an~~  
9     ~~individual health care service plan contract shall become effective~~  
10    ~~unless the plan has delivered a written notice of the change at least~~  
11    ~~60 days prior to the effective date of the contract renewal or the~~  
12    ~~date on which the rate or coverage changes. A notice of an increase~~  
13    ~~in the premium rate shall include the reasons for the rate increase.~~

14    ~~(2) The written notice required pursuant to paragraph (1) shall~~  
15    ~~be delivered to the individual contractholder at his or her last~~  
16    ~~address known to the plan, at least 60 days prior to the effective~~  
17    ~~date of the change. The notice shall state in italics and in 12-point~~  
18    ~~type the actual dollar amount of the premium rate increase and the~~  
19    ~~specific percentage by which the current premium will be~~  
20    ~~increased. The notice shall describe in plain, understandable~~  
21    ~~English any changes in the plan design or any changes in benefits,~~  
22    ~~including a reduction in benefits or changes to waivers, exclusions,~~  
23    ~~or conditions, and highlight this information by printing it in italics.~~  
24    ~~The notice shall specify in a minimum of 10-point bold typeface,~~  
25    ~~the reason for a premium rate change or a change to the plan design~~  
26    ~~or benefits. For individual grandfathered health plans, the notice~~  
27    ~~shall also inform the individual contractholder about the availability~~  
28    ~~of new coverage options and the potential for subsidized coverage~~  
29    ~~in the California Health Benefit Exchange. The notice shall direct~~  
30    ~~persons seeking more information to the California Health Benefit~~  
31    ~~Exchange, the Office of Patient Advocate, plan or policy~~  
32    ~~representatives, and insurance brokers or health navigators.~~

33    ~~(e) (1) A health care service plan that declines to offer coverage~~  
34    ~~or denies enrollment for an individual or his or her dependents~~  
35    ~~applying for an individual grandfathered health plan or that offers~~  
36    ~~an individual grandfathered health plan at a rate that is higher than~~  
37    ~~the standard rate, shall, at the time of the denial or offer of~~  
38    ~~coverage, provide the individual applicant with the specific reason~~  
39    ~~or reasons for the decision in writing in clear, easily understandable~~  
40    ~~language.~~

1 ~~(2) If a plan rejects the dependents of an applicant for an~~  
2 ~~individual grandfathered health plan or offers an individual~~  
3 ~~grandfathered health plan at a rate that is higher than the standard~~  
4 ~~rate, the plan shall inform the applicant about the new coverage~~  
5 ~~options and the potential for subsidized coverage in the California~~  
6 ~~Health Benefit Exchange. The plan shall direct persons seeking~~  
7 ~~more information to the California Health Benefit Exchange, the~~  
8 ~~Office of Patient Advocate, plan or policy representatives, and~~  
9 ~~insurance brokers or health navigators.~~

10 ~~(d) A notice provided pursuant to this section is a private and~~  
11 ~~confidential communication and, at the time of application, the~~  
12 ~~plan shall give the individual applicant the opportunity to designate~~  
13 ~~the address for receipt of the written notice in order to protect the~~  
14 ~~confidentiality of any personal or privileged information.~~

15 ~~(e) This section shall become operative on November 1, 2013.~~

16 ~~SEC. 6. Section 1389.4 of the Health and Safety Code is~~  
17 ~~amended to read:~~

18 ~~1389.4. (a) A full service health care service plan that issues,~~  
19 ~~renews, or amends individual health plan contracts shall be subject~~  
20 ~~to this section.~~

21 ~~(b) A health care service plan subject to this section shall have~~  
22 ~~written policies, procedures, or underwriting guidelines establishing~~  
23 ~~the criteria and process whereby the plan makes its decision to~~  
24 ~~provide or to deny coverage to individuals applying for coverage~~  
25 ~~and sets the rate for that coverage. These guidelines, policies, or~~  
26 ~~procedures shall assure that the plan rating and underwriting criteria~~  
27 ~~comply with Sections 1365.5 and 1389.11 and all other applicable~~  
28 ~~provisions of state and federal law.~~

29 ~~(c) On or before June 1, 2006, and annually thereafter, every~~  
30 ~~health care service plan shall file with the department a general~~  
31 ~~description of the criteria, policies, procedures, or guidelines the~~  
32 ~~plan uses for rating and underwriting decisions related to individual~~  
33 ~~health plan contracts, which means automatic declinable health~~  
34 ~~conditions, health conditions that may lead to a coverage decline,~~  
35 ~~height and weight standards, health history, health care utilization,~~  
36 ~~lifestyle, or behavior that might result in a decline for coverage or~~  
37 ~~severely limit the plan products for which they would be eligible.~~  
38 ~~A plan may comply with this section by submitting to the~~  
39 ~~department underwriting materials or resource guides provided to~~

1 plan solicitors or solicitor firms, provided that those materials  
2 include the information required to be submitted by this section.

3 (d) Commencing January 1, 2011, the director shall post on the  
4 department’s Internet Web site, in a manner accessible and  
5 understandable to consumers, general, noncompany specific  
6 information about rating and underwriting criteria and practices  
7 in the individual market and information about the California Major  
8 Risk Medical Insurance Program (Part 6.5 (commencing with  
9 Section 12700) of Division 2 of the Insurance Code) and the federal  
10 temporary high risk pool established pursuant to Part 6.6  
11 (commencing with Section 12739.5) of Division 2 of the Insurance  
12 Code. The director shall develop the information for the Internet  
13 Web site in consultation with the Department of Insurance to  
14 enhance the consistency of information provided to consumers.  
15 Information about individual health coverage shall also include  
16 the following notification:

17 “Please examine your options carefully before declining group  
18 coverage or continuation coverage, such as COBRA, that may be  
19 available to you. You should be aware that companies selling  
20 individual health insurance typically require a review of your  
21 medical history that could result in a higher premium or you could  
22 be denied coverage entirely.”

23 (e) Nothing in this section shall authorize public disclosure of  
24 company specific rating and underwriting criteria and practices  
25 submitted to the director.

26 (f) This section shall not apply to a closed block of business, as  
27 defined in Section 1367.15.

28 (g) This section shall become inoperative on November 1, 2013,  
29 and, as of January 1, 2014, is repealed, unless a later enacted  
30 statute, that becomes operative on or before January 1, 2014,  
31 deletes or extends the dates on which it becomes inoperative and  
32 is repealed.

33 SEC. 7. Section 1389.4 is added to the Health and Safety Code,  
34 to read:

35 1389.4. (a) A full service health care service plan that renews  
36 individual grandfathered health plans shall be subject to this  
37 section.

38 (b) A health care service plan subject to this section shall have  
39 written policies, procedures, or underwriting guidelines establishing  
40 the criteria and process whereby the plan makes its decision to

1 provide or to deny coverage to individuals applying for an  
2 individual grandfathered health plan and sets the rate for that  
3 coverage. These guidelines, policies, or procedures shall ensure  
4 that the plan rating and underwriting criteria comply with Sections  
5 1365.5 and 1389.11 and all other applicable provisions of state  
6 and federal law.

7 (e) On or before November 1, 2013, and annually thereafter,  
8 every health care service plan shall file with the department a  
9 general description of the criteria, policies, procedures, or  
10 guidelines the plan uses for rating and underwriting decisions  
11 related to individual grandfathered health plans, which means  
12 automatic declinable health conditions, health conditions that may  
13 lead to a coverage decline, height and weight standards, health  
14 history, health care utilization, lifestyle, or behavior that might  
15 result in a decline for coverage or severely limit the plan products  
16 for which they would be eligible. A plan may comply with this  
17 section by submitting to the department underwriting materials or  
18 resource guides provided to plan solicitors or solicitor firms,  
19 provided that those materials include the information required to  
20 be submitted by this section.

21 (d) Nothing in this section shall authorize public disclosure of  
22 company specific rating and underwriting criteria and practices  
23 submitted to the director.

24 (e) This section shall not apply to a closed block of business,  
25 as defined in Section 1367.15.

26 (f) This section shall become operative on November 1, 2013.

27 SEC. 8. Section 1389.5 of the Health and Safety Code is  
28 amended to read:

29 1389.5. (a) This section shall apply to a health care service  
30 plan that provides coverage under an individual plan contract that  
31 is issued, amended, delivered, or renewed on or after January 1,  
32 2007.

33 (b) At least once each year, the health care service plan shall  
34 permit an individual who has been covered for at least 18 months  
35 under an individual plan contract to transfer, without medical  
36 underwriting, to any other individual plan contract offered by that  
37 same health care service plan that provides equal or lesser benefits,  
38 as determined by the plan.

39 “Without medical underwriting” means that the health care  
40 service plan shall not decline to offer coverage to, or deny

- 1 enrollment of, the individual or impose any preexisting condition  
 2 exclusion on the individual who transfers to another individual  
 3 plan contract pursuant to this section.
- 4 (e) ~~The plan shall establish, for the purposes of subdivision (b),  
 5 a ranking of the individual plan contracts it offers to individual  
 6 purchasers and post the ranking on its Internet Web site or make  
 7 the ranking available upon request. The plan shall update the  
 8 ranking whenever a new benefit design for individual purchasers  
 9 is approved.~~
- 10 (d) ~~The plan shall notify in writing all enrollees of the right to  
 11 transfer to another individual plan contract pursuant to this section,  
 12 at a minimum, when the plan changes the enrollee's premium rate.  
 13 Posting this information on the plan's Internet Web site shall not  
 14 constitute notice for purposes of this subdivision. The notice shall  
 15 adequately inform enrollees of the transfer rights provided under  
 16 this section, including information on the process to obtain details  
 17 about the individual plan contracts available to that enrollee and  
 18 advising that the enrollee may be unable to return to his or her  
 19 current individual plan contract if the enrollee transfers to another  
 20 individual plan contract.~~
- 21 (e) ~~The requirements of this section shall not apply to the  
 22 following:~~
- 23 (1) ~~A federally eligible defined individual, as defined in  
 24 subdivision (c) of Section 1399.801, who is enrolled in an  
 25 individual health benefit plan contract offered pursuant to Section  
 26 1366.35.~~
- 27 (2) ~~An individual offered conversion coverage pursuant to  
 28 Section 1373.6.~~
- 29 (3) ~~Individual coverage under a specialized health care service  
 30 plan contract.~~
- 31 (4) ~~An individual enrolled in the Medi-Cal program pursuant  
 32 to Chapter 7 (commencing with Section 14000) of Division 9 of  
 33 Part 3 of the Welfare and Institutions Code.~~
- 34 (5) ~~An individual enrolled in the Access for Infants and Mothers  
 35 Program pursuant to Part 6.3 (commencing with Section 12695)  
 36 of Division 2 of the Insurance Code.~~
- 37 (6) ~~An individual enrolled in the Healthy Families Program  
 38 pursuant to Part 6.2 (commencing with Section 12693) of Division  
 39 2 of the Insurance Code.~~



1 (f) It is the intent of the Legislature that individuals shall have  
2 more choice in their health coverage when health care service plans  
3 guarantee the right of an individual to transfer to another product  
4 based on the plan's own ranking system. The Legislature does not  
5 intend for the department to review or verify the plan's ranking  
6 for actuarial or other purposes.

7 (g) This section shall remain in effect only until January 1, 2014,  
8 and as of that date is repealed, unless a later enacted statute, that  
9 is enacted before January 1, 2014, deletes or extends that date.

10 SEC. 9. Section 1389.7 of the Health and Safety Code is  
11 amended to read:

12 1389.7. (a) Every health care service plan that offers, issues,  
13 or renews individual plan contracts shall offer to any individual,  
14 who was covered under an individual plan contract that was  
15 rescinded, a new individual plan contract, without medical  
16 underwriting, that provides equal benefits. A health care service  
17 plan may also permit an individual, who was covered under an  
18 individual plan contract that was rescinded, to remain covered  
19 under that individual plan contract, with a revised premium rate  
20 that reflects the number of persons remaining on the plan contract.

21 (b) "Without medical underwriting" means that the health care  
22 service plan shall not decline to offer coverage to, or deny  
23 enrollment of, the individual or impose any preexisting condition  
24 exclusion on the individual who is issued a new individual plan  
25 contract or remains covered under an individual plan contract  
26 pursuant to this section.

27 (c) If a new individual plan contract is issued, the plan may  
28 revise the premium rate to reflect only the number of persons  
29 covered on the new individual plan contract.

30 (d) Notwithstanding subdivision (a) and (b), if an individual  
31 was subject to a preexisting condition provision or a waiting or an  
32 affiliation period under the individual plan contract that was  
33 rescinded, the health care service plan may apply the same  
34 preexisting condition provision or waiting or affiliation period in  
35 the new individual plan contract. The time period in the new  
36 individual plan contract for the preexisting condition provision or  
37 waiting or affiliation period shall not be longer than the one in the  
38 individual plan contract that was rescinded and the health care  
39 service plan shall credit any time that the individual was covered  
40 under the rescinded individual plan contract.

1     ~~(e) The plan shall notify in writing all enrollees of the right to~~  
2 ~~coverage under an individual plan contract pursuant to this section,~~  
3 ~~at a minimum, when the plan rescinds the individual plan contract.~~  
4 ~~The notice shall adequately inform enrollees of the right to~~  
5 ~~coverage provided under this section.~~

6     ~~(f) The plan shall provide 60 days for enrollees to accept the~~  
7 ~~offered new individual plan contract and this contract shall be~~  
8 ~~effective as of the effective date of the original plan contract and~~  
9 ~~there shall be no lapse in coverage.~~

10    ~~(g) This section shall not apply to any individual whose~~  
11 ~~information in the application for coverage and related~~  
12 ~~communications led to the rescission.~~

13    ~~(h) This section shall remain in effect only until January 1, 2014,~~  
14 ~~and as of that date is repealed, unless a later enacted statute, that~~  
15 ~~is enacted before January 1, 2014, deletes or extends that date.~~

16    ~~SEC. 10. Section 1389.7 is added to the Health and Safety~~  
17 ~~Code, to read:~~

18    ~~1389.7. (a) Every health care service plan that offers, issues,~~  
19 ~~or renews individual plan contracts shall offer to any individual,~~  
20 ~~who was covered under an individual plan contract that was~~  
21 ~~rescinded, a new individual plan contract that provides equal~~  
22 ~~benefits. A health care service plan may also permit an individual,~~  
23 ~~who was covered under an individual plan contract that was~~  
24 ~~rescinded, to remain covered under that individual plan contract,~~  
25 ~~with a revised premium rate that reflects the number of persons~~  
26 ~~remaining on the plan contract consistent with Section 1399.855.~~

27    ~~(b) If a new individual plan contract is issued, the plan may~~  
28 ~~revise the premium rate to reflect only the number of persons~~  
29 ~~covered on the new individual plan contract consistent with Section~~  
30 ~~1399.855.~~

31    ~~(c) The plan shall notify in writing all enrollees of the right to~~  
32 ~~coverage under an individual plan contract pursuant to this section,~~  
33 ~~at a minimum, when the plan rescinds the individual plan contract.~~  
34 ~~The notice shall adequately inform enrollees of the right to~~  
35 ~~coverage provided under this section.~~

36    ~~(d) The plan shall provide 60 days for enrollees to accept the~~  
37 ~~offered new individual plan contract, and this contract shall be~~  
38 ~~effective as of the effective date of the original plan contract and~~  
39 ~~there shall be no lapse in coverage.~~

1 ~~(e) This section shall not apply to any individual whose~~  
2 ~~information in the application for coverage and related~~  
3 ~~communications led to the rescission.~~

4 ~~(f) This section shall apply notwithstanding subdivision (a) or~~  
5 ~~(d) of Section 1399.849.~~

6 ~~(g) This section shall become operative on January 1, 2014.~~

7 SEC. 11. Section 1399.805 of the Health and Safety Code is  
8 amended to read:

9 1399.805. (a) (1) After the federally eligible defined individual  
10 submits a completed application form for a plan contract, the plan  
11 shall, within 30 days, notify the individual of the individual's actual  
12 premium charges for that plan contract, unless the plan has  
13 provided notice of the premium charge prior to the application  
14 being filed. In no case shall the premium charged for any health  
15 care service plan contract identified in subdivision (d) of Section  
16 1366.35 exceed the following amounts:

17 (A) For health care service plan contracts that offer services  
18 through a preferred provider arrangement, the average premium  
19 paid by a subscriber of the Major Risk Medical Insurance Program  
20 who is of the same age and resides in the same geographic area as  
21 the federally eligible defined individual. However, for federally  
22 qualified individuals who are between the ages of 60 and 64,  
23 inclusive, the premium shall not exceed the average premium paid  
24 by a subscriber of the Major Risk Medical Insurance Program who  
25 is 59 years of age and resides in the same geographic area as the  
26 federally eligible defined individual.

27 (B) For health care service plan contracts identified in  
28 subdivision (d) of Section 1366.35 that do not offer services  
29 through a preferred provider arrangement, 170 percent of the  
30 standard premium charged to an individual who is of the same age  
31 and resides in the same geographic area as the federally eligible  
32 defined individual. However, for federally qualified individuals  
33 who are between the ages of 60 and 64, inclusive, the premium  
34 shall not exceed 170 percent of the standard premium charged to  
35 an individual who is 59 years of age and resides in the same  
36 geographic area as the federally eligible defined individual. The  
37 individual shall have 30 days in which to exercise the right to buy  
38 coverage at the quoted premium rates.

39 (2) A plan may adjust the premium based on family size, not to  
40 exceed the following amounts:

1 (A) For health care service plans that offer services through a  
2 preferred provider arrangement, the average of the Major Risk  
3 Medical Insurance Program rate for families of the same size that  
4 reside in the same geographic area as the federally eligible defined  
5 individual.

6 (B) For health care service plans identified in subdivision (d)  
7 of Section 1366.35 that do not offer services through a preferred  
8 provider arrangement, 170 percent of the standard premium charged  
9 to a family that is of the same size and resides in the same  
10 geographic area as the federally eligible defined individual.

11 (b) When a federally eligible defined individual submits a  
12 premium payment, based on the quoted premium charges, and that  
13 payment is delivered or postmarked, whichever occurs earlier,  
14 within the first 15 days of the month, coverage shall begin no later  
15 than the first day of the following month. When that payment is  
16 neither delivered or postmarked until after the 15th day of a month,  
17 coverage shall become effective no later than the first day of the  
18 second month following delivery or postmark of the payment.

19 (c) During the first 30 days after the effective date of the plan  
20 contract, the individual shall have the option of changing coverage  
21 to a different plan contract offered by the same health care service  
22 plan. If the individual notified the plan of the change within the  
23 first 15 days of a month, coverage under the new plan contract  
24 shall become effective no later than the first day of the following  
25 month. If an enrolled individual notified the plan of the change  
26 after the 15th day of a month, coverage under the new plan contract  
27 shall become effective no later than the first day of the second  
28 month following notification.

29 (d) This section shall remain in effect only until January 1, 2014,  
30 and as of that date is repealed, unless a later enacted statute, that  
31 is enacted before January 1, 2014, deletes or extends that date.

32 SEC. 12. Section 1399.805 is added to the Health and Safety  
33 Code, to read:

34 1399.805. (a) After the federally eligible defined individual  
35 submits a completed application form for a plan contract, the plan  
36 shall, within 30 days, notify the individual of the individual's actual  
37 premium charges for that plan contract, unless the plan has  
38 provided notice of the premium charge prior to the application  
39 being filed. In no case shall the premium charged for any health  
40 care service plan contract identified in subdivision (d) of Section

1 1366.35 exceed the premium for the second lowest cost silver plan  
2 of the individual market in the rating area in which the individual  
3 resides which is offered through the California Health Benefit  
4 Exchange established under Title 22 (commencing with Section  
5 100500) of the Government Code, as described in Section  
6 36B(b)(3)(B) of Title 26 of the United States Code.

7 (b) ~~When a federally eligible defined individual submits a~~  
8 ~~premium payment, based on the quoted premium charges, and that~~  
9 ~~payment is delivered or postmarked, whichever occurs earlier,~~  
10 ~~within the first 15 days of the month, coverage shall begin no later~~  
11 ~~than the first day of the following month. When that payment is~~  
12 ~~neither delivered nor postmarked until after the 15th day of a~~  
13 ~~month, coverage shall become effective no later than the first day~~  
14 ~~of the second month following delivery or postmark of the~~  
15 ~~payment.~~

16 (e) ~~During the first 30 days after the effective date of the plan~~  
17 ~~contract, the individual shall have the option of changing coverage~~  
18 ~~to a different plan contract offered by the same health care service~~  
19 ~~plan. If the individual notified the plan of the change within the~~  
20 ~~first 15 days of a month, coverage under the new plan contract~~  
21 ~~shall become effective no later than the first day of the following~~  
22 ~~month. If an enrolled individual notified the plan of the change~~  
23 ~~after the 15th day of a month, coverage under the new plan contract~~  
24 ~~shall become effective no later than the first day of the second~~  
25 ~~month following notification.~~

26 (d) ~~This section shall become operative on January 1, 2014.~~

27 ~~SEC. 13. Section 1399.811 of the Health and Safety Code is~~  
28 ~~amended to read:~~

29 ~~1399.811. Premiums for contracts offered, delivered, amended,~~  
30 ~~or renewed by plans on or after January 1, 2001, shall be subject~~  
31 ~~to the following requirements:~~

32 (a) ~~The premium for new business for a federally eligible defined~~  
33 ~~individual shall not exceed the following amounts:~~

34 (1) ~~For health care service plan contracts identified in~~  
35 ~~subdivision (d) of Section 1366.35 that offer services through a~~  
36 ~~preferred provider arrangement, the average premium paid by a~~  
37 ~~subscriber of the Major Risk Medical Insurance Program who is~~  
38 ~~of the same age and resides in the same geographic area as the~~  
39 ~~federally eligible defined individual. However, for federally~~  
40 ~~qualified individuals who are between the ages of 60 to 64 years,~~

1 inclusive, the premium shall not exceed the average premium paid  
2 by a subscriber of the Major Risk Medical Insurance Program who  
3 is 59 years of age and resides in the same geographic area as the  
4 federally eligible defined individual.

5 ~~(2) For health care service plan contracts identified in~~  
6 ~~subdivision (d) of Section 1366.35 that do not offer services~~  
7 ~~through a preferred provider arrangement, 170 percent of the~~  
8 ~~standard premium charged to an individual who is of the same age~~  
9 ~~and resides in the same geographic area as the federally eligible~~  
10 ~~defined individual. However, for federally qualified individuals~~  
11 ~~who are between the ages of 60 to 64 years, inclusive, the premium~~  
12 ~~shall not exceed 170 percent of the standard premium charged to~~  
13 ~~an individual who is 59 years of age and resides in the same~~  
14 ~~geographic area as the federally eligible defined individual.~~

15 ~~(b) The premium for in force business for a federally eligible~~  
16 ~~defined individual shall not exceed the following amounts:~~

17 ~~(1) For health care service plan contracts identified in~~  
18 ~~subdivision (d) of Section 1366.35 that offer services through a~~  
19 ~~preferred provider arrangement, the average premium paid by a~~  
20 ~~subscriber of the Major Risk Medical Insurance Program who is~~  
21 ~~of the same age and resides in the same geographic area as the~~  
22 ~~federally eligible defined individual. However, for federally~~  
23 ~~qualified individuals who are between the ages of 60 and 64 years,~~  
24 ~~inclusive, the premium shall not exceed the average premium paid~~  
25 ~~by a subscriber of the Major Risk Medical Insurance Program who~~  
26 ~~is 59 years of age and resides in the same geographic area as the~~  
27 ~~federally eligible defined individual.~~

28 ~~(2) For health care service plan contracts identified in~~  
29 ~~subdivision (d) of Section 1366.35 that do not offer services~~  
30 ~~through a preferred provider arrangement, 170 percent of the~~  
31 ~~standard premium charged to an individual who is of the same age~~  
32 ~~and resides in the same geographic area as the federally eligible~~  
33 ~~defined individual. However, for federally qualified individuals~~  
34 ~~who are between the ages of 60 and 64 years, inclusive, the~~  
35 ~~premium shall not exceed 170 percent of the standard premium~~  
36 ~~charged to an individual who is 59 years of age and resides in the~~  
37 ~~same geographic area as the federally eligible defined individual.~~  
38 ~~The premium effective on January 1, 2001, shall apply to in force~~  
39 ~~business at the earlier of either the time of renewal or July 1, 2001.~~

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

3 ~~(1) For health care service plan contracts identified in~~  
4 ~~subdivision (d) of Section 1366.35 that offer services through a~~  
5 ~~preferred provider arrangement, the average increase in the~~  
6 ~~premiums charged to a subscriber of the Major Risk Medical~~  
7 ~~Insurance Program who is of the same age and resides in the same~~  
8 ~~geographic area as the federally eligible defined individual.~~

9 ~~(2) For health care service plan contracts identified in~~  
10 ~~subdivision (d) of Section 1366.35 that do not offer services~~  
11 ~~through a preferred provider arrangement, the increase in premiums~~  
12 ~~charged to a nonfederally qualified individual who is of the same~~  
13 ~~age and resides in the same geographic area as the federally defined~~  
14 ~~eligible individual. The premium for an eligible individual may~~  
15 ~~not be modified more frequently than every 12 months.~~

16 ~~(3) For a contract that a plan has discontinued offering, the~~  
17 ~~premium applied to the first rating period of the new contract that~~  
18 ~~the federally eligible defined individual elects to purchase shall~~  
19 ~~be no greater than the premium applied in the prior rating period~~  
20 ~~to the discontinued contract.~~

21 ~~(4) This section shall remain in effect only until January 1, 2014,~~  
22 ~~and as of that date is repealed, unless a later enacted statute, that~~  
23 ~~is enacted before January 1, 2014, deletes or extends that date.~~

24 ~~SEC. 14. Section 1399.811 is added to the Health and Safety~~  
25 ~~Code, to read:~~

26 ~~1399.811.—(a) Premiums for contracts offered, delivered,~~  
27 ~~amended, or renewed by plans on or after January 1, 2014, shall~~  
28 ~~be subject to the following requirements:~~

29 ~~(1) The premium for in force or new business for a federally~~  
30 ~~eligible defined individual shall not exceed the premium for the~~  
31 ~~second lowest cost silver plan of the individual market in the rating~~  
32 ~~area in which the individual resides which is offered through the~~  
33 ~~California Health Benefit Exchange established under Title 22~~  
34 ~~(commencing with Section 100500) of the Government Code, as~~  
35 ~~described in Section 36B(b)(3)(B) of Title 26 of the United States~~  
36 ~~Code.~~

37 ~~(2) For a contract that a plan has discontinued offering, the~~  
38 ~~premium applied to the first rating period of the new contract that~~  
39 ~~the federally eligible defined individual elects to purchase shall~~

1 be no greater than the premium applied in the prior rating period  
2 to the discontinued contract.

3 (b) This section shall become operative on January 1, 2014.

4 SEC. 15. Section 1399.816 of the Health and Safety Code is  
5 amended to read:

6 1399.816. (a) Carriers and health care service plans that offer  
7 contracts to individuals may elect to establish a mechanism or  
8 method to share in the financing of high-risk individuals. This  
9 mechanism or method shall be established through a committee  
10 of all carriers and health care service plans offering coverage to  
11 individuals by July 1, 2002, and shall be implemented by January  
12 1, 2003. If carriers and health care service plans wish to establish  
13 a risk-sharing mechanism but cannot agree on the terms and  
14 conditions of such an agreement, the Managed Risk Medical  
15 Insurance Board shall develop a risk-sharing mechanism or method  
16 by January 1, 2003, and it shall be implemented by July 1, 2003.

17 (b) This section shall remain in effect only until January 1, 2014,  
18 and as of that date is repealed, unless a later enacted statute, that  
19 is enacted before January 1, 2014, deletes or extends that date.

20 SEC. 2. Section 1399.816 of the Health and Safety Code is  
21 repealed.

22 1399.816. Carriers and health care service plans that offer  
23 contracts to individuals may elect to establish a mechanism or  
24 method to share in the financing of high-risk individuals. This  
25 mechanism or method shall be established through a committee  
26 of all carriers and health care service plans offering coverage to  
27 individuals by July 1, 2002, and shall be implemented by January  
28 1, 2003. If carriers and health care service plans wish to establish  
29 a risk-sharing mechanism but cannot agree on the terms and  
30 conditions of such an agreement, the Managed Risk Medical  
31 Insurance Board shall develop a risk-sharing mechanism or method  
32 by January 1, 2003, and it shall be implemented by July 1, 2003.

33 SEC. 16.

34 SEC. 3. The heading of Article 11.7 (commencing with Section  
35 1399.825) of Chapter 2.2 of Division 2 of the Health and Safety  
36 Code is amended to read:

37  
38 Article 11.7. Child Access to Health Care Coverage  
39



1 ~~SEC. 17.~~

2 *SEC. 4.* Section 1399.829 of the Health and Safety Code is  
3 amended to read:

4 1399.829. (a) A health care service plan may use the following  
5 characteristics of an eligible child for purposes of establishing the  
6 rate of the plan contract for that child, where consistent with federal  
7 regulations under PPACA: age, geographic region, and family  
8 composition, plus the health care service plan contract selected by  
9 the child or the responsible party for the child.

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

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

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

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

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

34 (c) For any individual health care service plan contract issued,  
35 sold, or renewed prior to December 31, 2013, the health plan shall  
36 provide to a child or responsible party for a child a notice that  
37 states the following:

38  
39 "Please consider your options carefully before failing to maintain  
40 or renewing coverage for a child for whom you are responsible.

1 If you attempt to obtain new individual coverage for that child,  
 2 the premium for the same coverage may be higher than the  
 3 premium you pay now.”

4  
 5 (d) A child who applied for coverage between September 23,  
 6 2010, and the end of the initial open enrollment period shall be  
 7 deemed to have maintained coverage during that period.

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

11 (e)  
 12 (f) Health care service plans—~~may~~ *shall not* require  
 13 documentation from applicants relating to their coverage history.

14 (f)  
 15 (g) (1) On and after January 1, 2013, *and until January 1, 2014,*  
 16 a health care service plan shall provide a notice to all applicants  
 17 for coverage under this article and to all enrollees, or the  
 18 responsible party for an enrollee, renewing coverage under this  
 19 article that contains the following information:

20 (A) Information about the open enrollment period provided  
 21 under Section 1399.849.

22 (B) An explanation that obtaining coverage during the open  
 23 enrollment period described in Section 1399.849 will not affect  
 24 the effective dates of coverage for coverage purchased pursuant  
 25 to this article unless the applicant cancels that coverage.

26 (C) An explanation that coverage purchased pursuant to this  
 27 section shall be effective as required under subdivision (d) of  
 28 Section 1399.826 and that such coverage shall not prevent an  
 29 applicant from obtaining new coverage during the open enrollment  
 30 period described in Section 1399.849.

31 (D) *Information about the Medi-Cal program and the Healthy*  
 32 *Families Program and about subsidies available through the*  
 33 *California Health Benefit Exchange.*

34 (2) The notice described in paragraph (1) shall be in plain  
 35 language and 14-point type.

36 (3) The department may adopt a model notice to be used by  
 37 health care service plans in order to comply with this subdivision,  
 38 *and shall consult with the Department of Insurance in adopting*  
 39 *that model notice.* Use of the model notice shall not require prior  
 40 approval of the department. Any model notice designated by the

1 department for purposes of this section shall not be subject to the  
2 Administrative Procedure Act (Chapter 3.5 (commencing with  
3 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
4 Code).

5 ~~SEC. 18. Section 1399.836 is added to the Health and Safety  
6 Code, to read:~~

7 ~~1399.836. This article shall remain in effect only until January  
8 1, 2014, and as of that date is repealed, unless a later enacted  
9 statute, that is enacted before January 1, 2014, deletes or extends  
10 that date.~~

11 *SEC. 5. Section 1399.836 is added to the Health and Safety  
12 Code, to read:*

13 *1399.836. Commencing January 1, 2014, in the event of a  
14 conflict between the provisions of this chapter and the provisions  
15 of Chapter 11.8 (commencing with Section 1399.845), the  
16 provisions of Chapter 11.8 (commencing with Section 1399.845)  
17 shall prevail, except where subdivision (j) of Section 1399.849 or  
18 subdivision (e) of Section 1399.855 makes any of the provisions  
19 of Chapter 11.8 (commencing with Section 1399.845) inoperative,  
20 in which case the provisions of this chapter and the operative  
21 provisions of Chapter 11.8 (commencing with Section 1399.845)  
22 shall be harmonized to the extent permitted by federal law.*

23 ~~SEC. 19.~~

24 *SEC. 6. Article 11.8 (commencing with Section 1399.845) is  
25 added to Chapter 2.2 of Division 2 of the Health and Safety Code,  
26 to read:*

27  
28 *Article 11.8. Individual Access to Health Care Coverage*

29  
30 *1399.845. For purposes of this article, the following definitions  
31 shall apply:*

32 *(a) "Child" means a child described in Section 22775 of the  
33 Government Code and subdivisions (n) to (p), inclusive, of Section  
34 599.500 of Title 2 of the California Code of Regulations.*

35 *(b) "Dependent" means the spouse, or registered domestic  
36 partner, or child, of an individual, subject to applicable terms of  
37 the health benefit plan.*

38 *(c) "Exchange" means the California Health Benefit Exchange  
39 created by Section 100500 of the Government Code.*

1 (d) “Grandfathered health plan” has the same meaning as that  
2 term is defined in Section 1251 of PPACA.

3 (e) “Health benefit plan” means any individual or group ~~policy~~  
4 ~~of health insurance as defined in Section 106 of the Insurance Code~~  
5 ~~or health care service plan contract that provides medical, hospital,~~  
6 ~~and surgical benefits. The term does not include a specialized~~  
7 ~~health insurance policy, as defined in Section 106 of the Insurance~~  
8 ~~Code, a specialized health care service plan contract, a health care~~  
9 ~~service plan conversion contract offered pursuant to Section 1373.6,~~  
10 ~~a health insurance conversion policy offered pursuant to Section~~  
11 ~~12682.1 of the Insurance Code, a health insurance policy or health~~  
12 ~~care service plan contract provided in the Medi-Cal program~~  
13 ~~(Chapter 7 (commencing with Section 14000) of Part 3 of Division~~  
14 ~~9 of the Welfare and Institutions Code), the Healthy Families~~  
15 ~~Program (Part 6.2 (commencing with Section 12693) of Division~~  
16 ~~2 of the Insurance Code), the Access for Infants and Mothers~~  
17 ~~Program (Part 6.3 (commencing with Section 12695) of Division~~  
18 ~~2 of the Insurance Code), or the program under Part 6.4~~  
19 ~~(commencing with Section 12699.50) of Division 2 of the~~  
20 ~~Insurance Code, a health care service plan contract or health~~  
21 ~~insurance policy offered to a federally eligible defined individual~~  
22 ~~under Article 4.6 (commencing with Section 1366.35) of this code~~  
23 ~~or Chapter 9.5 (commencing with Section 10900) of Part 2 of~~  
24 ~~Division 2 of the Insurance Code, or Medicare supplement~~  
25 ~~coverage, to the extent consistent with PPACA.~~

26 (f) “Policy year” has the meaning set forth in Section 144.103  
27 of Title 45 of the Code of Federal Regulations.

28 (f)

29 (g) “PPACA” means the federal Patient Protection and  
30 Affordable Care Act (Public Law 111-148), as amended by the  
31 federal Health Care and Education Reconciliation Act of 2010  
32 (Public Law 111-152), and any rules, regulations, or guidance  
33 issued pursuant to that law.

34 (g)

35 (h) “Preexisting condition provision” means a contract provision  
36 that excludes coverage for charges or expenses incurred during a  
37 specified period following the enrollee’s effective date of coverage,  
38 as to a condition for which medical advice, diagnosis, care, or  
39 treatment was recommended or received during a specified period  
40 immediately preceding the effective date of coverage.

1     ~~(h)~~

2     (i) “Qualified health plan” has the same meaning as that term  
3 is defined in Section 1301 of PPACA.

4     ~~(i)~~

5     (j) “Rating period” means the period for which premium rates  
6 established by a plan are in effect.

7     (k) “Registered domestic partner” means a person who has  
8 established a domestic partnership as described in Section 297 of  
9 the Family Code.

10     1399.847. Every health care service plan offering individual  
11 health benefit plans shall, in addition to complying with the  
12 provisions of this chapter and rules adopted thereunder, comply  
13 with the provisions of this article.

14     1399.849. (a) (1) On and after October 1, 2013, a plan shall  
15 fairly and affirmatively offer, market, and sell all of the plan’s  
16 health benefit plans that are sold in the individual market *for policy*  
17 *years on or after January 1, 2014*, to all individuals and dependents  
18 in each service area in which the plan provides or arranges for the  
19 provision of health care services. A plan shall limit enrollment in  
20 individual health benefit plans to open enrollment periods and  
21 special enrollment periods as provided in subdivisions (c) and (d).

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

27     (3) A plan shall allow the subscriber of an individual health  
28 benefit plan to add a dependent to the subscriber’s plan at the  
29 option of the subscriber, consistent with the open enrollment,  
30 annual enrollment, and special enrollment period requirements in  
31 this section.

32     (4) *A health care service plan offering coverage in the individual*  
33 *market shall not reject the request of a subscriber during an open*  
34 *enrollment period to include a dependent of the subscriber as a*  
35 *dependent on an existing individual health benefit plan.*

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

39     (c) A plan shall provide an initial open enrollment period from  
40 October 1, 2013, to March 31, 2014, inclusive, and annual

1 enrollment periods for plan years on or after January 1, 2015, from  
2 October 15 to December 7, inclusive, of the preceding calendar  
3 year.

4 (d) (I) Subject to subdivision (e), commencing January 1,  
5 2014, a plan shall allow an individual to enroll in or change  
6 individual health benefit plans *offered outside the Exchange* as a  
7 result of the following triggering events:

8 (1)

9 (A) He or she or his or her dependent loses minimum essential  
10 coverage. For purposes of this paragraph, both of the following  
11 definitions shall apply:

12 (A)

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

16 (B)

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

24 (2)

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

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

28 (4)

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

31 (5)

32 (D) He or she has been released from incarceration.

33 (6)

34 (E) His or her health benefit plan substantially violated a  
35 material provision of the contract.

36 (7)

37 (F) He or she gains access to new health benefit plans as a result  
38 of a permanent move.

39 (8)

1 (G) He or she was receiving services from a contracting provider  
2 under another health benefit plan, *as defined in Section 1399.845*  
3 *or Section 10965 of the Insurance Code*, for one of the conditions  
4 described in subdivision (c) of Section 1373.96 and that provider  
5 is ~~terminated no longer participating in the health benefit plan.~~

6 ~~(9) With respect to~~

7 (2) *Subject to subdivision (e), commencing January 1, 2014, a*  
8 *health insurer shall allow an individual to enroll in or change*  
9 *individual health benefit plans offered through the Exchange, in*  
10 ~~*addition to the triggering events listed in this subdivision, the*~~  
11 ~~*individual meets any of the requirements as a result of the*~~  
12 ~~*triggering events listed in Section 155.420(d) of Title 45 of the*~~  
13 ~~*Code of Federal Regulations. To the extent permitted by federal*~~  
14 ~~*law, any triggering event described in paragraph (1) that is not*~~  
15 ~~*listed in Section 155.420(d)(1) to (8), inclusive, of Title 45 of the*~~  
16 ~~*Code of Federal Regulations shall be considered an exceptional*~~  
17 ~~*circumstance under Section 155.420(d)(9) of Title 45 of the Code*~~  
18 ~~*of Federal Regulations.*~~

19 (e) With respect to individual health benefit plans offered outside  
20 the Exchange, an individual shall have ~~63~~ 60 days from the date  
21 of a triggering event identified in subdivision (d) to apply for  
22 coverage from a health care service plan subject to this section.  
23 With respect to individual health benefit plans offered through the  
24 Exchange, an individual shall have ~~63~~ 60 days from the date of a  
25 triggering event identified in subdivision ~~(d)~~ to (d) to select a plan  
26 offered through the Exchange.

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

34 ~~(2)~~

35 (g) (1) With respect to an individual health benefit plan offered  
36 outside the Exchange for which an individual applies during the  
37 initial open enrollment period described in subdivision (c), when  
38 the subscriber submits a premium payment, based on the quoted  
39 premium charges, and that payment is delivered or postmarked,  
40 whichever occurs earlier, by December 15, 2013, coverage under

1 the individual health benefit plan shall become effective no later  
2 than January 1, 2014. When that payment is delivered or  
3 postmarked within the first 15 days of any subsequent month,  
4 coverage shall become effective no later than the first day of the  
5 following month. When that payment is delivered or postmarked  
6 between December 16, 2013, and December 31, 2013, inclusive,  
7 or after the 15th day of any subsequent month, coverage shall  
8 become effective no later than the first day of the second month  
9 following delivery or postmark of the payment.

10 ~~(3)~~

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

25 ~~(4)~~

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

30 (A) When the individual submits a premium payment, based  
31 on the quoted premium charges, and that payment is delivered or  
32 postmarked, whichever occurs earlier, within the first 15 days of  
33 the month, coverage under the plan shall become effective no later  
34 than the first day of the following month.

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



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

4 (D) Notwithstanding subparagraph (A) or (B), in the case of  
5 marriage *or becoming a registered domestic partner* or in the case  
6 where a qualified individual loses minimum essential coverage,  
7 the coverage effective date shall be the first day of the following  
8 month.

9 ~~(5)~~

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

15 ~~(g)~~

16 (h) (1) On or after January 1, 2014, a health care service plan  
17 shall not establish rules for eligibility, including continued  
18 eligibility, of any individual to enroll under the terms of an  
19 individual health benefit plan based on any of the following factors:

20 (A) Health status.

21 (B) Medical condition, including physical and mental illnesses.

22 (C) Claims experience.

23 (D) Receipt of health care.

24 (E) Medical history.

25 (F) Genetic information.

26 (G) Evidence of insurability, including conditions arising out  
27 of acts of domestic violence.

28 (H) Disability.

29 (I) Any other health status-related factor as determined by any  
30 federal regulations, rules, or guidance issued pursuant to Section  
31 2705 of the federal Public Health Service Act.

32 (2) ~~Notwithstanding Section 1389.1~~, a health care service  
33 plan shall not require an individual applicant or his or her  
34 dependent to fill out a health assessment or medical questionnaire  
35 prior to enrollment under an individual health benefit plan. *A health*  
36 *care service plan shall not acquire or request information that*  
37 *relates to a health status-related factor from the applicant or his*  
38 *or her dependent or any other source prior to enrollment of the*  
39 *individual.*

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.~~

5 (i) This section shall not apply to an individual health benefit  
6 plan that is a grandfathered health plan.

7 (j) *The following provisions of this section shall become*  
8 *inoperative if Section 2702 of the federal Public Health Service*  
9 *Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA,*  
10 *is repealed:*

11 (1) *Subdivision (a).*

12 (2) *Subdivisions (c), (d), (e), and (g), except as they relate to*  
13 *health benefit plans offered through the Exchange.*

14 1399.851. (a) Commencing January 1, 2014, no health care  
15 service plan or solicitor shall, directly or indirectly, engage in the  
16 following activities:

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

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

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

38 1399.853. (a) All individual health benefit plans shall conform  
39 to the requirements of Sections 1365, 1366.3, 1367.001, and  
40 1373.6, and any other requirements imposed by this chapter, and

1 shall be renewable at the option of the enrollee except as permitted  
2 to be canceled, rescinded, or not renewed pursuant to Section 1365.

3 (b) Any plan that ceases to offer for sale new individual health  
4 benefit plans pursuant to Section 1365 shall continue to be  
5 governed by this article with respect to business conducted under  
6 this article.

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

14 (1) ~~Age, as described in regulations adopted by the department~~  
15 ~~in conjunction with the Department of Insurance that do not prevent~~  
16 ~~the application of PPACA pursuant to the age bands established~~  
17 ~~by the United States Secretary of Health and Human Services~~  
18 ~~pursuant to Section 2701(a)(3) of the federal Public Health Service~~  
19 ~~Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be~~  
20 ~~determined based on the individual's birthday and shall not vary~~  
21 ~~by more than three to one for adults. A plan shall not use any age~~  
22 ~~bands for rating purposes that are inconsistent with the age bands~~  
23 ~~established by the United States Secretary of Health and Human~~  
24 ~~Services pursuant to Section 2701(a)(3) of the federal Public Health~~  
25 ~~Service Act (42 U.S.C. Sec. 300gg(a)(3)).~~

26 (2) (A) Geographic region. The geographic regions for purposes  
27 of rating shall be the following:

28 (A)

29 (i) Region 1 shall consist of the Counties of Alpine, Del Norte,  
30 Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama,  
31 Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter,  
32 Yuba, Colusa, Amador, Calaveras, and Tuolumne.

33 (B)

34 (ii) Region 2 shall consist of the Counties of Napa, Sonoma,  
35 Solano, and Marin.

36 (C)

37 (iii) Region 3 shall consist of the Counties of Sacramento,  
38 Placer, El Dorado, and Yolo.

39 (D) ~~Region 4 shall consist of the Counties of San Francisco,~~  
40 ~~Contra Costa, Alameda, Santa Clara, and San Mateo.~~

- 1     ~~(E)~~
- 2     (iv) *Region 4 shall consist of the County of San Francisco.*
- 3     (v) *Region 5 shall consist of the County of Contra Costa.*
- 4     (vi) *Region 6 shall consist of the County of Alameda.*
- 5     (vii) *Region 7 shall consist of the County of Santa Clara.*
- 6     (viii) *Region 8 shall consist of the County of San Mateo.*
- 7     (ix) ~~Region-5~~ *9 shall consist of the Counties of Santa Cruz,*
- 8     Monterey, and San Benito.
- 9     ~~(F)~~
- 10    (x) ~~Region-6~~ *10 shall consist of the Counties of San Joaquin,*
- 11    Stanislaus, Merced, Mariposa, ~~Madera, Fresno, Kings,~~ and Tulare.
- 12    (xi) *Region 11 shall consist of the Counties of Madera, Fresno,*
- 13    *and Kings.*
- 14    ~~(G)~~
- 15    (xii) ~~Region-7~~ *12 shall consist of the Counties of San Luis*
- 16    Obispo, Santa Barbara, and Ventura.
- 17    ~~(H)~~
- 18    (xiii) ~~Region-8~~ *13 shall consist of the Counties of Mono, Inyo,*
- 19    ~~Kern,~~ and Imperial.
- 20    (xiv) *Region 14 shall consist of the County of Kern.*
- 21    ~~(I)~~
- 22    (xv) ~~Region-9~~ *15 shall consist of the ZIP Codes in Los Angeles*
- 23    County starting with 906 to 912, inclusive, 915, 917, 918, and 935.
- 24    ~~(J)~~
- 25    (xvi) ~~Region-10~~ *16 shall consist of the ZIP Codes in Los Angeles*
- 26    County other than those identified in ~~subparagraph (I)~~ *clause (xv).*
- 27    ~~(K)~~
- 28    (xvii) ~~Region-11~~ *17 shall consist of the Counties of San*
- 29    Bernardino and Riverside.
- 30    ~~(L)~~
- 31    (xviii) ~~Region-12~~ *18 shall consist of the County of Orange.*
- 32    ~~(M)~~
- 33    (xix) ~~Region-13~~ *19 shall consist of the County of San Diego.*
- 34    (B) *No later than June 1, 2017, the department, in collaboration*
- 35    *with the Exchange and the Department of Insurance, shall review*
- 36    *the geographic rating regions specified in this paragraph and the*
- 37    *impacts of those regions on the health care coverage market in*
- 38    *California, and make a report to the appropriate policy committees*
- 39    *of the Legislature.*

1 (3) Whether the health benefit plan covers an individual or  
2 family, *as described in PPACA*.

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

5 (c) The rating period for rates subject to this section shall be  
6 from January 1 to December 31, inclusive.

7 (d) This section shall not apply to an individual health benefit  
8 plan that is a grandfathered health plan.

9 (e) *This section shall become inoperative if Section 2701 of the*  
10 *federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added*  
11 *by Section 1201 of PPACA, is repealed.*

12 1399.857. A health care service plan shall not be required to  
13 offer an individual health benefit plan or accept applications for  
14 the plan pursuant to this article in the case of any of the following:

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

17 (b) (1) Within a specific service area or portion of a service  
18 area, if the plan reasonably anticipates and demonstrates to the  
19 satisfaction of the director that it will not have sufficient health  
20 care delivery resources to ensure that health care services will be  
21 available and accessible to the individual because of its obligations  
22 to existing enrollees.

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

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

36 1399.859. The director may require a health care service plan  
37 to discontinue the offering of individual health benefit plans or  
38 acceptance of applications from any individual upon a  
39 determination by the director that the plan does not have sufficient  
40 financial viability or organizational and administrative capacity

1 to ensure the delivery of health care services to its enrollees. In  
 2 determining whether the conditions of this section have been met,  
 3 the director shall consider, but not be limited to, the plan’s  
 4 compliance with the requirements of Section 1367, Article 6  
 5 (commencing with Section 1375.1), and the rules adopted under  
 6 those provisions.

7 1399.860. (a) On or before October 1, 2013, and annually  
 8 thereafter, a health care service plan shall issue the following notice  
 9 to all subscribers enrolled in an individual health benefit plan that  
 10 is a grandfathered health plan:

11 ~~Beginning on and after January 1, 2014, new~~  
 12 *New improved health insurance options are available in*  
 13 *California. You currently have health insurance that is exempt*  
 14 *from many of the new requirements. For instance, your plan may*  
 15 *not include certain consumer protections that apply to other plans,*  
 16 *such as the requirement for the provision of preventive health*  
 17 *services without any cost sharing and the prohibition against*  
 18 *increasing your rates based on your health status. You have the*  
 19 *option to remain in your current plan or switch to a new plan.*  
 20 *Under the new rules, a health insurance company plan cannot deny*  
 21 *your application based on any health conditions you may have.*  
 22 *For more information about your options, please contact the*  
 23 *California Health Benefit Exchange, the Office of Patient*  
 24 *Advocate, your plan or policy representative, an insurance broker,*  
 25 *or a health care navigator.*  
 26

27  
 28 (b) A health care service plan shall include the notice described  
 29 in subdivision (a) in any ~~marketing~~ *renewal* material of the  
 30 individual grandfathered health plan *and in any application for*  
 31 *dependent coverage under the individual grandfathered health*  
 32 *plan.*

33 1399.861. *Except as otherwise provided in this article, this*  
 34 *article shall be implemented to the extent that it meets or exceeds*  
 35 *the requirements set forth in the federal Patient Protection and*  
 36 *Affordable Care Act (Public Law 111-148), as amended by the*  
 37 *federal Health Care and Education Reconciliation Act of 2010*  
 38 *(Public Law 111-152), and any rules, regulations, or guidance*  
 39 *issued pursuant to that law.*

1     ~~SEC. 20. Section 10113.9 of the Insurance Code is amended~~  
2 ~~to read:~~

3     ~~10113.9. (a) This section shall not apply to short-term limited~~  
4 ~~duration health insurance, vision-only, dental-only, or~~  
5 ~~CHAMPUS-supplement insurance, or to hospital indemnity,~~  
6 ~~hospital-only, accident-only, or specified disease insurance that~~  
7 ~~does not pay benefits on a fixed benefit, cash payment only basis.~~

8     ~~(b) (1) A health insurer that declines to offer coverage to or~~  
9 ~~denies enrollment for an individual or his or her dependents~~  
10 ~~applying for individual coverage or that offers individual coverage~~  
11 ~~at a rate that is higher than the standard rate shall, at the time of~~  
12 ~~the denial or offer of coverage, provide the applicant with the~~  
13 ~~specific reason or reasons for the decision in writing, in clear,~~  
14 ~~easily understandable language.~~

15     ~~(2) No change in the premium rate or coverage for an individual~~  
16 ~~health insurance policy shall become effective unless the insurer~~  
17 ~~has delivered a written notice of the change at least 60 days prior~~  
18 ~~to the effective date of the policy renewal or the date on which the~~  
19 ~~rate or coverage changes. A notice of an increase in the premium~~  
20 ~~rate shall include the reasons for the rate increase.~~

21     ~~(3) The written notice required pursuant to paragraph (2) shall~~  
22 ~~be delivered to the individual policyholder at his or her last address~~  
23 ~~known to the insurer, at least 60 days prior to the effective date of~~  
24 ~~the change. The notice shall state in italics and in 12-point type~~  
25 ~~the actual dollar amount of the premium increase and the specific~~  
26 ~~percentage by which the current premium will be increased. The~~  
27 ~~notice shall describe in plain, understandable English any changes~~  
28 ~~in the policy or any changes in benefits, including a reduction in~~  
29 ~~benefits or changes to waivers, exclusions, or conditions, and~~  
30 ~~highlight this information by printing it in italics. The notice shall~~  
31 ~~specify in a minimum of 10-point bold typeface, the reason for a~~  
32 ~~premium rate change or a change in coverage or benefits.~~

33     ~~(4) If an insurer rejects an applicant or the dependents of an~~  
34 ~~applicant for coverage or offers individual coverage at a rate that~~  
35 ~~is higher than the standard rate, the insurer shall inform the~~  
36 ~~applicant about the state's high-risk health insurance pool, the~~  
37 ~~California Major Risk Medical Insurance Program (MRMIP) (Part~~  
38 ~~6.5 (commencing with Section 12700)), and the federal temporary~~  
39 ~~high risk pool established pursuant to Part 6.6 (commencing with~~  
40 ~~Section 12739.5). The information provided to the applicant by~~

1 the insurer shall be in accordance with standards developed by the  
 2 department, in consultation with the Managed Risk Medical  
 3 Insurance Board, and shall specifically include the toll-free  
 4 telephone number and Internet Web site address for MRMIP and  
 5 the federal temporary high risk pool. The requirement to notify  
 6 applicants of the availability of MRMIP and the federal temporary  
 7 high risk pool shall not apply when a health plan rejects an  
 8 applicant for Medicare supplement coverage.

9 (e) A notice provided pursuant to this section is a private and  
 10 confidential communication and, at the time of application, the  
 11 insurer shall give the applicant the opportunity to designate the  
 12 address for receipt of the written notice in order to protect the  
 13 confidentiality of any personal or privileged information.

14 (d) This section shall become inoperative on November 1, 2013,  
 15 and, as of January 1, 2014, is repealed, unless a later enacted  
 16 statute, that becomes operative on or before January 1, 2014,  
 17 deletes or extends the dates on which it becomes inoperative and  
 18 is repealed.

19 SEC. 21. Section 10113.9 is added to the Insurance Code, to  
 20 read:

21 10113.9. (a) This section shall not apply to short-term limited  
 22 duration health insurance, vision-only, dental-only, or  
 23 CHAMPUS-supplement insurance, or to hospital indemnity,  
 24 hospital-only, accident-only, or specified disease insurance that  
 25 does not pay benefits on a fixed benefit, cash payment only basis.

26 (b) (1) No change in the premium rate or coverage for an  
 27 individual health insurance policy shall become effective unless  
 28 the insurer has delivered a written notice of the change at least 60  
 29 days prior to the effective date of the plan renewal or the date on  
 30 which the rate or coverage changes. A notice of an increase in the  
 31 premium rate shall include the reasons for the rate increase.

32 (2) The written notice required pursuant to paragraph (1) shall  
 33 be delivered to the individual policyholder at his or her last address  
 34 known to the insurer, at least 60 days prior to the effective date of  
 35 the change. The notice shall state in italics and in 12-point type  
 36 the actual dollar amount of the premium increase and the specific  
 37 percentage by which the current premium will be increased. The  
 38 notice shall describe in plain, understandable English any changes  
 39 in the policy or any changes in benefits, including a reduction in  
 40 benefits or changes to waivers, exclusions, or conditions, and



1 highlight this information by printing it in italics. The notice shall  
2 specify in a minimum of 10-point bold typeface, the reason for a  
3 premium rate change or a change in coverage or benefits. For  
4 individual grandfathered health plans, the notice shall also inform  
5 the individual contractholder about the availability of coverage  
6 through the California Health Benefit Exchange established under  
7 Title 22 (commencing with Section 100500) of the Government  
8 Code and shall include the toll-free telephone number and Internet  
9 Web site for the California Health Benefit Exchange.

10 (e) (1) A health insurer that declines to offer coverage to or  
11 denies enrollment for an individual or his or her dependents  
12 applying for an individual grandfathered health plan or that offers  
13 an individual grandfathered health plan at a rate that is higher than  
14 the standard rate shall, at the time of the denial or offer of coverage,  
15 provide the applicant with the specific reason or reasons for the  
16 decision in writing, in clear, easily understandable language.

17 (2) If a health insurer rejects an applicant or the dependents of  
18 an applicant for an individual grandfathered health plan or offers  
19 an individual grandfathered health plan at a rate that is higher than  
20 the standard rate, the insurer shall inform the applicant about the  
21 California Health Benefit Exchange established under Title 22  
22 (commencing with Section 100500) of the Government Code. The  
23 information provided to the applicant by the insurer shall include  
24 the toll-free telephone number and Internet Web site for the  
25 California Health Benefit Exchange.

26 (d) A notice provided pursuant to this section is a private and  
27 confidential communication and, at the time of application, the  
28 insurer shall give the applicant the opportunity to designate the  
29 address for receipt of the written notice in order to protect the  
30 confidentiality of any personal or privileged information.

31 (e) For purposes of this section, the following definitions shall  
32 apply:

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

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

40 (f) This section shall become operative on November 1, 2013.

1 SEC. 22.— Section 10113.95 of the Insurance Code is amended  
2 to read:

3 10113.95. (a) A health insurer that issues, renews, or amends  
4 individual health insurance policies shall be subject to this section.

5 (b) An insurer subject to this section shall have written policies,  
6 procedures, or underwriting guidelines establishing the criteria  
7 and process whereby the insurer makes its decision to provide or  
8 to deny coverage to individuals applying for coverage and sets the  
9 rate for that coverage. These guidelines, policies, or procedures  
10 shall ensure that the plan rating and underwriting criteria comply  
11 with Sections 10140 and 10291.5 and all other applicable  
12 provisions.

13 (c) On or before June 1, 2006, and annually thereafter, every  
14 insurer shall file with the commissioner a general description of  
15 the criteria, policies, procedures, or guidelines that the insurer uses  
16 for rating and underwriting decisions related to individual health  
17 insurance policies, which means automatic declinable health  
18 conditions, health conditions that may lead to a coverage decline,  
19 height and weight standards, health history, health care utilization,  
20 lifestyle, or behavior that might result in a decline for coverage or  
21 severely limit the health insurance products for which individuals  
22 applying for coverage would be eligible. An insurer may comply  
23 with this section by submitting to the department underwriting  
24 materials or resource guides provided to agents and brokers,  
25 provided that those materials include the information required to  
26 be submitted by this section.

27 (d) Commencing January 1, 2011, the commissioner shall post  
28 on the department’s Internet Web site, in a manner accessible and  
29 understandable to consumers, general, noncompany specific  
30 information about rating and underwriting criteria and practices  
31 in the individual market and information about the California Major  
32 Risk Medical Insurance Program (Part 6.5 (commencing with  
33 Section 12700)) and the federal temporary high risk pool  
34 established pursuant to Part 6.6 (commencing with Section  
35 12739.5). The commissioner shall develop the information for the  
36 Internet Web site in consultation with the Department of Managed  
37 Health Care to enhance the consistency of information provided  
38 to consumers. Information about individual health insurance shall  
39 also include the following notification:

1 ~~“Please examine your options carefully before declining group~~  
2 ~~coverage or continuation coverage, such as COBRA, that may be~~  
3 ~~available to you. You should be aware that companies selling~~  
4 ~~individual health insurance typically require a review of your~~  
5 ~~medical history that could result in a higher premium or you could~~  
6 ~~be denied coverage entirely.”~~

7 ~~(e) Nothing in this section shall authorize public disclosure of~~  
8 ~~company-specific rating and underwriting criteria and practices~~  
9 ~~submitted to the commissioner.~~

10 ~~(f) This section shall not apply to a closed block of business, as~~  
11 ~~defined in Section 10176.10.~~

12 ~~(g) This section shall become inoperative on November 1, 2013,~~  
13 ~~and, as of January 1, 2014, is repealed, unless a later enacted~~  
14 ~~statute, that becomes operative on or before January 1, 2014,~~  
15 ~~deletes or extends the dates on which it becomes inoperative and~~  
16 ~~is repealed.~~

17 ~~SEC. 23. Section 10113.95 is added to the Insurance Code, to~~  
18 ~~read:~~

19 ~~10113.95.—(a) A health insurer that renews individual~~  
20 ~~grandfathered health plans shall be subject to this section.~~

21 ~~(b) An insurer subject to this section shall have written policies,~~  
22 ~~procedures, or underwriting guidelines establishing the criteria~~  
23 ~~and process whereby the insurer makes its decision to provide or~~  
24 ~~to deny coverage to individuals applying for an individual~~  
25 ~~grandfathered health plan and sets the rate for that coverage. These~~  
26 ~~guidelines, policies, or procedures shall ensure that the plan rating~~  
27 ~~and underwriting criteria comply with Sections 10140 and 10291.5~~  
28 ~~and all other applicable provisions.~~

29 ~~(c) On or before November 1, 2013, and annually thereafter,~~  
30 ~~every insurer shall file with the commissioner a general description~~  
31 ~~of the criteria, policies, procedures, or guidelines that the insurer~~  
32 ~~uses for rating and underwriting decisions related to individual~~  
33 ~~grandfathered health plans, which means automatic declinable~~  
34 ~~health conditions, health conditions that may lead to a coverage~~  
35 ~~decline, height and weight standards, health history, health care~~  
36 ~~utilization, lifestyle, or behavior that might result in a decline for~~  
37 ~~coverage or severely limit the health insurance products for which~~  
38 ~~individuals applying for coverage would be eligible. An insurer~~  
39 ~~may comply with this section by submitting to the department~~  
40 ~~underwriting materials or resource guides provided to agents and~~

1 brokers, provided that those materials include the information  
2 required to be submitted by this section.

3 (d) ~~Nothing in this section shall authorize public disclosure of~~  
4 ~~company-specific rating and underwriting criteria and practices~~  
5 ~~submitted to the commissioner.~~

6 (e) ~~This section shall not apply to a closed block of business,~~  
7 ~~as defined in Section 10176.10.~~

8 (f) ~~For purposes of this section, the following definitions shall~~  
9 ~~apply:~~

10 (1) ~~“PPACA” means the federal Patient Protection and~~  
11 ~~Affordable Care Act (Public Law 111-148), as amended by the~~  
12 ~~federal Health Care and Education Reconciliation Act of 2010~~  
13 ~~(Public Law 111-152), and any rules, regulations, or guidance~~  
14 ~~issued pursuant to that law.~~

15 (2) ~~“Grandfathered health plan” has the same meaning as that~~  
16 ~~term is defined in Section 1251 of PPACA.~~

17 (g) ~~This section shall become operative on November 1, 2013.~~

18 ~~SEC. 24. Section 10119.1 of the Insurance Code is amended~~  
19 ~~to read:~~

20 ~~10119.1. (a) This section shall apply to a health insurer that~~  
21 ~~covers hospital, medical, or surgical expenses under an individual~~  
22 ~~health benefit plan, as defined in subdivision (a) of Section~~  
23 ~~10198.6, that is issued, amended, renewed, or delivered on or after~~  
24 ~~January 1, 2007.~~

25 (b) ~~At least once each year, a health insurer shall permit an~~  
26 ~~individual who has been covered for at least 18 months under an~~  
27 ~~individual health benefit plan to transfer, without medical~~  
28 ~~underwriting, to any other individual health benefit plan offered~~  
29 ~~by that same health insurer that provides equal or lesser benefits~~  
30 ~~as determined by the insurer.~~

31 ~~“Without medical underwriting” means that the health insurer~~  
32 ~~shall not decline to offer coverage to, or deny enrollment of, the~~  
33 ~~individual or impose any preexisting condition exclusion on the~~  
34 ~~individual who transfers to another individual health benefit plan~~  
35 ~~pursuant to this section.~~

36 (c) ~~The insurer shall establish, for the purposes of subdivision~~  
37 ~~(b), a ranking of the individual health benefit plans it offers to~~  
38 ~~individual purchasers and post the ranking on its Internet Web site~~  
39 ~~or make the ranking available upon request. The insurer shall~~

1 update the ranking whenever a new benefit design for individual  
2 purchasers is approved.

3 ~~(d) The insurer shall notify in writing all insureds of the right  
4 to transfer to another individual health benefit plan pursuant to  
5 this section, at a minimum, when the insurer changes the insured's  
6 premium rate. Posting this information on the insurer's Internet  
7 Web site shall not constitute notice for purposes of this subdivision.  
8 The notice shall adequately inform insureds of the transfer rights  
9 provided under this section including information on the process  
10 to obtain details about the individual health benefit plans available  
11 to that insured and advising that the insured may be unable to  
12 return to his or her current individual health benefit plan if the  
13 insured transfers to another individual health benefit plan.~~

14 ~~(e) The requirements of this section shall not apply to the  
15 following:~~

16 ~~(1) A federally eligible defined individual, as defined in  
17 subdivision (e) of Section 10900, who purchases individual  
18 coverage pursuant to Section 10785.~~

19 ~~(2) An individual offered conversion coverage pursuant to  
20 Sections 12672 and 12682.1.~~

21 ~~(3) An individual enrolled in the Medi-Cal program pursuant  
22 to Chapter 7 (commencing with Section 14000) of Part 3 of  
23 Division 9 of the Welfare and Institutions Code.~~

24 ~~(4) An individual enrolled in the Access for Infants and Mothers  
25 Program, pursuant to Part 6.3 (commencing with Section 12695).~~

26 ~~(5) An individual enrolled in the Healthy Families Program  
27 pursuant to Part 6.2 (commencing with Section 12693).~~

28 ~~(f) It is the intent of the Legislature that individuals shall have  
29 more choice in their health care coverage when health insurers  
30 guarantee the right of an individual to transfer to another product  
31 based on the insurer's own ranking system. The Legislature does  
32 not intend for the department to review or verify the insurer's  
33 ranking for actuarial or other purposes.~~

34 ~~(g) This section shall remain in effect only until January 1, 2014,  
35 and as of that date is repealed, unless a later enacted statute, that  
36 is enacted before January 1, 2014, deletes or extends that date.~~

37 ~~SEC. 25. Section 10119.2 of the Insurance Code is amended  
38 to read:~~

39 ~~10119.2. (a) Every health insurer that offers, issues, or renews  
40 health insurance under an individual health benefit plan, as defined~~

1 in subdivision (a) of Section 10198.6, shall offer to any individual,  
2 who was covered under an individual health benefit plan that was  
3 rescinded, a new individual health benefit plan without medical  
4 underwriting that provides equal benefits. A health insurer may  
5 also permit an individual, who was covered under an individual  
6 health benefit plan that was rescinded, to remain covered under  
7 that individual health benefit plan, with a revised premium rate  
8 that reflects the number of persons remaining on the health benefit  
9 plan.

10 (b) ~~“Without medical underwriting” means that the health insurer~~  
11 ~~shall not decline to offer coverage to, or deny enrollment of, the~~  
12 ~~individual or impose any preexisting condition exclusion on the~~  
13 ~~individual who is issued a new individual health benefit plan or~~  
14 ~~remains covered under an individual health benefit plan pursuant~~  
15 ~~to this section.~~

16 (c) ~~If a new individual health benefit plan is issued, the insurer~~  
17 ~~may revise the premium rate to reflect only the number of persons~~  
18 ~~covered under the new individual health benefit plan.~~

19 (d) ~~Notwithstanding subdivision (a) and (b), if an individual~~  
20 ~~was subject to a preexisting condition provision or a waiting or~~  
21 ~~affiliation period under the individual health benefit plan that was~~  
22 ~~rescinded, the health insurer may apply the same preexisting~~  
23 ~~condition provision or waiting or affiliation period in the new~~  
24 ~~individual health benefit plan. The time period in the new~~  
25 ~~individual health benefit plan for the preexisting condition~~  
26 ~~provision or waiting or affiliation period shall not be longer than~~  
27 ~~the one in the individual health benefit plan that was rescinded~~  
28 ~~and the health insurer shall credit any time that the individual was~~  
29 ~~covered under the rescinded individual health benefit plan.~~

30 (e) ~~The insurer shall notify in writing all insureds of the right~~  
31 ~~to coverage under an individual health benefit plan pursuant to~~  
32 ~~this section, at a minimum, when the insurer rescinds the individual~~  
33 ~~health benefit plan. The notice shall adequately inform insureds~~  
34 ~~of the right to coverage provided under this section.~~

35 (f) ~~The insurer shall provide 60 days for insureds to accept the~~  
36 ~~offered new individual health benefit plan and this plan shall be~~  
37 ~~effective as of the effective date of the original individual health~~  
38 ~~benefit plan and there shall be no lapse in coverage.~~

1 ~~(g) This section shall not apply to any individual whose~~  
2 ~~information in the application for coverage and related~~  
3 ~~communications led to the rescission.~~

4 ~~(h) This section shall remain in effect only until January 1, 2014,~~  
5 ~~and as of that date is repealed, unless a later enacted statute, that~~  
6 ~~is enacted before January 1, 2014, deletes or extends that date.~~

7 SEC. 26. Section 10119.2 is added to the Insurance Code, to  
8 read:

9 10119.2. (a) Every health insurer that offers, issues, or renews  
10 health insurance under an individual health benefit plan, as defined  
11 in subdivision (a) of Section 10198.6, shall offer to any individual,  
12 who was covered under an individual health benefit plan that was  
13 rescinded, a new individual health benefit plan. A health insurer  
14 may also permit an individual, who was covered under an  
15 individual health benefit plan that was rescinded, to remain covered  
16 under that individual health benefit plan, with a revised premium  
17 rate that reflects the number of persons remaining on the health  
18 benefit plan consistent with Section 10965.9.

19 (b) If a new individual health benefit plan is issued, the insurer  
20 may revise the premium rate to reflect only the number of persons  
21 covered under the new individual health benefit plan consistent  
22 with Section 10965.9.

23 (c) ~~The insurer shall notify in writing all insureds of the right~~  
24 ~~to coverage under an individual health benefit plan pursuant to~~  
25 ~~this section, at a minimum, when the insurer rescinds the individual~~  
26 ~~health benefit plan. The notice shall adequately inform insureds~~  
27 ~~of the right to coverage provided under this section.~~

28 (d) ~~The insurer shall provide 60 days for insureds to accept the~~  
29 ~~offered new individual health benefit plan and this plan shall be~~  
30 ~~effective as of the effective date of the original individual health~~  
31 ~~benefit plan and there shall be no lapse in coverage.~~

32 (e) ~~This section shall not apply to any individual whose~~  
33 ~~information in the application for coverage and related~~  
34 ~~communications led to the rescission.~~

35 (f) ~~This section shall apply notwithstanding subdivision (a) or~~  
36 ~~(d) of Section 10965.3.~~

37 (g) ~~This section shall become operative on January 1, 2014.~~

38 SEC. 27. Section 10291.5 of the Insurance Code is amended  
39 to read:

1     ~~10291.5.—(a) The purpose of this section is to achieve both of~~  
2 ~~the following:~~

3     ~~(1) Prevent, in respect to disability insurance, fraud, unfair trade~~  
4 ~~practices, and insurance economically unsound to the insured.~~

5     ~~(2) Assure that the language of all insurance policies can be~~  
6 ~~readily understood and interpreted.~~

7     ~~(b) The commissioner shall not approve any disability policy~~  
8 ~~for insurance or delivery in this state in any of the following~~  
9 ~~circumstances:~~

10     ~~(1) If the commissioner finds that it contains any provision, or~~  
11 ~~has any label, description of its contents, title, heading, backing,~~  
12 ~~or other indication of its provisions which is unintelligible,~~  
13 ~~uncertain, ambiguous, or abstruse, or likely to mislead a person to~~  
14 ~~whom the policy is offered, delivered or issued.~~

15     ~~(2) If it contains any provision for payment at a rate, or in an~~  
16 ~~amount (other than the product of rate times the periods for which~~  
17 ~~payments are promised) for loss caused by particular event or~~  
18 ~~events (as distinguished from character of physical injury or illness~~  
19 ~~of the insured) more than triple the lowest rate, or amount,~~  
20 ~~promised in the policy for the same loss caused by any other event~~  
21 ~~or events (loss caused by sickness, loss caused by accident, and~~  
22 ~~different degrees of disability each being considered, for the~~  
23 ~~purpose of this paragraph, a different loss); or if it contains any~~  
24 ~~provision for payment for any confining loss of time at a rate more~~  
25 ~~than six times the least rate payable for any partial loss of time or~~  
26 ~~more than twice the least rate payable for any nonconfining total~~  
27 ~~loss of time; or if it contains any provision for payment for any~~  
28 ~~nonconfining total loss of time at a rate more than three times the~~  
29 ~~least rate payable for any partial loss of time.~~

30     ~~(3) If it contains any provision for payment for disability caused~~  
31 ~~by particular event or events (as distinguished from character of~~  
32 ~~physical injury or illness of the insured) payable for a term more~~  
33 ~~than twice the least term of payment provided by the policy for~~  
34 ~~the same degree of disability caused by any other event or events;~~  
35 ~~or if it contains any benefit for total nonconfining disability payable~~  
36 ~~for lifetime or for more than 12 months and any benefit for partial~~  
37 ~~disability, unless the benefit for partial disability is payable for at~~  
38 ~~least three months; or if it contains any benefit for total confining~~  
39 ~~disability payable for lifetime or for more than 12 months, unless~~  
40 ~~it also contains benefit for total nonconfining disability caused by~~



1 the same event or events payable for at least three months, and, if  
2 it also contains any benefit for partial disability, unless the benefit  
3 for partial disability is payable for at least three months. The  
4 provisions of this paragraph shall apply separately to accident  
5 benefits and to sickness benefits.

6 ~~(4) If it contains provision or provisions which would have the~~  
7 ~~effect, upon any termination of the policy, of reducing or ending~~  
8 ~~the liability as the insurer would have, but for the termination, for~~  
9 ~~loss of time resulting from accident occurring while the policy is~~  
10 ~~in force or for loss of time commencing while the policy is in force~~  
11 ~~and resulting from sickness contracted while the policy is in force~~  
12 ~~or for other losses resulting from accident occurring or sickness~~  
13 ~~contracted while the policy is in force, and also contains provision~~  
14 ~~or provisions reserving to the insurer the right to cancel or refuse~~  
15 ~~to renew the policy, unless it also contains other provision or~~  
16 ~~provisions the effect of which is that termination of the policy as~~  
17 ~~the result of the exercise by the insurer of any such right shall not~~  
18 ~~reduce or end the liability in respect to the hereinafter specified~~  
19 ~~losses as the insurer would have had under the policy, including~~  
20 ~~its other limitations, conditions, reductions, and restrictions, had~~  
21 ~~the policy not been so terminated.~~

22 The specified losses referred to in the preceding paragraph are:

23 (i) ~~Loss of time which commences while the policy is in force~~  
24 ~~and results from sickness contracted while the policy is in force.~~

25 (ii) ~~Loss of time which commences within 20 days following~~  
26 ~~and results from accident occurring while the policy is in force.~~

27 (iii) ~~Losses which result from accident occurring or sickness~~  
28 ~~contracted while the policy is in force and arise out of the care or~~  
29 ~~treatment of illness or injury and which occur within 90 days from~~  
30 ~~the termination of the policy or during a period of continuous~~  
31 ~~compensable loss or losses which period commences prior to the~~  
32 ~~end of such 90 days.~~

33 (iv) ~~Losses other than those specified in clause (i), (ii), or (iii)~~  
34 ~~of this paragraph which result from accident occurring or sickness~~  
35 ~~contracted while the policy is in force and which losses occur~~  
36 ~~within 90 days following the accident or the contraction of the~~  
37 ~~sickness.~~

38 (5) ~~If by any caption, label, title, or description of contents the~~  
39 ~~policy states, implies, or infers without reasonable qualification~~  
40 ~~that it provides loss of time indemnity for lifetime, or for any period~~

1 of more than two years, if the loss of time indemnity is made  
2 payable only when house confined or only under special  
3 contingencies not applicable to other total loss of time indemnity.

4 (6) If it contains any benefit for total confining disability payable  
5 only upon condition that the confinement be of an abnormally  
6 restricted nature unless the caption of the part containing any such  
7 benefit is accurately descriptive of the nature of the confinement  
8 required and unless, if the policy has a description of contents,  
9 label, or title, at least one of them contain reference to the nature  
10 of the confinement required.

11 (7) (A) If, irrespective of the premium charged therefor, any  
12 benefit of the policy is, or the benefits of the policy as a whole are,  
13 not sufficient to be of real economic value to the insured.

14 (B) In determining whether benefits are of real economic value  
15 to the insured, the commissioner shall not differentiate between  
16 insureds of the same or similar economic or occupational classes  
17 and shall give due consideration to all of the following:

18 (i) The right of insurers to exercise sound underwriting judgment  
19 in the selection and amounts of risks.

20 (ii) Amount of benefit, length of time of benefit, nature or extent  
21 of benefit, or any combination of those factors.

22 (iii) The relative value in purchasing power of the benefit or  
23 benefits.

24 (iv) Differences in insurance issued on an industrial or other  
25 special basis.

26 (C) To be of real economic value, it shall not be necessary that  
27 any benefit or benefits cover the full amount of any loss which  
28 might be suffered by reason of the occurrence of any hazard or  
29 event insured against.

30 (8) If it substitutes a specified indemnity upon the occurrence  
31 of accidental death for any benefit of the policy, other than a  
32 specified indemnity for dismemberment, which would accrue prior  
33 to the time of that death or if it contains any provision which has  
34 the effect, other than at the election of the insured exercisable  
35 within not less than 20 days in the case of benefits specifically  
36 limited to the loss by removal of one or more fingers or one or  
37 more toes or within not less than 90 days in all other cases, of  
38 doing any of the following:

39 (A) Of substituting, upon the occurrence of the loss of both  
40 hands, both feet, one hand and one foot, the sight of both eyes or

1 the sight of one eye and the loss of one hand or one foot, some  
2 specified indemnity for any or all benefits under the policy unless  
3 the indemnity so specified is equal to or greater than the total of  
4 the benefit or benefits for which such specified indemnity is  
5 substituted and which, assuming in all cases that the insured would  
6 continue to live, could possibly accrue within four years from the  
7 date of such dismemberment under all other provisions of the  
8 policy applicable to the particular event or events (as distinguished  
9 from character of physical injury or illness) causing the  
10 dismemberment.

11 (B) Of substituting, upon the occurrence of any other  
12 dismemberment some specified indemnity for any or all benefits  
13 under the policy unless the indemnity so specified is equal to or  
14 greater than one-fourth of the total of the benefit or benefits for  
15 which the specified indemnity is substituted and which, assuming  
16 in all cases that the insured would continue to live, could possibly  
17 accrue within four years from the date of the dismemberment under  
18 all other provisions of the policy applicable to the particular event  
19 or events (as distinguished from character of physical injury or  
20 illness) causing the dismemberment.

21 (C) Of substituting a specified indemnity upon the occurrence  
22 of any dismemberment for any benefit of the policy which would  
23 accrue prior to the time of dismemberment.

24 As used in this section, loss of a hand shall be severance at or  
25 above the wrist joint, loss of a foot shall be severance at or above  
26 the ankle joint, loss of an eye shall be the irrecoverable loss of the  
27 entire sight thereof, loss of a finger shall mean at least one entire  
28 phalanx thereof and loss of a toe the entire toe.

29 (9) If it contains provision, other than as provided in Section  
30 10369.3, reducing any original benefit more than 50 percent on  
31 account of age of the insured.

32 (10) If the insuring clause or clauses contain no reference to the  
33 exceptions, limitations, and reductions (if any) or no specific  
34 reference to, or brief statement of, each abnormally restrictive  
35 exception, limitation, or reduction.

36 (11) If it contains benefit or benefits for loss or losses from  
37 specified diseases only unless:

38 (A) All of the diseases so specified in each provision granting  
39 the benefits fall within some general classification based upon the  
40 following:

1 (i) ~~The part or system of the human body principally subject to~~  
2 ~~all such diseases.~~

3 (ii) ~~The similarity in nature or cause of such diseases.~~

4 (iii) ~~In case of diseases of an unusually serious nature and~~  
5 ~~protracted course of treatment, the common characteristics of all~~  
6 ~~such diseases with respect to severity of affliction and cost of~~  
7 ~~treatment.~~

8 (B) ~~The policy is entitled and each provision granting the~~  
9 ~~benefits is separately captioned in clearly understandable words~~  
10 ~~so as to accurately describe the classification of diseases covered~~  
11 ~~and expressly point out, when that is the case, that not all diseases~~  
12 ~~of the classification are covered.~~

13 (12) ~~If it does not contain provision for a grace period of at least~~  
14 ~~the number of days specified below for the payment of each~~  
15 ~~premium falling due after the first premium, during which grace~~  
16 ~~period the policy shall continue in force provided, that the grace~~  
17 ~~period to be included in the policy shall be not less than seven days~~  
18 ~~for policies providing for weekly payment of premium, not less~~  
19 ~~than 10 days for policies providing for monthly payment of~~  
20 ~~premium and not less than 31 days for all other policies.~~

21 (13) ~~If it fails to conform in any respect with any law of this~~  
22 ~~state.~~

23 (e) ~~The commissioner shall not approve any disability policy~~  
24 ~~covering hospital, medical, or surgical expenses unless the~~  
25 ~~commissioner finds that the application conforms to the following~~  
26 ~~requirements, as applicable:~~

27 (1) ~~All applications for disability insurance covering hospital,~~  
28 ~~medical, or surgical expenses, except that which is guaranteed~~  
29 ~~issue, which include questions relating to medical conditions, shall~~  
30 ~~contain clear and unambiguous questions designed to ascertain the~~  
31 ~~health condition or history of the applicant.~~

32 (2) ~~The application questions designed to ascertain the health~~  
33 ~~condition or history of the applicant in applications subject to~~  
34 ~~paragraph (1) shall be based on medical information that is~~  
35 ~~reasonable and necessary for medical underwriting purposes. The~~  
36 ~~application shall include a prominently displayed notice that states:~~  
37 ~~“California law prohibits an HIV test from being required or~~  
38 ~~used by health insurance companies as a condition of obtaining~~  
39 ~~health insurance coverage.”~~

1 ~~(3) All applications for coverage subject to Chapter 9.9~~  
2 ~~(commencing with Section 10965) shall comply with paragraph~~  
3 ~~(2) of subdivision (g) of Section 10965.3.~~

4 ~~(d) Nothing in this section authorizes the commissioner to~~  
5 ~~establish or require a single or standard application form for~~  
6 ~~application questions.~~

7 ~~(e) The commissioner may, from time to time as conditions~~  
8 ~~warrant, after notice and hearing, promulgate such reasonable rules~~  
9 ~~and regulations, and amendments and additions thereto, as are~~  
10 ~~necessary or convenient, to establish, in advance of the submission~~  
11 ~~of policies, the standard or standards conforming to subdivision~~  
12 ~~(b), by which he or she shall disapprove or withdraw approval of~~  
13 ~~any disability policy.~~

14 ~~In promulgating any such rule or regulation the commissioner~~  
15 ~~shall give consideration to the criteria herein established and to~~  
16 ~~the desirability of approving for use in policies in this state uniform~~  
17 ~~provisions, nationwide or otherwise, and is hereby granted the~~  
18 ~~authority to consult with insurance authorities of any other state~~  
19 ~~and their representatives individually or by way of convention or~~  
20 ~~committee, to seek agreement upon those provisions.~~

21 ~~Any such rule or regulation shall be promulgated in accordance~~  
22 ~~with the procedure provided in Chapter 3.5 (commencing with~~  
23 ~~Section 11340) of Part 1 of Division 3 of Title 2 of the Government~~  
24 ~~Code.~~

25 ~~(f) The commissioner may withdraw approval of filing of any~~  
26 ~~policy or other document or matter required to be approved by the~~  
27 ~~commissioner, or filed with him or her, by this chapter when the~~  
28 ~~commissioner would be authorized to disapprove or refuse filing~~  
29 ~~of the same if originally submitted at the time of the action of~~  
30 ~~withdrawal.~~

31 ~~Any such withdrawal shall be in writing and shall specify~~  
32 ~~reasons. An insurer adversely affected by any such withdrawal~~  
33 ~~may, within a period of 30 days following mailing or delivery of~~  
34 ~~the writing containing the withdrawal, by written request secure~~  
35 ~~a hearing to determine whether the withdrawal should be annulled,~~  
36 ~~modified, or confirmed. Unless, at any time, it is mutually agreed~~  
37 ~~to the contrary, a hearing shall be granted and commenced within~~  
38 ~~30 days following filing of the request and shall proceed with~~  
39 ~~reasonable dispatch to determination. Unless the commissioner in~~  
40 ~~writing in the withdrawal, or subsequent thereto, grants an~~

1 extension, any such withdrawal shall, in the absence of any such  
2 request, be effective, prospectively and not retroactively, on the  
3 91st day following the mailing or delivery of the withdrawal, and,  
4 if request for the hearing is filed, on the 91st day following mailing  
5 or delivery of written notice of the commissioner's determination.

6 ~~(g) No proceeding under this section is subject to Chapter 5  
7 (commencing with Section 11500) of Part 1 of Division 3 of Title  
8 2 of the Government Code.~~

9 ~~(h) Except as provided in subdivision (k), any action taken by  
10 the commissioner under this section is subject to review by the  
11 courts of this state and proceedings on review shall be in  
12 accordance with the Code of Civil Procedure.~~

13 ~~Notwithstanding any other provision of law to the contrary,  
14 petition for any such review may be filed at any time before the  
15 effective date of the action taken by the commissioner. No action  
16 of the commissioner shall become effective before the expiration  
17 of 20 days after written notice and a copy thereof are mailed or  
18 delivered to the person adversely affected, and any action so  
19 submitted for review shall not become effective for a further period  
20 of 15 days after the filing of the petition in court. The court may  
21 stay the effectiveness thereof for a longer period.~~

22 ~~(i) This section shall be liberally construed to effectuate the  
23 purpose and intentions herein stated; but shall not be construed to  
24 grant the commissioner power to fix or regulate rates for disability  
25 insurance or prescribe a standard form of disability policy, except  
26 that the commissioner shall prescribe a standard supplementary  
27 disclosure form for presentation with all disability insurance  
28 policies, pursuant to Section 10603.~~

29 ~~(j) This section shall be effective on and after July 1, 1950, as  
30 to all policies thereafter submitted and on and after January 1,  
31 1951, the commissioner may withdraw approval pursuant to  
32 subdivision (d) of any policy thereafter issued or delivered in this  
33 state irrespective of when its form may have been submitted or  
34 approved, and prior to those dates the provisions of law in effect  
35 on January 1, 1949, shall apply to those policies.~~

36 ~~(k) Any such policy issued by an insurer to an insured on a form  
37 approved by the commissioner, and in accordance with the  
38 conditions, if any, contained in the approval, at a time when that  
39 approval is outstanding shall, as between the insurer and the~~

1 insured, or any person claiming under the policy, be conclusively  
2 presumed to comply with, and conform to, this section.

3 ~~SEC. 28.~~ Section 10901.3 of the Insurance Code is amended  
4 to read:

5 ~~10901.3. (a) (1) After the federally eligible defined individual~~  
6 ~~submits a completed application form for a health benefit plan,~~  
7 ~~the carrier shall, within 30 days, notify the individual of the~~  
8 ~~individual's actual premium charges for that health benefit plan~~  
9 ~~design. In no case shall the premium charged for any health benefit~~  
10 ~~plan identified in subdivision (d) of Section 10785 exceed the~~  
11 ~~following amounts:~~

12 ~~(A) For health benefit plans that offer services through a~~  
13 ~~preferred provider arrangement, the average premium paid by a~~  
14 ~~subscriber of the Major Risk Medical Insurance Program who is~~  
15 ~~of the same age and resides in the same geographic area as the~~  
16 ~~federally eligible defined individual. However, for federally~~  
17 ~~qualified individuals who are between the ages of 60 and 64,~~  
18 ~~inclusive, the premium shall not exceed the average premium paid~~  
19 ~~by a subscriber of the Major Risk Medical Insurance Program who~~  
20 ~~is 59 years of age and resides in the same geographic area as the~~  
21 ~~federally eligible defined individual.~~

22 ~~(B) For health benefit plans identified in subdivision (d) of~~  
23 ~~Section 10785 that do not offer services through a preferred~~  
24 ~~provider arrangement, 170 percent of the standard premium charged~~  
25 ~~to an individual who is of the same age and resides in the same~~  
26 ~~geographic area as the federally eligible defined individual.~~  
27 ~~However, for federally qualified individuals who are between the~~  
28 ~~ages of 60 and 64, inclusive, the premium shall not exceed 170~~  
29 ~~percent of the standard premium charged to an individual who is~~  
30 ~~59 years of age and resides in the same geographic area as the~~  
31 ~~federally eligible defined individual. The individual shall have 30~~  
32 ~~days in which to exercise the right to buy coverage at the quoted~~  
33 ~~premium rates.~~

34 ~~(2) A carrier may adjust the premium based on family size, not~~  
35 ~~to exceed the following amounts:~~

36 ~~(A) For health benefit plans that offer services through a~~  
37 ~~preferred provider arrangement, the average of the Major Risk~~  
38 ~~Medical Insurance Program rate for families of the same size that~~  
39 ~~reside in the same geographic area as the federally eligible defined~~  
40 ~~individual.~~

1 ~~(B) For health benefit plans identified in subdivision (d) of~~  
2 ~~Section 10785 that do not offer services through a preferred~~  
3 ~~provider arrangement, 170 percent of the standard premium charged~~  
4 ~~to a family that is of the same size and resides in the same~~  
5 ~~geographic area as the federally eligible defined individual.~~

6 ~~(b) When a federally eligible defined individual submits a~~  
7 ~~premium payment, based on the quoted premium charges, and that~~  
8 ~~payment is delivered or postmarked, whichever occurs earlier,~~  
9 ~~within the first 15 days of the month, coverage shall begin no later~~  
10 ~~than the first day of the following month. When that payment is~~  
11 ~~neither delivered or postmarked until after the 15th day of a month,~~  
12 ~~coverage shall become effective no later than the first day of the~~  
13 ~~second month following delivery or postmark of the payment.~~

14 ~~(c) During the first 30 days after the effective date of the health~~  
15 ~~benefit plan, the individual shall have the option of changing~~  
16 ~~coverage to a different health benefit plan design offered by the~~  
17 ~~same carrier. If the individual notified the plan of the change within~~  
18 ~~the first 15 days of a month, coverage under the new health benefit~~  
19 ~~plan shall become effective no later than the first day of the~~  
20 ~~following month. If an enrolled individual notified the carrier of~~  
21 ~~the change after the 15th day of a month, coverage under the health~~  
22 ~~benefit plan shall become effective no later than the first day of~~  
23 ~~the second month following notification.~~

24 ~~(d) This section shall remain in effect only until January 1, 2014,~~  
25 ~~and as of that date is repealed, unless a later enacted statute, that~~  
26 ~~is enacted before January 1, 2014, deletes or extends that date.~~

27 ~~SEC. 29. Section 10901.3 is added to the Insurance Code, to~~  
28 ~~read:~~

29 ~~10901.3. (a) After the federally eligible defined individual~~  
30 ~~submits a completed application form for a health benefit plan,~~  
31 ~~the carrier shall, within 30 days, notify the individual of the~~  
32 ~~individual's actual premium charges for that health benefit plan~~  
33 ~~design. In no case shall the premium charged for any health benefit~~  
34 ~~plan identified in subdivision (d) of Section 10785 exceed the~~  
35 ~~premium for the second lowest cost silver plan of the individual~~  
36 ~~market in the rating area in which the individual resides which is~~  
37 ~~offered through the California Health Benefit Exchange established~~  
38 ~~under Title 22 (commencing with Section 100500) of the~~  
39 ~~Government Code, as described in Section 36B(b)(3)(B) of Title~~  
40 ~~26 of the United States Code.~~



1 ~~(b) When a federally eligible defined individual submits a~~  
2 ~~premium payment, based on the quoted premium charges, and that~~  
3 ~~payment is delivered or postmarked, whichever occurs earlier,~~  
4 ~~within the first 15 days of the month, coverage shall begin no later~~  
5 ~~than the first day of the following month. When that payment is~~  
6 ~~neither delivered or postmarked until after the 15th day of a month,~~  
7 ~~coverage shall become effective no later than the first day of the~~  
8 ~~second month following delivery or postmark of the payment.~~

9 ~~(c) During the first 30 days after the effective date of the health~~  
10 ~~benefit plan, the individual shall have the option of changing~~  
11 ~~coverage to a different health benefit plan design offered by the~~  
12 ~~same carrier. If the individual notified the plan of the change within~~  
13 ~~the first 15 days of a month, coverage under the new health benefit~~  
14 ~~plan shall become effective no later than the first day of the~~  
15 ~~following month. If an enrolled individual notified the carrier of~~  
16 ~~the change after the 15th day of a month, coverage under the health~~  
17 ~~benefit plan shall become effective no later than the first day of~~  
18 ~~the second month following notification.~~

19 ~~(d) This section shall become operative on January 1, 2014.~~

20 ~~SEC. 30. Section 10901.9 of the Insurance Code is amended~~  
21 ~~to read:~~

22 ~~10901.9. Commencing January 1, 2001, premiums for health~~  
23 ~~benefit plans offered, delivered, amended, or renewed by carriers~~  
24 ~~shall be subject to the following requirements:~~

25 ~~(a) The premium for new business for a federally eligible defined~~  
26 ~~individual shall not exceed the following amounts:~~

27 ~~(1) For health benefit plans identified in subdivision (d) of~~  
28 ~~Section 10785 that offer services through a preferred provider~~  
29 ~~arrangement, the average premium paid by a subscriber of the~~  
30 ~~Major Risk Medical Insurance Program who is of the same age~~  
31 ~~and resides in the same geographic area as the federally eligible~~  
32 ~~defined individual. However, for federally qualified individuals~~  
33 ~~who are between the ages of 60 to 64, inclusive, the premium shall~~  
34 ~~not exceed the average premium paid by a subscriber of the Major~~  
35 ~~Risk Medical Insurance Program who is 59 years of age and resides~~  
36 ~~in the same geographic area as the federally eligible defined~~  
37 ~~individual.~~

38 ~~(2) For health benefit plans identified in subdivision (d) of~~  
39 ~~Section 10785 that do not offer services through a preferred~~  
40 ~~provider arrangement, 170 percent of the standard premium charged~~

1 to an individual who is of the same age and resides in the same  
2 geographic area as the federally eligible defined individual.  
3 However, for federally qualified individuals who are between the  
4 ages of 60 to 64, inclusive, the premium shall not exceed 170  
5 percent of the standard premium charged to an individual who is  
6 59 years of age and resides in the same geographic area as the  
7 federally eligible defined individual.

8 (b) The premium for in force business for a federally eligible  
9 defined individual shall not exceed the following amounts:

10 (1) For health benefit plans identified in subdivision (d) of  
11 Section 10785 that offer services through a preferred provider  
12 arrangement, the average premium paid by a subscriber of the  
13 Major Risk Medical Insurance Program who is of the same age  
14 and resides in the same geographic area as the federally eligible  
15 defined individual. However, for federally qualified individuals  
16 who are between the ages of 60 and 64, inclusive, the premium  
17 shall not exceed the average premium paid by a subscriber of the  
18 Major Risk Medical Insurance Program who is 59 years of age  
19 and resides in the same geographic area as the federally eligible  
20 defined individual.

21 (2) For health benefit plans identified in subdivision (d) of  
22 Section 10785 that do not offer services through a preferred  
23 provider arrangement, 170 percent of the standard premium charged  
24 to an individual who is of the same age and resides in the same  
25 geographic area as the federally eligible defined individual.  
26 However, for federally qualified individuals who are between the  
27 ages of 60 and 64, inclusive, the premium shall not exceed 170  
28 percent of the standard premium charged to an individual who is  
29 59 years of age and resides in the same geographic area as the  
30 federally eligible defined individual. The premium effective on  
31 January 1, 2001, shall apply to in force business at the earlier of  
32 either the time of renewal or July 1, 2001.

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

35 (1) For health benefit plans identified in subdivision (d) of  
36 Section 10785 that offer services through a preferred provider  
37 arrangement, the average increase in the premiums charged to a  
38 subscriber of the Major Risk Medical Insurance Program who is  
39 of the same age and resides in the same geographic area as the  
40 federally eligible defined individual.

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

8 ~~(3) For a contract that a carrier has discontinued offering, the~~  
9 ~~premium applied to the first rating period of the new contract that~~  
10 ~~the federally eligible defined individual elects to purchase shall~~  
11 ~~be no greater than the premium applied in the prior rating period~~  
12 ~~to the discontinued contract.~~

13 ~~(d) This section shall remain in effect only until January 1, 2014,~~  
14 ~~and as of that date is repealed, unless a later enacted statute, that~~  
15 ~~is enacted before January 1, 2014, deletes or extends that date.~~

16 ~~SEC. 31. Section 10901.9 is added to the Insurance Code, to~~  
17 ~~read:~~

18 ~~10901.9. (a) Commencing January 1, 2014, premiums for~~  
19 ~~health benefit plans offered, delivered, amended, or renewed by~~  
20 ~~carriers shall be subject to the following requirements:~~

21 ~~(1) The premium for in force or new business for a federally~~  
22 ~~eligible defined individual shall not exceed the premium for the~~  
23 ~~second lowest cost silver plan of the individual market in the rating~~  
24 ~~area in which the individual resides which is offered through the~~  
25 ~~California Health Benefit Exchange established under Title 22~~  
26 ~~(commencing with Section 100500) of the Government Code, as~~  
27 ~~described in Section 36B(b)(3)(B) of Title 26 of the United States~~  
28 ~~Code.~~

29 ~~(2) For a contract that a carrier has discontinued offering, the~~  
30 ~~premium applied to the first rating period of the new contract that~~  
31 ~~the federally eligible defined individual elects to purchase shall~~  
32 ~~be no greater than the premium applied in the prior rating period~~  
33 ~~to the discontinued contract.~~

34 ~~(b) This section shall become operative on January 1, 2014.~~

35 ~~SEC. 32. Section 10902.4 of the Insurance Code is amended~~  
36 ~~to read:~~

37 ~~10902.4. (a) Carriers and health care service plans that offer~~  
38 ~~contracts to individuals may elect to establish a mechanism or~~  
39 ~~method to share in the financing of high-risk individuals. This~~  
40 ~~mechanism or method shall be established through a committee~~

1 of all carriers and health care service plans offering coverage to  
 2 individuals by July 1, 2002, and shall be implemented by January  
 3 1, 2003. If carriers and health care service plans wish to establish  
 4 a risk-sharing mechanism but cannot agree on the terms and  
 5 conditions of such an agreement, the Managed Risk Medical  
 6 Insurance Board shall develop a risk-sharing mechanism or method  
 7 by January 1, 2003, and it shall be implemented by July 1, 2003.

8 (b) This section shall remain in effect only until January 1, 2014,  
 9 and as of that date is repealed, unless a later enacted statute, that  
 10 is enacted before January 1, 2014, deletes or extends that date.

11 SEC. 33. The heading of Chapter 9.7 (commencing with  
 12 Section 10950) of Part 2 of Division 2 of the Insurance Code is  
 13 amended to read:

14  
 15 CHAPTER 9.7. CHILD ACCESS TO HEALTH INSURANCE

16  
 17 SEC. 34. Section 10954 of the Insurance Code is amended to  
 18 read:

19 10954. (a) A carrier may use the following characteristics of  
 20 an eligible child for purposes of establishing the rate of the health  
 21 benefit plan for that child, where consistent with federal regulations  
 22 under PPACA: age, geographic region, and family composition,  
 23 plus the health benefit plan selected by the child or the responsible  
 24 party for a child.

25 (b) From the effective date of this chapter to December 31,  
 26 2013, inclusive, rates for a child applying for coverage shall be  
 27 subject to the following limitations:

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

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

38 (3) If expressly permitted under PPACA and any rules,  
 39 regulations, or guidance issued pursuant to that act, a carrier may

1 rate a child based on health status during any period other than an  
2 open enrollment period if the child is not a late enrollee.

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

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

13  
14 ~~“Please consider your options carefully before failing to maintain~~  
15 ~~or renewing coverage for a child for whom you are responsible.~~  
16 ~~If you attempt to obtain new individual coverage for that child,~~  
17 ~~the premium for the same coverage may be higher than the~~  
18 ~~premium you pay now.”~~

19  
20 ~~(d) A child who applied for coverage between September 23,~~  
21 ~~2010, and the end of the initial enrollment period shall be deemed~~  
22 ~~to have maintained coverage during that period.~~

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

25 ~~(f) (1) On and after January 1, 2013, a carrier shall provide a~~  
26 ~~notice to all applicants for coverage under this chapter and to all~~  
27 ~~insureds, or the responsible party for an insured, renewing coverage~~  
28 ~~under this chapter that contains the following information:~~

29 ~~(A) Information about the open enrollment period provided~~  
30 ~~under Section 10965.3.~~

31 ~~(B) An explanation that obtaining coverage during the open~~  
32 ~~enrollment period described in Section 10965.3 will not affect the~~  
33 ~~effective dates of coverage for coverage purchased pursuant to~~  
34 ~~this chapter unless the applicant cancels that coverage.~~

35 ~~(C) An explanation that coverage purchased pursuant to this~~  
36 ~~section shall be effective as required under subdivision (d) of~~  
37 ~~Section 10951 and that such coverage shall not prevent an applicant~~  
38 ~~from obtaining new coverage during the open enrollment period~~  
39 ~~described in Section 10965.3.~~

1 ~~(2) The notice described in paragraph (1) shall be in plain~~  
2 ~~language and 14-point type.~~

3 ~~(3) The department may adopt a model notice to be used by~~  
4 ~~carriers in order to comply with this subdivision. Use of the model~~  
5 ~~notice shall not require prior approval of the department. Any~~  
6 ~~model notice designated by the department for purposes of this~~  
7 ~~section shall not be subject to the Administrative Procedure Act~~  
8 ~~(Chapter 3.5 (commencing with Section 11340) of Part 1 of~~  
9 ~~Division 3 of Title 2 of the Government Code).~~

10 SEC. 35. ~~Section 10961 is added to the Insurance Code, to~~  
11 ~~read:~~

12 ~~10961. This chapter shall remain in effect only until January~~  
13 ~~1, 2014, and as of that date is repealed, unless a later enacted~~  
14 ~~statute, that is enacted before January 1, 2014, deletes or extends~~  
15 ~~that date.~~

16 SEC. 36. ~~Chapter 9.9 (commencing with Section 10965) is~~  
17 ~~added to Part 2 of Division 2 of the Insurance Code, to read:~~

18  
19 ~~CHAPTER 9.9. INDIVIDUAL ACCESS TO HEALTH INSURANCE~~

20  
21 ~~10965. For purposes of this chapter, the following definitions~~  
22 ~~shall apply:~~

23 ~~(a) "Child" means a child described in Section 22775 of the~~  
24 ~~Government Code and subdivisions (n) to (p), inclusive, of Section~~  
25 ~~599.500 of Title 2 of the California Code of Regulations.~~

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

28 ~~(c) "Exchange" means the California Health Benefit Exchange~~  
29 ~~created by Section 100500 of the Government Code.~~

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

32 ~~(e) "Health benefit plan" means any individual or group policy~~  
33 ~~of health insurance, as defined in Section 106, or health care service~~  
34 ~~plan contract that provides medical, hospital, and surgical benefits.~~  
35 ~~The term does not include a health insurance policy consisting~~  
36 ~~solely of coverage of excepted benefits, as described in Sections~~  
37 ~~2722 and 2791 of the federal Public Health Service Act (42 U.S.C.~~  
38 ~~Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91), subject to Section~~  
39 ~~10965.01, a specialized health care service plan contract, as defined~~  
40 ~~in Section 1345 of the Health and Safety Code, a health care service~~

1 plan conversion contract offered pursuant to Section 1373.6 of the  
2 Health and Safety Code, a health insurance conversion policy  
3 offered pursuant to Section 12682.1, a health insurance policy or  
4 health care service plan contract provided in the Medi-Cal program  
5 (Chapter 7 (commencing with Section 14000) of Part 3 of Division  
6 9 of the Welfare and Institutions Code), the Healthy Families  
7 Program (Part 6.2 (commencing with Section 12693) of Division  
8 2), the Access for Infants and Mothers Program (Part 6.3  
9 (commencing with Section 12695) of Division 2), or the program  
10 under Part 6.4 (commencing with Section 12699.50) of Division  
11 2, a health care service plan contract or health insurance policy  
12 offered to a federally eligible defined individual under Article 4.6  
13 (commencing with Section 1366.35) of Chapter 2.2 of Division 2  
14 of the Health and Safety Code or Chapter 9.5 (commencing with  
15 Section 10900), or Medicare supplement coverage, to the extent  
16 consistent with PPACA.

17 (f) “PPACA” means the federal Patient Protection and  
18 Affordable Care Act (Public Law 111-148), as amended by the  
19 federal Health Care and Education Reconciliation Act of 2010  
20 (Public Law 111-152), and any rules, regulations, or guidance  
21 issued pursuant to that law.

22 (g) “Preexisting condition provision” means a policy provision  
23 that excludes coverage for charges or expenses incurred during a  
24 specified period following the insured’s effective date of coverage,  
25 as to a condition for which medical advice, diagnosis, care, or  
26 treatment was recommended or received during a specified period  
27 immediately preceding the effective date of coverage.

28 (h) “Qualified health plan” has the same meaning as that term  
29 is defined in Section 1301 of PPACA.

30 (i) “Rating period” means the period for which premium rates  
31 established by an insurer are in effect.

32 10965.01. (a) For purposes of this chapter, “health benefit  
33 plan” does not include policies or certificates of specified disease  
34 or hospital confinement indemnity provided that the carrier offering  
35 those policies or certificates complies with the following:

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

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

1     ~~(A) A statement from the carrier certifying that policies or~~  
 2 ~~certificates described in this section (i) are being offered and~~  
 3 ~~marketed as supplemental health insurance and not as a substitute~~  
 4 ~~for coverage that provides essential health benefits as defined by~~  
 5 ~~the state pursuant to Section 1302 of PPACA, and (ii) the disclosure~~  
 6 ~~forms as described in Section 10603 contains the following~~  
 7 ~~statement prominently on the first page:~~

8  
 9     ~~“This is a supplement to health insurance. It is not a substitute~~  
 10 ~~for essential health benefits or minimum essential coverage as~~  
 11 ~~defined in PPACA. Commencing January 1, 2014, you may be~~  
 12 ~~subject to a federal tax if you do not obtain minimum essential~~  
 13 ~~coverage.”~~

14  
 15     ~~(B) A summary description of each policy or certificate~~  
 16 ~~described in this section, including the average annual premium~~  
 17 ~~rates, or range of premium rates in cases where premiums vary by~~  
 18 ~~age, gender, or other factors, charged for the policies and~~  
 19 ~~certificates in this state.~~

20     ~~(3) In the case of a policy or certificate that is described in this~~  
 21 ~~section and that is offered for the first time in this state on or after~~  
 22 ~~January 1, 2013, the carrier files with the commissioner the~~  
 23 ~~information and statement required in paragraph (2) at least 30~~  
 24 ~~days prior to the date such a policy or certificate is issued or~~  
 25 ~~delivered in this state.~~

26     ~~(b) As used in this section, “policies or certificates of specified~~  
 27 ~~disease” and “policies or certificates of hospital confinement~~  
 28 ~~indemnity” mean policies or certificates of insurance sold to an~~  
 29 ~~insured to supplement other health insurance coverage as specified~~  
 30 ~~in this section.~~

31     ~~10965.1. Every health insurer offering individual health benefit~~  
 32 ~~plans shall, in addition to complying with the provisions of this~~  
 33 ~~part and rules adopted thereunder, comply with the provisions of~~  
 34 ~~this chapter.~~

35     ~~10965.3. (a) (1) On and after October 1, 2013, a health insurer~~  
 36 ~~shall fairly and affirmatively offer, market, and sell all of the~~  
 37 ~~insurer’s health benefit plans that are sold in the individual market~~  
 38 ~~to all individuals and dependents in each service area in which the~~  
 39 ~~insurer provides or arranges for the provision of health care~~  
 40 ~~services. An insurer shall limit enrollment in individual health~~



1 benefit plans to open enrollment periods and special enrollment  
2 periods as provided in subdivisions (c) and (d).

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

8 (3) A health insurer shall allow the policyholder of an individual  
9 health benefit plan to add a dependent to the policyholder's health  
10 benefit plan at the option of the policyholder, consistent with the  
11 open enrollment, annual enrollment, and special enrollment period  
12 requirements in this section.

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

16 (e) A health insurer shall provide an initial open enrollment  
17 period from October 1, 2013, to March 31, 2014, inclusive, and  
18 annual enrollment periods for plan years on or after January 1,  
19 2015, from October 15 to December 7, inclusive, of the preceding  
20 calendar year.

21 (d) Subject to subdivision (e), commencing January 1, 2014, a  
22 health insurer shall allow an individual to enroll in or change  
23 individual health benefit plans as a result of the following triggering  
24 events:

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

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

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

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

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

- 1     ~~(4) He or she is mandated to be covered pursuant to a valid state~~  
2 ~~or federal court order.~~
- 3     ~~(5) He or she has been released from incarceration.~~
- 4     ~~(6) His or her health benefit plan substantially violated a material~~  
5 ~~provision of the policy~~
- 6     ~~(7) He or she gains access to new health benefit plans as a result~~  
7 ~~of a permanent move.~~
- 8     ~~(8) He or she was receiving services from a contracting provider~~  
9 ~~under another health benefit plan for one of the conditions~~  
10 ~~described in subdivision (a) of Section 10133.56 and that provider~~  
11 ~~is terminated.~~
- 12     ~~(9) With respect to individual health benefit plans offered~~  
13 ~~through the Exchange, in addition to the triggering events listed~~  
14 ~~in this subdivision, the individual meets any of the requirements~~  
15 ~~listed in Section 155.420(d) of Title 45 of the Code of Federal~~  
16 ~~Regulations.~~
- 17     ~~(e) With respect to individual health benefit plans offered outside~~  
18 ~~the Exchange, an individual shall have 63 days from the date of a~~  
19 ~~triggering event identified in subdivision (d) to apply for coverage~~  
20 ~~from a health benefit plan subject to this section. With respect to~~  
21 ~~individual health benefit plans offered through the Exchange, an~~  
22 ~~individual shall have 63 days from the date of a triggering event~~  
23 ~~identified in subdivision (d) to select a plan offered through the~~  
24 ~~Exchange.~~
- 25     ~~(f) (1) With respect to individual health benefit plans offered~~  
26 ~~outside the Exchange, after an individual submits a completed~~  
27 ~~application form for a plan, the insurer shall, within 30 days, notify~~  
28 ~~the individual of the individual's actual premium charges for that~~  
29 ~~plan established in accordance with Section 10965.9. The~~  
30 ~~individual shall have 30 days in which to exercise the right to buy~~  
31 ~~coverage at the quoted premium charges.~~
- 32     ~~(2) With respect to an individual health benefit plan offered~~  
33 ~~outside the Exchange for which an individual applies during the~~  
34 ~~initial open enrollment period described in subdivision (c), when~~  
35 ~~the individual submits a premium payment, based on the quoted~~  
36 ~~premium charges, and that payment is delivered or postmarked,~~  
37 ~~whichever occurs earlier, by December 15, 2013, coverage under~~  
38 ~~the individual health benefit plan shall become effective no later~~  
39 ~~than January 1, 2014. When that payment is delivered or~~  
40 ~~postmarked within the first 15 days of any subsequent month,~~

1 coverage shall become effective no later than the first day of the  
2 following month. When that payment is delivered or postmarked  
3 between December 16, 2013, and December 31, 2013, inclusive,  
4 or after the 15th day of any subsequent month, coverage shall  
5 become effective no later than the first day of the second month  
6 following delivery or postmark of the payment.

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

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

25 ~~(A) When the individual submits a premium payment, based~~  
26 ~~on the quoted premium charges, and that payment is delivered or~~  
27 ~~postmarked, whichever occurs earlier, within the first 15 days of~~  
28 ~~the month, coverage under the plan shall become effective no later~~  
29 ~~than the first day of the following month.~~

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

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

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

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

6     ~~(g) (1) On or after January 1, 2014, a health insurer shall not~~  
7 ~~establish rules for eligibility, including continued eligibility, of~~  
8 ~~any individual to enroll under the terms of an individual health~~  
9 ~~benefit plan based on any of the following factors:~~

10     ~~(A) Health status.~~  
11     ~~(B) Medical condition, including physical and mental illnesses.~~  
12     ~~(C) Claims experience.~~  
13     ~~(D) Receipt of health care.~~  
14     ~~(E) Medical history.~~  
15     ~~(F) Genetic information.~~  
16     ~~(G) Evidence of insurability, including conditions arising out~~  
17 ~~of acts of domestic violence.~~  
18     ~~(H) Disability.~~  
19     ~~(I) Any other health status-related factor as determined by any~~  
20 ~~federal regulations, rules, or guidance issued pursuant to Section~~  
21 ~~2705 of the federal Public Health Service Act.~~

22     ~~(2) A health insurer shall not require an individual applicant or~~  
23 ~~his or her dependent to fill out a health assessment or medical~~  
24 ~~questionnaire prior to enrollment under an individual health benefit~~  
25 ~~plan.~~

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

30     ~~(i) This section shall not apply to an individual health benefit~~  
31 ~~plan that is a grandfathered health plan.~~

32     ~~10965.5. (a) Commencing January 1, 2014, no health insurer~~  
33 ~~or agent or broker shall, directly or indirectly, engage in the~~  
34 ~~following activities:~~

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

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

7 ~~(b) Commencing January 1, 2014, a health insurer shall not,~~  
8 ~~directly or indirectly, enter into any contract, agreement, or~~  
9 ~~arrangement with a broker or agent that provides for or results in~~  
10 ~~the compensation paid to a broker or agent for the sale of an~~  
11 ~~individual health benefit plan to be varied because of the health~~  
12 ~~status, claims experience, industry, occupation, or geographic~~  
13 ~~location of the individual. This subdivision does not apply to a~~  
14 ~~compensation arrangement that provides compensation to a broker~~  
15 ~~or agent on the basis of percentage of premium, provided that the~~  
16 ~~percentage shall not vary because of the health status, claims~~  
17 ~~experience, industry, occupation, or geographic area of the~~  
18 ~~individual.~~

19 ~~10965.7. (a) All individual health benefit plans shall conform~~  
20 ~~to the requirements of Sections 10112.1, 10127.18, 10273.4, and~~  
21 ~~12682.1, and any other requirements imposed by this code, and~~  
22 ~~shall be renewable at the option of the insured except as permitted~~  
23 ~~to be canceled, rescinded, or not renewed pursuant to Section~~  
24 ~~10273.4.~~

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

29 ~~10965.9. (a) With respect to individual health benefit plans~~  
30 ~~issued, amended, or renewed on or after January 1, 2014, a health~~  
31 ~~insurer may use only the following characteristics of an individual,~~  
32 ~~and any dependent thereof, for purposes of establishing the rate~~  
33 ~~of the individual health benefit plan covering the individual and~~  
34 ~~the eligible dependents thereof, along with the health benefit plan~~  
35 ~~selected by the individual:~~

36 ~~(1) Age, as described in regulations adopted by the department~~  
37 ~~in conjunction with the Department of Managed Health Care that~~  
38 ~~do not prevent the application of PPACA. Rates based on age shall~~  
39 ~~be determined based on the individual's birthday. A plan shall not~~  
40 ~~use any age bands for rating purposes that are inconsistent with~~

1 the age bands established by the United States Secretary of Health  
2 and Human Services pursuant to Section 2701(a)(3) of the federal  
3 Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).  
4 (2) Geographic region. The geographic regions for purposes of  
5 rating shall be the following:  
6 (A) Region 1 shall consist of the Counties of Alpine, Del Norte,  
7 Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama,  
8 Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter,  
9 Yuba, Colusa, Amador, Calaveras, and Tuolumne.  
10 (B) Region 2 shall consist of the Counties of Napa, Sonoma,  
11 Solano, and Marin.  
12 (C) Region 3 shall consist of the Counties of Sacramento, Placer,  
13 El Dorado, and Yolo.  
14 (D) Region 4 shall consist of the Counties of San Francisco,  
15 Contra Costa, Alameda, Santa Clara, and San Mateo.  
16 (E) Region 5 shall consist of the Counties of Santa Cruz,  
17 Monterey, and San Benito.  
18 (F) Region 6 shall consist of the Counties of San Joaquin,  
19 Stanislaus, Merced, Mariposa, Madera, Fresno, Kings, and Tulare.  
20 (G) Region 7 shall consist of the Counties of San Luis Obispo,  
21 Santa Barbara, and Ventura.  
22 (H) Region 8 shall consist of the Counties of Mono, Inyo, Kern,  
23 and Imperial.  
24 (I) Region 9 shall consist of the ZIP Codes in Los Angeles  
25 County starting with 906 to 912, inclusive, 915, 917, 918, and 935.  
26 (J) Region 10 shall consist of the ZIP Codes in Los Angeles  
27 County other than those identified in subparagraph (I).  
28 (K) Region 11 shall consist of the Counties of San Bernardino  
29 and Riverside.  
30 (L) Region 12 shall consist of the County of Orange.  
31 (M) Region 13 shall consist of the County of San Diego.  
32 (3) Whether the health benefit plan covers an individual or  
33 family:  
34 (b) The rate for a health benefit plan subject to this section shall  
35 not vary by any factor not described in this section.  
36 (c) The rating period for rates subject to this section shall be  
37 from January 1 to December 31, inclusive.  
38 (d) This section shall not apply to an individual health benefit  
39 plan that is a grandfathered health plan.

1     ~~10965.11.— A health insurer shall not be required to offer an~~  
2 ~~individual health benefit plan or accept applications for the plan~~  
3 ~~pursuant to this chapter in the case of any of the following:~~

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

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

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

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

25     ~~10965.13.— The commissioner may require a health insurer to~~  
26 ~~discontinue the offering of individual health benefit plans or~~  
27 ~~acceptance of applications from any individual upon a~~  
28 ~~determination by the commissioner that the insurer does not have~~  
29 ~~sufficient financial viability or organizational and administrative~~  
30 ~~capacity to ensure the delivery of health care services to its~~  
31 ~~insureds. In determining whether the conditions of this section~~  
32 ~~have been met, the commissioner shall consider, but not be limited~~  
33 ~~to, the insurer’s compliance with the requirements of this part and~~  
34 ~~the rules adopted under those provisions.~~

35     ~~10965.14.— (a) On or before October 1, 2013, and annually~~  
36 ~~thereafter, a health insurer shall issue the following notice to all~~  
37 ~~policyholders enrolled in an individual health benefit plan that is~~  
38 ~~a grandfathered health plan:~~

39

1     ~~Beginning on and after January 1, 2014, new improved health~~  
2 ~~insurance options are available in California. You currently have~~  
3 ~~health insurance that is exempt from many of the new requirements.~~  
4 ~~You have the option to remain in your current plan or switch to a~~  
5 ~~new plan. Under the new rules, a health insurance company cannot~~  
6 ~~deny your application based on any health conditions you may~~  
7 ~~have. For more information about your options, please contact the~~  
8 ~~California Health Benefit Exchange, the Office of Patient~~  
9 ~~Advocate, your plan or policy representative, an insurance broker,~~  
10 ~~or a health care navigator.~~

11  
12     ~~(b) A health insurer shall include the notice described in~~  
13 ~~subdivision (a) in any marketing material of the individual~~  
14 ~~grandfathered health plan.~~

15     ~~SEC. 37. This act shall be implemented to the extent consistent~~  
16 ~~with or more stringent than the federal Patient Protection and~~  
17 ~~Affordable Care Act (Public Law 111-148), as amended by the~~  
18 ~~federal Health Care and Education Reconciliation Act of 2010~~  
19 ~~(Public Law 111-152), and any rules, regulations, or guidance~~  
20 ~~issued pursuant to that law.~~

21     ~~SEC. 7. Section 10965.3 of the Insurance Code, as added by~~  
22 ~~Section 5 of Senate Bill 961 of the 2011–12 Regular Session, is~~  
23 ~~amended to read:~~

24     ~~10965.3. (a) (1) On and after October 1, 2013, a health insurer~~  
25 ~~shall fairly and affirmatively offer, market, and sell all of the~~  
26 ~~insurer’s health benefit plans that are sold in the individual market~~  
27 ~~for policy years on or after January 1, 2014, to all individuals and~~  
28 ~~dependents in each service area in which the insurer provides or~~  
29 ~~arranges for the provision of health care services. An insurer shall~~  
30 ~~limit enrollment in individual health benefit plans to open~~  
31 ~~enrollment periods and special enrollment periods as provided in~~  
32 ~~subdivisions (c) and (d).~~

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

38     ~~(3) A health insurer shall allow the policyholder of an individual~~  
39 ~~health benefit plan to add a dependent to the policyholder’s health~~  
40 ~~benefit plan at the option of the policyholder, consistent with the~~



1 open enrollment, annual enrollment, and special enrollment period  
2 requirements in this section.

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

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

10 (c) A health insurer shall provide an initial open enrollment  
11 period from October 1, 2013, to March 31, 2014, inclusive, and  
12 annual enrollment periods for plan years on or after January 1,  
13 2015, from October 15 to December 7, inclusive, of the preceding  
14 calendar year.

15 (d) (1) Subject to subdivision (e), commencing January 1, 2014,  
16 a health insurer shall allow an individual to enroll in or change  
17 individual health benefit plans offered outside the Exchange as a  
18 result of the following triggering events:

19 (A) He or she or his or her dependent loses minimum essential  
20 coverage. For purposes of this paragraph, both of the following  
21 definitions shall apply:

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

25 (ii) “Loss of minimum essential coverage” includes loss of that  
26 coverage due to the circumstances described in Section  
27 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of  
28 Federal Regulations. “Loss of minimum essential coverage” does  
29 not include loss of that coverage due to the individual’s failure to  
30 pay premiums on a timely basis or situations allowing for a  
31 rescission, subject to Section 10384.17.

32 (B) He or she gains a dependent or becomes a dependent.

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

35 (D) He or she has been released from incarceration.

36 (E) His or her health benefit plan substantially violated a  
37 material provision of the policy

38 (F) He or she gains access to new health benefit plans as a result  
39 of a permanent move.

1 (G) He or she was receiving services from a contracting provider  
2 under another health benefit plan, as defined in Section 10965 or  
3 Section 1399.845 of the Health and Safety Code, for one of the  
4 conditions described in subdivision (a) of Section 10133.56 and  
5 that provider is ~~terminated~~ *no longer participating in the health*  
6 *benefit plan.*

7 (2) Subject to subdivision (e), commencing January 1, 2014, a  
8 health insurer shall allow an individual to enroll in or change  
9 individual health benefit plans offered through the Exchange as a  
10 result of the triggering events listed in Section 155.420(d) of Title  
11 45 of the Code of Federal Regulations. To the extent permitted by  
12 federal law, any triggering event described in paragraph (1) that  
13 is not listed in Section 155.420(d)(1) to (8), inclusive, of Title 45  
14 of the Code of Federal Regulations shall be considered an  
15 exceptional circumstance under Section 155.420(d)(9) of Title 45  
16 of the Code of Federal Regulations.

17 (e) With respect to individual health benefit plans offered outside  
18 the Exchange, an individual shall have 60 days from the date of a  
19 triggering event identified in subdivision (d) to apply for coverage  
20 from a health benefit plan subject to this section. With respect to  
21 individual health benefit plans offered through the Exchange, an  
22 individual shall have 60 days from the date of a triggering event  
23 identified in subdivision (d) to select a plan offered through the  
24 Exchange.

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

32 (g) (1) With respect to an individual health benefit plan offered  
33 outside the Exchange for which an individual applies during the  
34 initial open enrollment period described in subdivision (c), when  
35 the individual submits a premium payment, based on the quoted  
36 premium charges, and that payment is delivered or postmarked,  
37 whichever occurs earlier, by December 15, 2013, coverage under  
38 the individual health benefit plan shall become effective no later  
39 than January 1, 2014. When that payment is delivered or  
40 postmarked within the first 15 days of any subsequent month,

1 coverage shall become effective no later than the first day of the  
2 following month. When that payment is delivered or postmarked  
3 between December 16, 2013, and December 31, 2013, inclusive,  
4 or after the 15th day of any subsequent month, coverage shall  
5 become effective no later than the first day of the second month  
6 following delivery or postmark of the payment.

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

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

25 (A) When the individual submits a premium payment, based  
26 on the quoted premium charges, and that payment is delivered or  
27 postmarked, whichever occurs earlier, within the first 15 days of  
28 the month, coverage under the plan shall become effective no later  
29 than the first day of the following month.

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

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

37 (D) Notwithstanding subparagraph (A) or (B), in the case of  
38 marriage or becoming a registered domestic partner or in the case  
39 where a qualified individual loses minimum essential coverage,

1 the coverage effective date shall be the first day of the following  
2 month.

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

8 (h) (1) On or after January 1, 2014, a health insurer shall not  
9 establish rules for eligibility, including continued eligibility, of  
10 any individual to enroll under the terms of an individual health  
11 benefit plan based on any of the following factors:

12 (A) Health status.

13 (B) Medical condition, including physical and mental illnesses.

14 (C) Claims experience.

15 (D) Receipt of health care.

16 (E) Medical history.

17 (F) Genetic information.

18 (G) Evidence of insurability, including conditions arising out  
19 of acts of domestic violence.

20 (H) Disability.

21 (I) Any other health status-related factor as determined by any  
22 federal regulations, rules, or guidance issued pursuant to Section  
23 2705 of the federal Public Health Service Act.

24 (2) Notwithstanding subdivision (c) of Section 10291.5, a health  
25 insurer shall not require an individual applicant or his or her  
26 dependent to fill out a health assessment or medical questionnaire  
27 prior to enrollment under an individual health benefit plan. A health  
28 insurer shall not acquire or request information that relates to a  
29 health status-related factor from the applicant or his or her  
30 dependent or any other source prior to enrollment of the individual.

31 (i) This section shall not apply to an individual health benefit  
32 plan that is a grandfathered health plan.

33 (j) The following provisions of this section shall become  
34 inoperative if Section 2702 of the federal Public Health Service  
35 Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of  
36 PPACA, is repealed:

37 (1) Subdivision (a).

38 (2) Subdivisions (c), (d), (e), and (g), except as they relate to  
39 health benefit plans offered through the Exchange.

1     ~~SEC. 38.~~

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

11     *SEC. 9.* *This act shall become operative only if Senate Bill 961*  
12 *of the 2011–12 Regular Session is enacted and takes effect.*

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