

AMENDED IN SENATE MARCH 7, 2013

CALIFORNIA LEGISLATURE—2013–14 FIRST EXTRAORDINARY SESSION

ASSEMBLY BILL

No. 2

Introduced by Assembly Member Pan

January 29, 2013

An act to amend Sections 1357.51, 1357.503, 1357.504, 1357.509, 1357.512, 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 and add Sections 1389.4 and 1389.7 of, to amend and repeal Section 1389.5 of, to amend, repeal, and add Sections 1399.805 and 1399.811 of, to add Sections 1348.96 and 1399.836 to, to add Article 11.8 (commencing with Section 1399.845) to Chapter 2.2 of Division 2 of, and to repeal Sections 1357.510 and 1399.816 of, the Health and Safety Code, and to amend Sections 10119.1, 10198.7, 10603, 10753.05, 10753.06.5, 10753.11, 10753.12, 10753.14, 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 add Sections 10113.95 and 10119.2 of, to amend and repeal Section 10119.1 of, to amend, repeal, and add Sections 10901.3 and 10901.9 of, to add Sections 10127.21 and 10960.5 to, to add Chapter 9.9 (commencing with Section 10965) to Part 2 of Division 2 of, to add Part 6.25 (commencing with Section 12694.50) to Division 2 of, and to repeal Section 10902.4 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2, as amended, Pan. 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 charged by a health insurance issuer offering small group or individual coverage to vary only by rating area, age, tobacco use, and whether the coverage is for an individual or family and prohibits discrimination against individuals based on health status, as specified. PPACA requires an issuer to consider all enrollees in its individual market plans to be part of a single risk pool and to consider all enrollees in its small group market plans to be part of a single risk pool, as specified. PPACA also requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified.

~~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. Existing law establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014.~~

This bill would require ~~a plan or~~ *an* insurer, on and after October 1, 2013, to offer, market, and sell all of the ~~plan's or~~ insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the ~~plan or~~ insurer provides or arranges for the provision of health care services, 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 *exclusion* upon any individual and from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as

specified. The bill would require a ~~health care service plan or~~ health insurer to consider the claims experience of all ~~enrollees or~~ insureds of its nongrandfathered individual health benefit plans *offered in the state* to be part of a single risk pool, *as specified*, would require the ~~plan or~~ insurer to establish a specified index rate for that market, and would authorize the ~~plan or~~ insurer to vary premiums from the index rate based only on specified factors. The bill would authorize ~~plans and~~ insurers to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans, as specified. The bill would require ~~plans and~~ insurers to provide specified information regarding the Exchange to applicants for and subscribers of individual health benefit plans offered outside the Exchange. The bill would prohibit a ~~plan or~~ an insurer from advertising or marketing an individual grandfathered health plan for the purpose of enrolling a dependent of the ~~subscriber or~~ policyholder in the plan and would also require ~~plans and~~ insurers to annually issue a specified notice to ~~subscribers and~~ policyholders enrolled in a grandfathered plan. *The bill would make certain of these provisions inoperative if, and 12 months after, certain provisions of PPACA are repealed or amended, as specified.*

Existing law requires ~~plans and~~ insurers to guarantee issue their small employer health benefit plans, as specified. With respect to nongrandfathered small employer health benefit plans for plan years on or after January 1, 2014, among other things, existing law provides certain exceptions from the guarantee issue requirement, allows the premium for small employer health benefit plans to vary only by age, geographic region, and family size, as specified, and requires ~~plans and~~ insurers to provide special enrollment periods and coverage effective dates consistent with the individual nongrandfathered market in the state. Existing law provides that these provisions shall be inoperative if specified provisions of PPACA are repealed.

This bill would modify the small employer special enrollment periods and coverage effective dates for purposes of consistency with the individual market reforms described above. The bill would also modify the exceptions from the guarantee issue requirement and the manner in which a ~~plan or~~ an insurer determines premium rates for a small employer health benefit plan, as specified. The bill would also require a ~~plan or~~ an insurer to consider the claims experience of all enrollees of its nongrandfathered small employer health benefit plans *offered in this state* to be part of a single risk pool, *as specified*, would require the ~~plan or~~ insurer to establish a specified index rate for that market, and

would authorize the ~~plan or insurer~~ to vary premiums from the index rate based only on specified factors. The bill would ~~delete the provisions making~~ *make certain of* these provisions inoperative, *as specified*, if, *and 12 months after* specified provisions of PPACA are repealed.

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

(2) PPACA requires a state or the United States Secretary of Health and Human Services to implement a risk adjustment program for the 2014 benefit year and every benefit year thereafter, under which a charge is assessed on low actuarial risk plans and a payment is made to high actuarial risk plans, as specified. If a state that elects to operate an American Health Benefit Exchange elects not to administer this risk adjustment program, the secretary will operate the program and issuers will be required to submit data for purposes of the program to the secretary.

This bill would require that any data submitted by ~~health care service plans and~~ health insurers to the secretary for purposes of the risk adjustment program also be submitted to the ~~Department of Managed Health Care or the Department of Insurance~~, *in the same format. The bill would require the department to use that data for specified purposes.*

~~(3) 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 issued by the plan, including the benefits and coverage of the contract, and the exceptions, reductions, and limitations that apply to the contract. 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 to waive or modify those requirements for purposes of compliance with PPACA through issuance of all-plan letters until January 1, 2015.~~

~~(4) 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 instead 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. The bill would make this requirement operative on the later of January 1, 2014, or the 91st day following the adjournment of the 2013–14 First Extraordinary Session. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.~~

~~(5) Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care services to eligible children through participating health, dental, and vision care plans, as defined. To be eligible for the program, existing law requires applicants to, among other requirements, be less than 19 years of age and have a limited gross household income, as specified. Existing law provides for the transition of specified enrollees of the Healthy Families Program to the Medi-Cal program, to the extent that those individuals are otherwise eligible, no sooner than January 1, 2013.~~

~~This bill would require plans offering coverage to Healthy Families Program enrollees, on or after January 1, 2012, including those transitioned to the Medi-Cal program, to offer 18 months of coverage, until a specified date, to individuals who were or are disenrolled from the program due to ineligibility because of age and are not eligible for full scope coverage under Medi-Cal. The bill would require plans to provide notice of eligibility for this coverage within a specified period of time and would require beneficiaries electing this coverage to pay no more than 110% of the average per subscriber payment made to all participating health, dental, or vision plans for program coverage, as specified.~~

~~(6) 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.~~

(3) Existing law requires insurers to provide a summary of information about each of their health insurance policies, as provided, upon the appropriate disclosure form as prescribed by the Insurance Commissioner.

This bill would provide that, on and after January 1, 2014, a health insurer issuing the federal uniform summary of benefits and coverage also complies with the commissioner’s disclosure requirements, but would require that the insurer ensure that all applicable state law disclosures are made in other documents. The bill would require the insurer to provide the commissioner a copy of the federal summary of benefits and coverage form and the corresponding health insurance policy, as specified.

(4) This bill would become operative only if S.B. 2 of the 2013–14 First Extraordinary Session is enacted and becomes effective.

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

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

1 SECTION 1.— Section 1348.96 is added to the Health and Safety
2 Code, to read:

3 1348.96.— Any data submitted by a health care service plan to
4 the United States Secretary of Health and Human Services, or his
5 or her designee, for purposes of the risk adjustment program
6 described in Section 1343 of the federal Patient Protection and
7 Affordable Care Act (42 U.S.C. Sec. 18063) shall be concurrently
8 submitted to the department.

9 SEC. 2.— Section 1357.51 of the Health and Safety Code, as
10 added by Chapter 852 of the Statutes of 2012, is amended to read:

11 1357.51.— (a) A health benefit plan for group coverage shall
12 not impose any preexisting condition provision or waived
13 condition provision upon any enrollee.

14 (b) A nongrandfathered health benefit plan for individual
15 coverage shall not impose any preexisting condition provision or
16 waived condition provision upon any enrollee. A grandfathered
17 health benefit plan for individual coverage shall not exclude
18 coverage on the basis of a waived condition provision or
19 preexisting condition provision for a period greater than 12 months
20 following the enrollee’s effective date of coverage, nor limit or
21 exclude coverage for a specific enrollee by type of illness;

1 treatment, medical condition, or accident, except for satisfaction
2 of a preexisting condition provision or waived condition
3 provision pursuant to this article. Waivered condition provisions
4 or preexisting condition provisions contained in individual
5 grandfathered health benefit plans may relate only to conditions
6 for which medical advice, diagnosis, care, or treatment, including
7 use of prescription drugs, was recommended or received from a
8 licensed health practitioner during the 12 months immediately
9 preceding the effective date of coverage.

10 (e) (1) A health benefit plan for group coverage may apply a
11 waiting period of up to 60 days as a condition of employment if
12 applied equally to all eligible employees and dependents and if
13 consistent with PPACA. A health benefit plan for group coverage
14 through a health maintenance organization, as defined in Section
15 2791 of the federal Public Health Service Act, shall not impose
16 any affiliation period that exceeds 60 days. A waiting or affiliation
17 period shall not be based on a preexisting condition of an employee
18 or dependent, the health status of an employee or dependent, or
19 any other factor listed in Section 1357.52. An affiliation period
20 shall run concurrently with a waiting period. During the waiting
21 or affiliation period, the plan is not required to provide health care
22 services and no premium shall be charged to the subscriber or
23 enrollees.

24 (2) A health benefit plan for individual coverage shall not
25 impose any waiting or affiliation period.

26 (d) In determining whether a preexisting condition provision,
27 a waived condition provision, or a waiting or affiliation period
28 applies to an enrollee, a plan shall credit the time the enrollee was
29 covered under creditable coverage, provided that the enrollee
30 becomes eligible for coverage under the succeeding plan contract
31 within 62 days of termination of prior coverage, exclusive of any
32 waiting or affiliation period, and applies for coverage under the
33 succeeding plan within the applicable enrollment period. A plan
34 shall also credit any time that an eligible employee must wait
35 before enrolling in the plan, including any postenrollment or
36 employer-imposed waiting or affiliation period.

37 However, if a person's employment has ended, the availability
38 of health coverage offered through employment or sponsored by
39 an employer has terminated, or an employer's contribution toward
40 health coverage has terminated, a plan shall credit the time the

1 person was covered under creditable coverage if the person
2 becomes eligible for health coverage offered through employment
3 or sponsored by an employer within 180 days, exclusive of any
4 waiting or affiliation period, and applies for coverage under the
5 succeeding plan contract within the applicable enrollment period.

6 (e) An individual's period of creditable coverage shall be
7 certified pursuant to Section 2704(e) of Title XXVII of the federal
8 Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

9 SEC. 3. Section 1357.503 of the Health and Safety Code is
10 amended to read:

11 1357.503. (a) (1) On and after October 1, 2013, a plan shall
12 fairly and affirmatively offer, market, and sell all of the plan's
13 small employer health care service plan contracts for plan years
14 on or after January 1, 2014, to all small employers in each service
15 area in which the plan provides or arranges for the provision of
16 health care services.

17 (2) On and after October 1, 2013, a plan shall make available
18 to each small employer all small employer health care service plan
19 contracts that the plan offers and sells to small employers or to
20 associations that include small employers in this state for plan
21 years on or after January 1, 2014.

22 (3) A plan that offers qualified health plans through the
23 Exchange shall be deemed to be in compliance with paragraphs
24 (1) and (2) with respect to small employer health care service plan
25 contracts offered through the Exchange in those geographic regions
26 in which the plan offers plan contracts through the Exchange.

27 (b) A plan shall provide enrollment periods consistent with
28 PPACA and described in Section 155.725 of Title 45 of the Code
29 of Federal Regulations. Commencing January 1, 2014, a plan shall
30 provide special enrollment periods consistent with the special
31 enrollment periods described in Section 1399.849, except for the
32 triggering events identified in paragraphs (d)(3) and (d)(6) of
33 Section 155.420 of Title 45 of the Code of Federal Regulations
34 with respect to plan contracts offered through the Exchange.

35 (c) No plan or solicitor shall induce or otherwise encourage a
36 small employer to separate or otherwise exclude an eligible
37 employee from a health care service plan contract that is provided
38 in connection with employee's employment or membership in a
39 guaranteed association.

1 ~~(d) Every plan shall file with the director the reasonable~~
2 ~~employee participation requirements and employer contribution~~
3 ~~requirements that will be applied in offering its plan contracts.~~
4 ~~Participation requirements shall be applied uniformly among all~~
5 ~~small employer groups, except that a plan may vary application~~
6 ~~of minimum employee participation requirements by the size of~~
7 ~~the small employer group and whether the employer contributes~~
8 ~~100 percent of the eligible employee's premium. Employer~~
9 ~~contribution requirements shall not vary by employer size. A health~~
10 ~~care service plan shall not establish a participation requirement~~
11 ~~that (1) requires a person who meets the definition of a dependent~~
12 ~~in Section 1357.500 to enroll as a dependent if he or she is~~
13 ~~otherwise eligible for coverage and wishes to enroll as an eligible~~
14 ~~employee and (2) allows a plan to reject an otherwise eligible small~~
15 ~~employer because of the number of persons that waive coverage~~
16 ~~due to coverage through another employer. Members of an~~
17 ~~association eligible for health coverage under subdivision (m) of~~
18 ~~Section 1357.500, but not electing any health coverage through~~
19 ~~the association, shall not be counted as eligible employees for~~
20 ~~purposes of determining whether the guaranteed association meets~~
21 ~~a plan's reasonable participation standards.~~

22 ~~(e) The plan shall not reject an application from a small~~
23 ~~employer for a small employer health care service plan contract~~
24 ~~if all of the following conditions are met:~~

25 ~~(1) The small employer offers health benefits to 100 percent of~~
26 ~~its eligible employees. Employees who waive coverage on the~~
27 ~~grounds that they have other group coverage shall not be counted~~
28 ~~as eligible employees.~~

29 ~~(2) The small employer agrees to make the required premium~~
30 ~~payments.~~

31 ~~(3) The small employer agrees to inform the small employer's~~
32 ~~employees of the availability of coverage and the provision that~~
33 ~~those not electing coverage must wait until the next open~~
34 ~~enrollment or a special enrollment period to obtain coverage~~
35 ~~through the group if they later decide they would like to have~~
36 ~~coverage.~~

37 ~~(4) The employees and their dependents who are to be covered~~
38 ~~by the plan contract work or reside in the service area in which~~
39 ~~the plan provides or otherwise arranges for the provision of health~~
40 ~~care services.~~

1 ~~(f) No plan or solicitor shall, directly or indirectly, engage in~~
2 ~~the following activities:~~

3 ~~(1) Encourage or direct small employers to refrain from filing~~
4 ~~an application for coverage with a plan because of the health status,~~
5 ~~claims experience, industry, occupation of the small employer, or~~
6 ~~geographic location provided that it is within the plan's approved~~
7 ~~service area.~~

8 ~~(2) Encourage or direct small employers to seek coverage from~~
9 ~~another plan because of the health status, claims experience,~~
10 ~~industry, occupation of the small employer, or geographic location~~
11 ~~provided that it is within the plan's approved service area.~~

12 ~~(3) Employ marketing practices or benefit designs that will have~~
13 ~~the effect of discouraging the enrollment of individuals with~~
14 ~~significant health needs.~~

15 ~~(g) A plan shall not, directly or indirectly, enter into any~~
16 ~~contract, agreement, or arrangement with a solicitor that provides~~
17 ~~for or results in the compensation paid to a solicitor for the sale of~~
18 ~~a health care service plan contract to be varied because of the health~~
19 ~~status, claims experience, industry, occupation, or geographic~~
20 ~~location of the small employer. This subdivision does not apply~~
21 ~~to a compensation arrangement that provides compensation to a~~
22 ~~solicitor on the basis of percentage of premium, provided that the~~
23 ~~percentage shall not vary because of the health status, claims~~
24 ~~experience, industry, occupation, or geographic area of the small~~
25 ~~employer.~~

26 ~~(h) (1) A policy or contract that covers a small employer, as~~
27 ~~defined in Section 1304(b) of PPACA and in Section 1357.500,~~
28 ~~shall not establish rules for eligibility, including continued~~
29 ~~eligibility, of an individual, or dependent of an individual, to enroll~~
30 ~~under the terms of the policy or contract based on any of the~~
31 ~~following health status-related factors:~~

32 ~~(A) Health status.~~

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

34 ~~(C) Claims experience.~~

35 ~~(D) Receipt of health care.~~

36 ~~(E) Medical history.~~

37 ~~(F) Genetic information.~~

38 ~~(G) Evidence of insurability, including conditions arising out~~
39 ~~of acts of domestic violence.~~

40 ~~(H) Disability.~~

1 ~~(1) Any other health status-related factor as determined by any~~
2 ~~federal regulations, rules, or guidance issued pursuant to Section~~
3 ~~2705 of the federal Public Health Service Act.~~

4 ~~(2) Notwithstanding Section 1389.1, a health care service plan~~
5 ~~shall not require an eligible employee or dependent to fill out a~~
6 ~~health assessment or medical questionnaire prior to enrollment~~
7 ~~under a small employer health care service plan contract. A health~~
8 ~~care service plan shall not acquire or request information that~~
9 ~~relates to a health status-related factor from the applicant or his or~~
10 ~~her dependent or any other source prior to enrollment of the~~
11 ~~individual.~~

12 ~~(i) (1) A health care service plan shall consider the claims~~
13 ~~experience of all enrollees in all nongrandfathered small employer~~
14 ~~health care service plan contracts offered in the state that are subject~~
15 ~~to subdivision (a), including those enrollees who do not enroll in~~
16 ~~the contracts through the Exchange, to be members of a single risk~~
17 ~~pool.~~

18 ~~(2) Each plan year, a health care service plan shall establish an~~
19 ~~index rate for the small employer market in the state based on the~~
20 ~~total combined claims costs for providing essential health benefits;~~
21 ~~as defined pursuant to Section 1302 of PPACA, within the single~~
22 ~~risk pool required under paragraph (1). The index rate shall be~~
23 ~~adjusted on a market-wide basis based on the total expected~~
24 ~~market-wide payments and charges under the risk adjustment and~~
25 ~~reinsurance programs established for the state pursuant to Sections~~
26 ~~1343 and 1341 of PPACA. The premium rate for all of the health~~
27 ~~care service plan's nongrandfathered small employer health care~~
28 ~~service plan contracts shall use the applicable index rate, as~~
29 ~~adjusted for total expected market-wide payments and charges~~
30 ~~under the risk adjustment and reinsurance programs established~~
31 ~~for the state pursuant to Sections 1343 and 1341 of PPACA, subject~~
32 ~~only to the adjustments permitted under paragraph (3).~~

33 ~~(3) A health care service plan may vary premiums rates for a~~
34 ~~particular nongrandfathered small employer health care service~~
35 ~~plan contract from its index rate based only on the following~~
36 ~~actuarially justified plan-specific factors:~~

37 ~~(A) The actuarial value and cost-sharing design of the plan~~
38 ~~contract.~~

39 ~~(B) The plan contract's provider network, delivery system~~
40 ~~characteristics, and utilization management practices.~~

1 ~~(C) The benefits provided under the plan contract that are in~~
2 ~~addition to the essential health benefits, as defined pursuant to~~
3 ~~Section 1302 of PPACA. These additional benefits shall be pooled~~
4 ~~with similar benefits within the single risk pool required under~~
5 ~~paragraph (1) and the claims experience from those benefits shall~~
6 ~~be utilized to determine rate variations for plan contracts that offer~~
7 ~~those benefits in addition to essential health benefits.~~

8 ~~(D) With respect to catastrophic plans, as described in subsection~~
9 ~~(e) of Section 1302 of PPACA, the expected impact of the specific~~
10 ~~eligibility categories for those plans.~~

11 ~~(j) A plan shall comply with the requirements of Section 1374.3.~~
12 ~~SEC. 4. Section 1357.504 of the Health and Safety Code is~~
13 ~~amended to read:~~

14 ~~1357.504. (a) With respect to small employer health care~~
15 ~~service plan contracts offered outside the Exchange, after a small~~
16 ~~employer submits a completed application form for a plan contract,~~
17 ~~the health care service plan shall, within 30 days, notify the~~
18 ~~employer of the employer's actual premium charges for that plan~~
19 ~~contract established in accordance with Section 1357.512. The~~
20 ~~employer shall have 30 days in which to exercise the right to buy~~
21 ~~coverage at the quoted premium charges.~~

22 ~~(b) Except as provided in subdivision (c), when a small employer~~
23 ~~submits a premium payment, based on the quoted premium charges,~~
24 ~~and that payment is delivered or postmarked, whichever occurs~~
25 ~~earlier, within the first 15 days of the month, coverage under the~~
26 ~~plan contract shall become effective no later than the first day of~~
27 ~~the following month. When that payment is neither delivered nor~~
28 ~~postmarked until after the 15th day of a month, coverage shall~~
29 ~~become effective no later than the first day of the second month~~
30 ~~following delivery or postmark of the payment.~~

31 ~~(e) (1) With respect to a small employer health care service~~
32 ~~plan contract offered through the Exchange, a plan shall apply~~
33 ~~coverage effective dates consistent with those required under~~
34 ~~Section 155.720 of Title 45 of the Code of Federal Regulations~~
35 ~~and paragraph (2) of subdivision (e) of Section 1399.849.~~

36 ~~(2) With respect to a small employer health care service plan~~
37 ~~contract offered outside the Exchange for which an individual~~
38 ~~applies during a special enrollment period described in subdivision~~
39 ~~(b) of Section 1357.503, the following provisions shall apply:~~

1 ~~(A) Coverage under the plan contract shall become effective no~~
2 ~~later than the first day of the first calendar month beginning after~~
3 ~~the date the plan receives the request for special enrollment.~~

4 ~~(B) Notwithstanding subparagraph (A), in the case of a birth,~~
5 ~~adoption, or placement for adoption, coverage under the plan~~
6 ~~contract shall become effective on the date of birth, adoption, or~~
7 ~~placement for adoption.~~

8 ~~(d) During the first 30 days after the effective date of the plan~~
9 ~~contract, the small employer shall have the option of changing~~
10 ~~coverage to a different plan contract offered by the same health~~
11 ~~care service plan. If a small employer notifies the plan of the~~
12 ~~change within the first 15 days of a month, coverage under the~~
13 ~~new plan contract shall become effective no later than the first day~~
14 ~~of the following month. If a small employer notifies the plan of~~
15 ~~the change after the 15th day of a month, coverage under the new~~
16 ~~plan contract shall become effective no later than the first day of~~
17 ~~the second month following notification.~~

18 ~~SEC. 5. Section 1357.509 of the Health and Safety Code is~~
19 ~~amended to read:~~

20 ~~1357.509. (a) To the extent permitted by PPACA, no plan~~
21 ~~shall be required to offer a health care service plan contract or~~
22 ~~accept applications for the contract pursuant to this article in the~~
23 ~~case of any of the following:~~

24 ~~(1) To a small employer, if the eligible employees and~~
25 ~~dependents who are to be covered by the plan contract do not live,~~
26 ~~work or reside within a plan's approved service areas.~~

27 ~~(2) (A) Within a specific service area or portion of a service~~
28 ~~area, if a plan reasonably anticipates and demonstrates to the~~
29 ~~satisfaction of the director both of the following:~~

30 ~~(i) It will not have sufficient health care delivery resources to~~
31 ~~ensure that health care services will be available and accessible to~~
32 ~~the eligible employee and dependents of the employee because of~~
33 ~~its obligations to existing enrollees.~~

34 ~~(ii) It is applying this subparagraph uniformly to all employers~~
35 ~~without regard to the claims experience of those employers, and~~
36 ~~their employees and dependents, or any health status-related factor~~
37 ~~relating to those employees and dependents.~~

38 ~~(B) A plan that cannot offer a health care service plan contract~~
39 ~~to small employers because it is lacking in sufficient health care~~
40 ~~delivery resources within a service area or a portion of a service~~

1 area pursuant to subparagraph (A) may not offer a contract in the
2 area in which the plan is not offering coverage to small employers
3 to new employer groups with more than 50 eligible employees
4 until the later of the following dates:

5 (i) The 181st day after the date that coverage is denied pursuant
6 to this paragraph.

7 (ii) The date the plan notifies the director that it has the ability
8 to deliver services to small employer groups, and certifies to the
9 director that from the date of the notice it will enroll all small
10 employer groups requesting coverage in that area from the plan.

11 (C) Subparagraph (B) shall not limit the plan's ability to renew
12 coverage already in force or relieve the plan of the responsibility
13 to renew that coverage as described in Section 1365.

14 (D) Coverage offered within a service area after the period
15 specified in subparagraph (B) shall be subject to the requirements
16 of this section.

17 (b) (1) A health care service plan may decline to offer a health
18 care service plan contract to a small employer if the plan
19 demonstrates to the satisfaction of the director both of the
20 following:

21 (A) It does not have the financial reserves necessary to
22 underwrite additional coverage. In determining whether this
23 subparagraph has been satisfied, the director shall consider, but
24 not be limited to, the plan's compliance with the requirements of
25 Section 1367, Article 6 (commencing with Section 1375), and the
26 rules adopted thereunder.

27 (B) It is applying this paragraph uniformly to all employers
28 without regard to the claims experience of those employers and
29 their employees and dependents or any health status-related factor
30 relating to those employees and dependents.

31 (2) A plan that denies coverage to a small employer under
32 paragraph (1) shall not offer coverage in the group market before
33 the later of the following dates:

34 (A) The 181st day after the date that coverage is denied pursuant
35 to paragraph (1).

36 (B) The date the plan demonstrates to the satisfaction of the
37 director that the plan has sufficient financial reserves necessary to
38 underwrite additional coverage.

1 ~~(3) Paragraph (2) shall not limit the plan's ability to renew~~
2 ~~coverage already in force or relieve the plan of the responsibility~~
3 ~~to renew that coverage as described in Section 1365.~~

4 ~~(4) Coverage offered within a service area after the period~~
5 ~~specified in paragraph (2) shall be subject to the requirements of~~
6 ~~this section.~~

7 ~~(e) Nothing in this article shall be construed to limit the~~
8 ~~director's authority to develop and implement a plan of~~
9 ~~rehabilitation for a health care service plan whose financial viability~~
10 ~~or organizational and administrative capacity has become impaired~~
11 ~~to the extent permitted by PPACA.~~

12 ~~SEC. 6. Section 1357.510 of the Health and Safety Code is~~
13 ~~repealed.~~

14 ~~SEC. 7. Section 1357.512 of the Health and Safety Code is~~
15 ~~amended to read:~~

16 ~~1357.512. (a) The premium rate for a small employer health~~
17 ~~care service plan contract shall vary with respect to the particular~~
18 ~~coverage involved only by the following:~~

19 ~~(1) Age, pursuant to the age bands established by the United~~
20 ~~States Secretary of Health and Human Services and the age rating~~
21 ~~curve established by the Centers for Medicare and Medicaid~~
22 ~~Services pursuant to Section 2701(a)(3) of the federal Public Health~~
23 ~~Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall~~
24 ~~be determined using the individual's age as of the date of the~~
25 ~~contract issuance or renewal, as applicable, and shall not vary by~~
26 ~~more than three to one for like individuals of different age who~~
27 ~~are 21 years of age or older as described in federal regulations~~
28 ~~adopted pursuant to Section 2701(a)(3) of the federal Public Health~~
29 ~~Service Act (42 U.S.C. Sec. 300gg(a)(3)).~~

30 ~~(2) (A) Geographic region. Except as provided in subparagraph~~
31 ~~(B), the geographic regions for purposes of rating shall be the~~
32 ~~following:~~

33 ~~(i) Region 1 shall consist of the Counties of Alpine, Amador,~~
34 ~~Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt,~~
35 ~~Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,~~
36 ~~Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou,~~
37 ~~Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.~~

38 ~~(ii) Region 2 shall consist of the Counties of Fresno, Imperial,~~
39 ~~Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin,~~
40 ~~San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.~~

- 1 ~~(iii) Region 3 shall consist of the Counties of Alameda, Contra~~
- 2 ~~Costa, Marin, San Francisco, San Mateo, and Santa Clara.~~
- 3 ~~(iv) Region 4 shall consist of the Counties of Orange, Santa~~
- 4 ~~Barbara, and Ventura.~~
- 5 ~~(v) Region 5 shall consist of the County of Los Angeles.~~
- 6 ~~(vi) Region 6 shall consist of the Counties of Riverside, San~~
- 7 ~~Bernardino, and San Diego.~~
- 8 ~~(B) For the 2015 plan year and plan years thereafter, the~~
- 9 ~~geographic regions for purposes of rating shall be the following,~~
- 10 ~~subject to federal approval if required pursuant to Section 2701 of~~
- 11 ~~the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and~~
- 12 ~~obtained by the department and the Department of Insurance by~~
- 13 ~~July 1, 2014:~~
- 14 ~~(i) Region 1 shall consist of the Counties of Alpine, Amador,~~
- 15 ~~Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,~~
- 16 ~~Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,~~
- 17 ~~Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.~~
- 18 ~~(ii) Region 2 shall consist of the Counties of Marin, Napa,~~
- 19 ~~Solano, and Sonoma.~~
- 20 ~~(iii) Region 3 shall consist of the Counties of El Dorado, Placer,~~
- 21 ~~Sacramento, and Yolo.~~
- 22 ~~(iv) Region 4 shall consist of the Counties of Alameda, Contra~~
- 23 ~~Costa, San Francisco, San Mateo, and Santa Clara.~~
- 24 ~~(v) Region 5 shall consist of the Counties of Monterey, San~~
- 25 ~~Benito, and Santa Cruz.~~
- 26 ~~(vi) Region 6 shall consist of the Counties of Fresno, Kings,~~
- 27 ~~Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.~~
- 28 ~~(vii) Region 7 shall consist of the Counties of San Luis Obispo,~~
- 29 ~~Santa Barbara, and Ventura.~~
- 30 ~~(viii) Region 8 shall consist of the Counties of Imperial, Inyo,~~
- 31 ~~Kern, and Mono.~~
- 32 ~~(ix) Region 9 shall consist of the ZIP Codes in Los Angeles~~
- 33 ~~County starting with 906 to 912, inclusive, 915, 917, 918, and 935.~~
- 34 ~~(x) Region 10 shall consist of the ZIP Codes in Los Angeles~~
- 35 ~~County other than those identified in clause (ix).~~
- 36 ~~(xi) Region 11 shall consist of the Counties of Riverside and~~
- 37 ~~San Bernardino.~~
- 38 ~~(xii) Region 12 shall consist of the County of Orange.~~
- 39 ~~(xiii) Region 13 shall consist of the County of San Diego.~~

1 ~~(C) No later than June 1, 2017, the department, in collaboration~~
2 ~~with the Exchange and the Department of Insurance, shall review~~
3 ~~the geographic rating regions specified in this paragraph and the~~
4 ~~impacts of those regions on the health care coverage market in~~
5 ~~California, and submit a report to the appropriate policy committees~~
6 ~~of the Legislature.~~

7 ~~(3) Whether the contract covers an individual or family, as~~
8 ~~described in PPACA.~~

9 ~~(b) The rate for a health care service plan contract subject to~~
10 ~~this section shall not vary by any factor not described in this~~
11 ~~section.~~

12 ~~(e) The total premium charged to a small employer pursuant to~~
13 ~~this section shall be determined by summing the premiums of~~
14 ~~covered employees and dependents in accordance with Section~~
15 ~~147.102(e)(1) of Title 45 of the Code of Federal Regulations.~~

16 ~~(d) The rating period for rates subject to this section shall be no~~
17 ~~less than 12 months from the date of issuance or renewal of the~~
18 ~~plan contract.~~

19 ~~SEC. 8. Section 1363 of the Health and Safety Code is amended~~
20 ~~to read:~~

21 ~~1363. (a) The director shall require the use by each plan of~~
22 ~~disclosure forms or materials containing information regarding~~
23 ~~the benefits, services, and terms of the plan contract as the director~~
24 ~~may require, so as to afford the public, subscribers, and enrollees~~
25 ~~with a full and fair disclosure of the provisions of the plan in~~
26 ~~readily understood language and in a clearly organized manner.~~
27 ~~The director may require that the materials be presented in a~~
28 ~~reasonably uniform manner so as to facilitate comparisons between~~
29 ~~plan contracts of the same or other types of plans. Nothing~~
30 ~~contained in this chapter shall preclude the director from permitting~~
31 ~~the disclosure form to be included with the evidence of coverage~~
32 ~~or plan contract.~~

33 ~~The disclosure form shall provide for at least the following~~
34 ~~information, in concise and specific terms, relative to the plan,~~
35 ~~together with additional information as may be required by the~~
36 ~~director, in connection with the plan or plan contract:~~

37 ~~(1) The principal benefits and coverage of the plan, including~~
38 ~~coverage for acute care and subacute care.~~

39 ~~(2) The exceptions, reductions, and limitations that apply to the~~
40 ~~plan.~~

1 ~~(3) The full premium cost of the plan.~~

2 ~~(4) Any copayment, coinsurance, or deductible requirements~~
3 ~~that may be incurred by the member or the member's family in~~
4 ~~obtaining coverage under the plan.~~

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

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

13 ~~(A) (i) States that the evidence of coverage discloses the terms~~
14 ~~and conditions of coverage.~~

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

22 ~~(B) Includes a statement that the disclosure and the evidence of~~
23 ~~coverage should be read completely and carefully and that~~
24 ~~individuals with special health care needs should read carefully~~
25 ~~those sections that apply to them.~~

26 ~~(C) Includes the plan's telephone number or numbers that may~~
27 ~~be used by an applicant to receive additional information about~~
28 ~~the benefits of the plan or a statement where the telephone number~~
29 ~~or numbers are located in the disclosure form.~~

30 ~~(D) For individual contracts, and small group plan contracts as~~
31 ~~defined in Article 3.1 (commencing with Section 1357), the~~
32 ~~disclosure form shall state where the health plan benefits and~~
33 ~~coverage matrix is located.~~

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

36 ~~(7) A statement as to when benefits shall cease in the event of~~
37 ~~nonpayment of the prepaid or periodic charge and the effect of~~
38 ~~nonpayment upon an enrollee who is hospitalized or undergoing~~
39 ~~treatment for an ongoing condition.~~

1 ~~(8) To the extent that the plan permits a free choice of provider~~
2 ~~to its subscribers and enrollees, the statement shall disclose the~~
3 ~~nature and extent of choice permitted and the financial liability~~
4 ~~that is, or may be, incurred by the subscriber, enrollee, or a third~~
5 ~~party by reason of the exercise of that choice.~~

6 ~~(9) A summary of the provisions required by subdivision (g) of~~
7 ~~Section 1373, if applicable.~~

8 ~~(10) If the plan utilizes arbitration to settle disputes, a statement~~
9 ~~of that fact.~~

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

14 ~~(12) A description of any limitations on the patient's choice of~~
15 ~~primary care physician, specialty care physician, or nonphysician~~
16 ~~health care practitioner, based on service area and limitations on~~
17 ~~the patient's choice of acute care hospital care, subacute or~~
18 ~~transitional inpatient care, or skilled nursing facility.~~

19 ~~(13) General authorization requirements for referral by a primary~~
20 ~~care physician to a specialty care physician or a nonphysician~~
21 ~~health care practitioner.~~

22 ~~(14) Conditions and procedures for disenrollment.~~

23 ~~(15) A description as to how an enrollee may request continuity~~
24 ~~of care as required by Section 1373.96 and request a second opinion~~
25 ~~pursuant to Section 1383.15.~~

26 ~~(16) Information concerning the right of an enrollee to request~~
27 ~~an independent review in accordance with Article 5.55~~
28 ~~(commencing with Section 1374.30).~~

29 ~~(17) A notice as required by Section 1364.5.~~

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

38 ~~(A) Deductibles.~~

39 ~~(B) Lifetime maximums.~~

40 ~~(C) Professional services.~~

- 1 ~~(D) Outpatient services.~~
- 2 ~~(E) Hospitalization services.~~
- 3 ~~(F) Emergency health coverage.~~
- 4 ~~(G) Ambulance services.~~
- 5 ~~(H) Prescription drug coverage.~~
- 6 ~~(I) Durable medical equipment.~~
- 7 ~~(J) Mental health services.~~
- 8 ~~(K) Chemical dependency services.~~
- 9 ~~(L) Home health services.~~
- 10 ~~(M) Other.~~

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

13
 14 ~~THIS MATRIX IS INTENDED TO BE USED TO HELP YOU~~
 15 ~~COMPARE COVERAGE BENEFITS AND IS A SUMMARY~~
 16 ~~ONLY. THE EVIDENCE OF COVERAGE AND PLAN~~
 17 ~~CONTRACT SHOULD BE CONSULTED FOR A DETAILED~~
 18 ~~DESCRIPTION OF COVERAGE BENEFITS AND~~
 19 ~~LIMITATIONS.~~

20
 21 ~~(e) Nothing in this section shall prevent a plan from using~~
 22 ~~appropriate footnotes or disclaimers to reasonably and fairly~~
 23 ~~describe coverage arrangements in order to clarify any part of the~~
 24 ~~matrix that may be unclear.~~

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

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

33 ~~(f) Group contractholders shall disseminate copies of the~~
 34 ~~completed disclosure form to all persons eligible to be a subscriber~~
 35 ~~under the group contract at the time those persons are offered the~~
 36 ~~plan. If the individual group members are offered a choice of plans,~~
 37 ~~separate disclosure forms shall be supplied for each plan available.~~
 38 ~~Each group contractholder shall also disseminate or cause to be~~
 39 ~~disseminated copies of the evidence of coverage to all applicants,~~

1 upon request, prior to enrollment and to all subscribers enrolled
2 under the group contract.

3 (g) In the case of conflicts between the group contract and the
4 evidence of coverage, the provisions of the evidence of coverage
5 shall be binding upon the plan notwithstanding any provisions in
6 the group contract that may be less favorable to subscribers or
7 enrollees.

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

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

21 (j) Until January 1, 2015, the department may waive or modify
22 the requirements of this section for the purpose of resolving
23 duplication or conflict with federal requirements for uniform
24 benefit disclosure in effect pursuant to Section 2715 of the federal
25 Public Health Service Act and the regulations adopted thereunder.
26 The department shall implement this subdivision in a manner that
27 preserves disclosure requirements of this section that exceed or
28 are not in direct conflict with federal requirements.
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 subdivision through issuance of all-plan letters.

33 SEC. 9. Section 1389.4 of the Health and Safety Code is
34 amended to read:

35 1389.4. (a) A full service health care service plan that issues,
36 renews, or amends individual health plan contracts shall be subject
37 to this 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 coverage
2 and sets the rate for that coverage. These guidelines, policies, or
3 procedures shall assure that the plan rating and underwriting criteria
4 comply with Sections 1365.5 and 1389.1 and all other applicable
5 provisions of state and federal law.

6 ~~(e) On or before June 1, 2006, and annually thereafter, every~~
7 ~~health care service plan shall file with the department a general~~
8 ~~description of the criteria, policies, procedures, or guidelines the~~
9 ~~plan uses for rating and underwriting decisions related to individual~~
10 ~~health plan contracts, which means automatic declinable health~~
11 ~~conditions, health conditions that may lead to a coverage decline,~~
12 ~~height and weight standards, health history, health care utilization,~~
13 ~~lifestyle, or behavior that might result in a decline for coverage or~~
14 ~~severely limit the plan products for which they would be eligible.~~
15 ~~A plan may comply with this section by submitting to the~~
16 ~~department underwriting materials or resource guides provided to~~
17 ~~plan solicitors or solicitor firms, provided that those materials~~
18 ~~include the information required to be submitted by this section.~~

19 ~~(d) Commencing January 1, 2011, the director shall post on the~~
20 ~~department's Internet Web site, in a manner accessible and~~
21 ~~understandable to consumers, general, noncompany specific~~
22 ~~information about rating and underwriting criteria and practices~~
23 ~~in the individual market and information about the California Major~~
24 ~~Risk Medical Insurance Program (Part 6.5 (commencing with~~
25 ~~Section 12700) of Division 2 of the Insurance Code) and the federal~~
26 ~~temporary high risk pool established pursuant to Part 6.6~~
27 ~~(commencing with Section 12739.5) of Division 2 of the Insurance~~
28 ~~Code. The director shall develop the information for the Internet~~
29 ~~Web site in consultation with the Department of Insurance to~~
30 ~~enhance the consistency of information provided to consumers.~~
31 ~~Information about individual health coverage shall also include~~
32 ~~the following notification:~~

33 ~~“Please examine your options carefully before declining group~~
34 ~~coverage or continuation coverage, such as COBRA, that may be~~
35 ~~available to you. You should be aware that companies selling~~
36 ~~individual health insurance typically require a review of your~~
37 ~~medical history that could result in a higher premium or you could~~
38 ~~be denied coverage entirely.”~~

1 ~~(e) Nothing in this section shall authorize public disclosure of~~
2 ~~company specific rating and underwriting criteria and practices~~
3 ~~submitted to the director.~~

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

6 ~~(g) This section shall become inoperative on November 1, 2013,~~
7 ~~or the 91st calendar day following the adjournment of the 2013-14~~
8 ~~First Extraordinary Session, whichever date is later.~~

9 SEC. 10. ~~Section 1389.4 is added to the Health and Safety~~
10 ~~Code, to read:~~

11 ~~1389.4. (a) A full service health care service plan that renews~~
12 ~~individual grandfathered health plans shall be subject to this~~
13 ~~section.~~

14 ~~(b) A health care service plan subject to this section shall have~~
15 ~~written policies, procedures, or underwriting guidelines establishing~~
16 ~~the criteria and process whereby the plan makes its decision to~~
17 ~~provide or to deny coverage to individuals applying for an~~
18 ~~individual grandfathered health plan and sets the rate for that~~
19 ~~coverage. These guidelines, policies, or procedures shall ensure~~
20 ~~that the plan rating and underwriting criteria comply with Sections~~
21 ~~1365.5 and 1389.1 and all other applicable provisions of state and~~
22 ~~federal law.~~

23 ~~(c) On or before the June 1 next following the operative date of~~
24 ~~this section, and annually thereafter, every health care service plan~~
25 ~~shall file with the department a general description of the criteria,~~
26 ~~policies, procedures, or guidelines the plan uses for rating and~~
27 ~~underwriting decisions related to individual grandfathered health~~
28 ~~plans, which means automatic declinable health conditions, health~~
29 ~~conditions that may lead to a coverage decline, height and weight~~
30 ~~standards, health history, health care utilization, lifestyle, or~~
31 ~~behavior that might result in a decline for coverage or severely~~
32 ~~limit the plan products for which they would be eligible. A plan~~
33 ~~may comply with this section by submitting to the department~~
34 ~~underwriting materials or resource guides provided to plan~~
35 ~~solicitors or solicitor firms, provided that those materials include~~
36 ~~the information required to be submitted by this section.~~

37 ~~(d) Nothing in this section shall authorize public disclosure of~~
38 ~~company specific rating and underwriting criteria and practices~~
39 ~~submitted to the director.~~

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

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

5 ~~(1) “PPACA” means the federal Patient Protection and~~
6 ~~Affordable Care Act (Public Law 111-148), as amended by the~~
7 ~~federal Health Care and Education Reconciliation Act of 2010~~
8 ~~(Public Law 111-152), and any rules, regulations, or guidancee~~
9 ~~issued pursuant to that law.~~

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

12 ~~(g) This section shall become operative on November 1, 2013,~~
13 ~~or the 91st calendar day following the adjournment of the 2013-14~~
14 ~~First Extraordinary Session, whichever date is later.~~

15 ~~SEC. 11. Section 1389.5 of the Health and Safety Code is~~
16 ~~amended to read:~~

17 ~~1389.5. (a) This section shall apply to a health care service~~
18 ~~plan that provides coverage under an individual plan contract that~~
19 ~~is issued, amended, delivered, or renewed on or after January 1,~~
20 ~~2007.~~

21 ~~(b) At least once each year, the health care service plan shall~~
22 ~~permit an individual who has been covered for at least 18 months~~
23 ~~under an individual plan contract to transfer, without medical~~
24 ~~underwriting, to any other individual plan contract offered by that~~
25 ~~same health care service plan that provides equal or lesser benefits,~~
26 ~~as determined by the plan.~~

27 ~~“Without medical underwriting” means that the health care~~
28 ~~service plan shall not decline to offer coverage to, or deny~~
29 ~~enrollment of, the individual or impose any preexisting condition~~
30 ~~exclusion on the individual who transfers to another individual~~
31 ~~plan contract pursuant to this section.~~

32 ~~(c) The plan shall establish, for the purposes of subdivision (b),~~
33 ~~a ranking of the individual plan contracts it offers to individual~~
34 ~~purchasers and post the ranking on its Internet Web site or make~~
35 ~~the ranking available upon request. The plan shall update the~~
36 ~~ranking whenever a new benefit design for individual purchasers~~
37 ~~is approved.~~

38 ~~(d) The plan shall notify in writing all enrollees of the right to~~
39 ~~transfer to another individual plan contract pursuant to this section,~~
40 ~~at a minimum, when the plan changes the enrollee’s premium rate.~~

1 ~~Posting this information on the plan's Internet Web site shall not~~
2 ~~constitute notice for purposes of this subdivision. The notice shall~~
3 ~~adequately inform enrollees of the transfer rights provided under~~
4 ~~this section, including information on the process to obtain details~~
5 ~~about the individual plan contracts available to that enrollee and~~
6 ~~advising that the enrollee may be unable to return to his or her~~
7 ~~current individual plan contract if the enrollee transfers to another~~
8 ~~individual plan contract.~~

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

11 ~~(1) A federally eligible defined individual, as defined in~~
12 ~~subdivision (c) of Section 1399.801, who is enrolled in an~~
13 ~~individual health benefit plan contract offered pursuant to Section~~
14 ~~1366.35.~~

15 ~~(2) An individual offered conversion coverage pursuant to~~
16 ~~Section 1373.6.~~

17 ~~(3) Individual coverage under a specialized health care service~~
18 ~~plan contract.~~

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

22 ~~(5) An individual enrolled in the Access for Infants and Mothers~~
23 ~~Program pursuant to Part 6.3 (commencing with Section 12695)~~
24 ~~of Division 2 of the Insurance Code.~~

25 ~~(6) An individual enrolled in the Healthy Families Program~~
26 ~~pursuant to Part 6.2 (commencing with Section 12693) of Division~~
27 ~~2 of the Insurance Code.~~

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

34 ~~(g) This section shall remain in effect only until January 1, 2014,~~
35 ~~or the 91st calendar day following the adjournment of the 2013-14~~
36 ~~First Extraordinary Session, whichever date is later, and as of that~~
37 ~~date is repealed, unless a later enacted statute, that becomes~~
38 ~~operative on or before that date, deletes or extends the date on~~
39 ~~which it is repealed.~~

1 ~~SEC. 12. Section 1389.7 of the Health and Safety Code is~~
2 ~~amended to read:~~

3 ~~1389.7. (a) Every health care service plan that offers, issues,~~
4 ~~or renews individual plan contracts shall offer to any individual,~~
5 ~~who was covered under an individual plan contract that was~~
6 ~~rescinded, a new individual plan contract, without medical~~
7 ~~underwriting, that provides equal benefits. A health care service~~
8 ~~plan may also permit an individual, who was covered under an~~
9 ~~individual plan contract that was rescinded, to remain covered~~
10 ~~under that individual plan contract, with a revised premium rate~~
11 ~~that reflects the number of persons remaining on the plan contract.~~

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

18 ~~(c) If a new individual plan contract is issued, the plan may~~
19 ~~revise the premium rate to reflect only the number of persons~~
20 ~~covered on the new individual plan contract.~~

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

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

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

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

~~(h) This section shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013-14 First Extraordinary Session, whichever date is later.~~

~~SEC. 13. Section 1389.7 is added to the Health and Safety Code, to read:~~

~~1389.7. (a) Every health care service plan that offers, issues, or renews individual plan contracts shall offer to any individual, who was covered by the plan under an individual plan contract that was rescinded, a new individual plan contract that provides the most equivalent benefits.~~

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

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

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

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

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

~~(g) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013-14 First Extraordinary Session, whichever date is later.~~

~~SEC. 14. Section 1399.805 of the Health and Safety Code is amended to read:~~

~~1399.805. (a) (1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has~~

1 provided notice of the premium charge prior to the application
2 being filed. In no case shall the premium charged for any health
3 care service plan contract identified in subdivision (d) of Section
4 1366.35 exceed the following amounts:

5 (A) For health care service plan contracts that offer services
6 through a preferred provider arrangement, the average premium
7 paid by a subscriber of the Major Risk Medical Insurance Program
8 who is of the same age and resides in the same geographic area as
9 the federally eligible defined individual. However, for federally
10 qualified individuals who are between the ages of 60 and 64,
11 inclusive, the premium shall not exceed the average premium paid
12 by a subscriber of the Major Risk Medical Insurance Program who
13 is 59 years of age and resides in the same geographic area as the
14 federally eligible defined individual.

15 (B) For health care service plan contracts identified in
16 subdivision (d) of Section 1366.35 that do not offer services
17 through a preferred provider arrangement, 170 percent of the
18 standard premium charged to an individual who is of the same age
19 and resides in the same geographic area as the federally eligible
20 defined individual. However, for federally qualified individuals
21 who are between the ages of 60 and 64, inclusive, the premium
22 shall not exceed 170 percent of the standard premium charged to
23 an individual who is 59 years of age and resides in the same
24 geographic area as the federally eligible defined individual. The
25 individual shall have 30 days in which to exercise the right to buy
26 coverage at the quoted premium rates.

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

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

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

39 (b) When a federally eligible defined individual submits a
40 premium payment, based on the quoted premium charges, and that

1 payment is delivered or postmarked, whichever occurs earlier,
2 within the first 15 days of the month, coverage shall begin no later
3 than the first day of the following month. When that payment is
4 neither delivered or postmarked until after the 15th day of a month,
5 coverage shall become effective no later than the first day of the
6 second month following delivery or postmark of the payment.

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

17 (d) ~~This section shall remain in effect only until January 1, 2014,~~
18 ~~or the 91st calendar day following the adjournment of the 2013-14~~
19 ~~First Extraordinary Session, whichever date is later, and as of that~~
20 ~~date is repealed, unless a later enacted statute, that becomes~~
21 ~~operative on or before that date, deletes or extends the date on~~
22 ~~which it is repealed.~~

23 SEC. 15. Section 1399.805 is added to the Health and Safety
24 Code, to read:

25 1399.805. (a) ~~After the federally eligible defined individual~~
26 ~~submits a completed application form for a plan contract, the plan~~
27 ~~shall, within 30 days, notify the individual of the individual's actual~~
28 ~~premium charges for that plan contract, unless the plan has~~
29 ~~provided notice of the premium charge prior to the application~~
30 ~~being filed. In no case shall the premium charged for any health~~
31 ~~care service plan contract identified in subdivision (d) of Section~~
32 ~~1366.35 exceed the premium for the second lowest cost silver plan~~
33 ~~of the individual market in the rating area in which the individual~~
34 ~~resides which is offered through the California Health Benefit~~
35 ~~Exchange established under Title 22 (commencing with Section~~
36 ~~100500) of the Government Code, as described in Section~~
37 ~~36B(b)(3)(B) of Title 26 of the United States Code.~~

38 (b) ~~When a federally eligible defined individual submits a~~
39 ~~premium payment, based on the quoted premium charges, and that~~
40 ~~payment is delivered or postmarked, whichever occurs earlier,~~

1 within the first 15 days of the month, coverage shall begin no later
 2 than the first day of the following month. When that payment is
 3 neither delivered nor postmarked until after the 15th day of a
 4 month, coverage shall become effective no later than the first day
 5 of the second month following delivery or postmark of the
 6 payment.

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

17 (d) ~~This section shall become operative on January 1, 2014, or~~
 18 ~~the 91st calendar day following the adjournment of the 2013-14~~
 19 ~~First Extraordinary Session, whichever date is later.~~

20 SEC. 16. ~~Section 1399.811 of the Health and Safety Code is~~
 21 ~~amended to read:~~

22 1399.811. ~~Premiums for contracts offered, delivered, amended,~~
 23 ~~or renewed by plans on or after January 1, 2001, shall be subject~~
 24 ~~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 care service plan contracts identified in~~
 28 ~~subdivision (d) of Section 1366.35 that offer services through a~~
 29 ~~preferred provider arrangement, the average premium paid by a~~
 30 ~~subscriber of the Major Risk Medical Insurance Program who is~~
 31 ~~of the same age and resides in the same geographic area as the~~
 32 ~~federally eligible defined individual. However, for federally~~
 33 ~~qualified individuals who are between the ages of 60 to 64 years,~~
 34 ~~inclusive, the premium shall not exceed the average premium paid~~
 35 ~~by a subscriber of the Major Risk Medical Insurance Program who~~
 36 ~~is 59 years of age and resides in the same geographic area as the~~
 37 ~~federally eligible defined individual.~~

38 (2) ~~For health care service plan contracts identified in~~
 39 ~~subdivision (d) of Section 1366.35 that do not offer services~~
 40 ~~through a preferred provider arrangement, 170 percent of the~~

1 standard premium charged to an individual who is of the same age
2 and resides in the same geographic area as the federally eligible
3 defined individual. However, for federally qualified individuals
4 who are between the ages of 60 to 64 years, inclusive, the premium
5 shall not exceed 170 percent of the standard premium charged to
6 an individual who is 59 years of age and resides in the same
7 geographic area as the 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 care service plan contracts identified in
11 subdivision (d) of Section 1366.35 that offer services through a
12 preferred provider arrangement, the average premium paid by a
13 subscriber of the Major Risk Medical Insurance Program who is
14 of the same age and resides in the same geographic area as the
15 federally eligible defined individual. However, for federally
16 qualified individuals who are between the ages of 60 and 64 years,
17 inclusive, the premium shall not exceed the average premium paid
18 by a subscriber of the Major Risk Medical Insurance Program who
19 is 59 years of age and resides in the same geographic area as the
20 federally eligible defined individual.

21 (2) For health care service plan contracts identified in
22 subdivision (d) of Section 1366.35 that do not offer services
23 through a preferred provider arrangement, 170 percent of the
24 standard premium charged to an individual who is of the same age
25 and resides in the same geographic area as the federally eligible
26 defined individual. However, for federally qualified individuals
27 who are between the ages of 60 and 64 years, inclusive, the
28 premium shall not exceed 170 percent of the standard premium
29 charged to an individual who is 59 years of age and resides in the
30 same geographic area as the federally eligible defined individual.

31 The premium effective on January 1, 2001, shall apply to in force
32 business at the earlier of 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 care service plan contracts identified in
36 subdivision (d) of Section 1366.35 that offer services through a
37 preferred provider arrangement, the average increase in the
38 premiums charged to a subscriber of the Major Risk Medical
39 Insurance Program who is of the same age and resides in the same
40 geographic area as the federally eligible defined individual.

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

8 ~~(3) For a contract that a plan 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 ~~or the 91st calendar day following the adjournment of the 2013–14~~
15 ~~First Extraordinary Session, whichever date is later, and as of that~~
16 ~~date is repealed, unless a later enacted statute, that becomes~~
17 ~~operative on or before that date, deletes or extends the date on~~
18 ~~which it is repealed.~~

19 ~~SEC. 17. Section 1399.811 is added to the Health and Safety~~
20 ~~Code, to read:~~

21 ~~1399.811. (a) Premiums for contracts offered, delivered,~~
22 ~~amended, or renewed by plans on or after the operative date of~~
23 ~~this section shall be subject to the following requirements:~~

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

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

37 ~~(b) This section shall become operative on January 1, 2014, or~~
38 ~~the 91st calendar day following the adjournment of the 2013–14~~
39 ~~First Extraordinary Session, whichever date is later.~~

1 ~~SEC. 18. Section 1399.816 of the Health and Safety Code is~~
2 ~~repealed.~~

3 ~~SEC. 19. The heading of Article 11.7 (commencing with~~
4 ~~Section 1399.825) of Chapter 2.2 of Division 2 of the Health and~~
5 ~~Safety Code is amended to read:~~

6
7 ~~Article 11.7. Child Access to Health Care Coverage~~
8

9 ~~SEC. 20. Section 1399.829 of the Health and Safety Code is~~
10 ~~amended to read:~~

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

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

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

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

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

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

1 ~~(e) For any individual health care service plan contract issued,~~
2 ~~sold, or renewed prior to December 31, 2013, the health plan shall~~
3 ~~provide to a child or responsible party for a child a notice that~~
4 ~~states the following:~~

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

11
12 ~~(d) A child who applied for coverage between September 23,~~
13 ~~2010, and the end of the initial open enrollment period shall be~~
14 ~~deemed to have maintained coverage during that period.~~

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

18 ~~(f) Health care service plans shall not require documentation~~
19 ~~from applicants relating to their coverage history.~~

20 ~~(g) (1) On and after the operative date of the act adding this~~
21 ~~subdivision, and until January 1, 2014, a health care service plan~~
22 ~~shall provide a notice to all applicants for coverage under this~~
23 ~~article and to all enrollees, or the responsible party for an enrollee,~~
24 ~~renewing coverage under this article that contains the following~~
25 ~~information:~~

26 ~~(A) Information about the open enrollment period provided~~
27 ~~under Section 1399.849.~~

28 ~~(B) An explanation that obtaining coverage during the open~~
29 ~~enrollment period described in Section 1399.849 will not affect~~
30 ~~the effective dates of coverage for coverage purchased pursuant~~
31 ~~to this article unless the applicant cancels that coverage.~~

32 ~~(C) An explanation that coverage purchased pursuant to this~~
33 ~~article shall be effective as required under subdivision (d) of~~
34 ~~Section 1399.826 and that such coverage shall not prevent an~~
35 ~~applicant from obtaining new coverage during the open enrollment~~
36 ~~period described in Section 1399.849.~~

37 ~~(D) Information about the Medi-Cal program and the Healthy~~
38 ~~Families Program and about subsidies available through the~~
39 ~~California Health Benefit Exchange.~~

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 ~~health care service plans in order to comply with this subdivision,~~
5 ~~and shall consult with the Department of Insurance in adopting~~
6 ~~that model notice. Use of the model notice shall not require prior~~
7 ~~approval of the department. Any model notice designated by the~~
8 ~~department for purposes of this section shall not be subject to the~~
9 ~~Administrative Procedure Act (Chapter 3.5 (commencing with~~
10 ~~Section 11340) of Part 1 of Division 3 of Title 2 of the Government~~
11 ~~Code).~~

12 ~~SEC. 21. Section 1399.836 is added to the Health and Safety~~
13 ~~Code, to read:~~

14 ~~1399.836. This article shall become inoperative on January 1,~~
15 ~~2014, or the 91st calendar day following the adjournment of the~~
16 ~~2013–14 First Extraordinary Session, whichever date is later.~~

17 ~~SEC. 22. Article 11.8 (commencing with Section 1399.845)~~
18 ~~is added to Chapter 2.2 of Division 2 of the Health and Safety~~
19 ~~Code, to read:~~

20
21 ~~Article 11.8. Individual Access to Health Care Coverage~~
22

23 ~~1399.845. For purposes of this article, the following definitions~~
24 ~~shall apply:~~

25 ~~(a) “Child” means a child described in Section 22775 of the~~
26 ~~Government Code and subdivisions (n) to (p), inclusive, of Section~~
27 ~~599.500 of Title 2 of the California Code of Regulations.~~

28 ~~(b) “Dependent” means the spouse or registered domestic~~
29 ~~partner, or child, of an individual, subject to applicable terms of~~
30 ~~the health benefit plan.~~

31 ~~(c) “Exchange” means the California Health Benefit Exchange~~
32 ~~created by Section 100500 of the Government Code.~~

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

35 ~~(e) “Health benefit plan” means any individual or group health~~
36 ~~care service plan contract that provides medical, hospital, and~~
37 ~~surgical benefits. The term does not include a specialized health~~
38 ~~care service plan contract, a health care service plan conversion~~
39 ~~contract offered pursuant to Section 1373.6, a health care service~~
40 ~~plan contract provided in the Medi-Cal program (Chapter 7~~

1 (commencing with Section 14000) of Part 3 of Division 9 of the
 2 Welfare and Institutions Code), the Healthy Families Program
 3 (Part 6.2 (commencing with Section 12693) of Division 2 of the
 4 Insurance Code), the Access for Infants and Mothers Program
 5 (Part 6.3 (commencing with Section 12695) of Division 2 of the
 6 Insurance Code), or the program under Part 6.4 (commencing with
 7 Section 12699.50) of Division 2 of the Insurance Code, a health
 8 care service plan contract offered to a federally eligible defined
 9 individual under Article 4.6 (commencing with Section 1366.35);
 10 or Medicare supplement coverage, to the extent consistent with
 11 PPACA.

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

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

19 (h) “Preexisting condition provision” means a contract provision
 20 that excludes coverage for charges or expenses incurred during a
 21 specified period following the enrollee’s effective date of coverage,
 22 as to a condition for which medical advice, diagnosis, care, or
 23 treatment was recommended or received during a specified period
 24 immediately preceding the effective date of coverage.

25 (i) “Rating period” means the period for which premium rates
 26 established by a plan are in effect.

27 (j) “Registered domestic partner” means a person who has
 28 established a domestic partnership as described in Section 297 of
 29 the Family Code.

30 1399.847. Every health care service plan offering individual
 31 health benefit plans shall, in addition to complying with the
 32 provisions of this chapter and rules adopted thereunder, comply
 33 with the provisions of this article.

34 1399.849. (a) (1) On and after October 1, 2013, a plan shall
 35 fairly and affirmatively offer, market, and sell all of the plan’s
 36 health benefit plans that are sold in the individual market for policy
 37 years on or after January 1, 2014, to all individuals and dependents
 38 in each service area in which the plan provides or arranges for the
 39 provision of health care services. A plan shall limit enrollment in

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

3 (2) A plan shall allow the subscriber of an individual health
4 benefit plan to add a dependent to the subscriber's plan at the
5 option of the subscriber, consistent with the open enrollment,
6 annual enrollment, and special enrollment period requirements in
7 this section.

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

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

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

20 (d) (1) Subject to paragraph (2), commencing January 1, 2014,
21 a plan shall allow an individual to enroll in or change individual
22 health benefit plans as a result of the following triggering events:

23 (A) He or she or his or her dependent loses minimum essential
24 coverage. For purposes of this paragraph, the following definitions
25 shall apply:

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

29 (ii) "Loss of minimum essential coverage" includes, but is not
30 limited to, loss of that coverage due to the circumstances described
31 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
32 Code of Federal Regulations and the circumstances described in
33 Section 1163 of Title 29 of the United States Code. "Loss of
34 minimum essential coverage" also includes loss of that coverage
35 for a reason that is not due to the fault of the individual.

36 (iii) "Loss of minimum essential coverage" does not include
37 loss of that coverage due to the individual's failure to pay
38 premiums on a timely basis or situations allowing for a rescission,
39 subject to clause (ii) and Sections 1389.7 and 1389.21.

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

1 ~~(C) He or she is mandated to be covered pursuant to a valid~~
2 ~~state or federal court order.~~

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

4 ~~(E) His or her health benefit plan substantially violated a~~
5 ~~material provision of the contract.~~

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

8 ~~(G) He or she was receiving services from a contracting provider~~
9 ~~under another health benefit plan, as defined in Section 1399.845~~
10 ~~or Section 10965 of the Insurance Code, for one of the conditions~~
11 ~~described in subdivision (e) of Section 1373.96 and that provider~~
12 ~~is no longer participating in the health benefit plan.~~

13 ~~(H) He or she demonstrates to the Exchange, with respect to~~
14 ~~health benefit plans offered through the Exchange, or to the~~
15 ~~department, with respect to health benefit plans offered outside~~
16 ~~the Exchange, that he or she did not enroll in a health benefit plan~~
17 ~~during the immediately preceding enrollment period available to~~
18 ~~the individual because he or she was misinformed that he or she~~
19 ~~was covered under minimum essential coverage.~~

20 ~~(I) With respect to individual health benefit plans offered~~
21 ~~through the Exchange, in addition to the triggering events listed~~
22 ~~in this paragraph, any other events listed in Section 155.420(d) of~~
23 ~~Title 45 of the Code of Federal Regulations.~~

24 ~~(2) With respect to individual health benefit plans offered~~
25 ~~outside the Exchange, an individual shall have 63 days from the~~
26 ~~date of a triggering event identified in paragraph (1) to apply for~~
27 ~~coverage from a health care service plan subject to this section.~~
28 ~~With respect to individual health benefit plans offered through the~~
29 ~~Exchange, an individual shall have 63 days from the date of a~~
30 ~~triggering event identified in paragraph (1) to select a plan offered~~
31 ~~through the Exchange, unless a longer period is provided in Part~~
32 ~~155 (commencing with Section 155.10) of Subchapter B of Subtitle~~
33 ~~A of Title 45 of the Code of Federal Regulations.~~

34 ~~(e) With respect to individual health benefit plans offered~~
35 ~~through the Exchange, the following provisions shall apply:~~

36 ~~(1) The effective date of coverage selected pursuant to this~~
37 ~~section shall be consistent with the dates specified in Section~~
38 ~~155.410 or 155.420 of Title 45 of the Code of Federal Regulations.~~

39 ~~(2) Notwithstanding paragraph (1), in the case where an~~
40 ~~individual acquires or becomes a dependent by entering into a~~

1 registered domestic partnership pursuant to Section 297 of the
2 Family Code and applies for coverage of that domestic partner
3 consistent with subdivision (d), the coverage effective date shall
4 be the first day of the month following the date he or she selects
5 a plan through the Exchange, unless an earlier date is agreed to
6 under Section 155.420(b)(3) of Title 45 of the Code of Federal
7 Regulations.

8 (f) With respect to individual health benefit plans offered outside
9 the Exchange, the following provisions shall apply:

10 (1) After an individual submits a completed application form
11 for a plan contract, the health care service plan shall, within 30
12 days, notify the individual of the individual's actual premium
13 charges for that plan established in accordance with Section
14 1399.855. The individual shall have 30 days in which to exercise
15 the right to buy coverage at the quoted premium charges.

16 (2) With respect to an individual health benefit plan for which
17 an individual applies during the initial open enrollment period
18 described in subdivision (e), when the subscriber submits a
19 premium payment, based on the quoted premium charges, and that
20 payment is delivered or postmarked, whichever occurs earlier, by
21 December 15, 2013, coverage under the individual health benefit
22 plan shall become effective no later than January 1, 2014. When
23 that payment is delivered or postmarked within the first 15 days
24 of any subsequent month, coverage shall become effective no later
25 than the first day of the following month. When that payment is
26 delivered or postmarked between December 16, 2013, and
27 December 31, 2013, inclusive, or after the 15th day of any
28 subsequent month, coverage shall become effective no later than
29 the first day of the second month following delivery or postmark
30 of the payment.

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

1 and December 31, inclusive, or after the 15th day of any subsequent
2 month, coverage shall become effective no later than the first day
3 of the second month following delivery or postmark of the
4 payment.

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

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

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

20 (C) Notwithstanding subparagraph (A), in the case of marriage
21 or becoming a registered domestic partner or in the case where a
22 qualified individual loses minimum essential coverage, the
23 coverage effective date shall be the first day of the month following
24 the date the plan receives the request for special enrollment.

25 (g) (1) A health care service plan shall not establish rules for
26 eligibility, including continued eligibility, of any individual to
27 enroll under the terms of an individual health benefit plan based
28 on any of the following factors:

29 (A) Health status.

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

31 (C) Claims experience.

32 (D) Receipt of health care.

33 (E) Medical history.

34 (F) Genetic information.

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

37 (H) Disability.

38 (I) Any other health status-related factor as determined by any
39 federal regulations, rules, or guidance issued pursuant to Section
40 2705 of the federal Public Health Service Act.

1 ~~(2) Notwithstanding Section 1389.1, a health care service plan~~
2 ~~shall not require an individual applicant or his or her dependent~~
3 ~~to fill out a health assessment or medical questionnaire prior to~~
4 ~~enrollment under an individual health benefit plan. A health care~~
5 ~~service plan shall not acquire or request information that relates~~
6 ~~to a health status-related factor from the applicant or his or her~~
7 ~~dependent or any other source prior to enrollment of the individual.~~

8 ~~(h) (1) A health care service plan shall consider the claims~~
9 ~~experience of all enrollees in all individual health benefit plans~~
10 ~~offered in the state that are subject to subdivision (a), including~~
11 ~~those enrollees who do not enroll in the plans through the~~
12 ~~Exchange, to be members of a single risk pool.~~

13 ~~(2) Each policy year, a health care service plan shall establish~~
14 ~~an index rate for the individual market in the state based on the~~
15 ~~total combined claims costs for providing essential health benefits,~~
16 ~~as defined pursuant to Section 1302 of PPACA, within the single~~
17 ~~risk pool required under paragraph (1). The index rate shall be~~
18 ~~adjusted on a market-wide basis based on the total expected~~
19 ~~market-wide payments and charges under the risk adjustment and~~
20 ~~reinsurance programs established for the state pursuant to Sections~~
21 ~~1343 and 1341 of PPACA. The premium rate for all of the health~~
22 ~~care service plan's health benefit plans in the individual market~~
23 ~~shall use the applicable index rate, as adjusted for total expected~~
24 ~~market-wide payments and charges under the risk adjustment and~~
25 ~~reinsurance programs established for the state pursuant to Sections~~
26 ~~1343 and 1341 of PPACA, subject only to the adjustments~~
27 ~~permitted under paragraph (3).~~

28 ~~(3) A health care service plan may vary premiums rates for a~~
29 ~~particular health benefit plan from its index rate based only on the~~
30 ~~following actuarially justified plan-specific factors:~~

31 ~~(A) The actuarial value and cost-sharing design of the health~~
32 ~~benefit plan.~~

33 ~~(B) The health benefit plan's provider network, delivery system~~
34 ~~characteristics, and utilization management practices.~~

35 ~~(C) The benefits provided under the health benefit plan that are~~
36 ~~in addition to the essential health benefits, as defined pursuant to~~
37 ~~Section 1302 of PPACA. These additional benefits shall be pooled~~
38 ~~with similar benefits within the single risk pool required under~~
39 ~~paragraph (1) and the claims experience from those benefits shall~~

1 be utilized to determine rate variations for plans that offer those
2 benefits in addition to essential health benefits:

3 ~~(D) With respect to catastrophic plans, as described in subsection~~
4 ~~(e) of Section 1302 of PPACA, the expected impact of the specific~~
5 ~~eligibility categories for those plans.~~

6 ~~(i) This section shall only apply with respect to individual health~~
7 ~~benefit plans for policy years on or after January 1, 2014.~~

8 ~~(j) This section shall not apply to an individual health benefit~~
9 ~~plan that is a grandfathered health plan.~~

10 ~~1399.851. (a) No health care service plan or solicitor shall,~~
11 ~~directly or indirectly, engage in the following activities:~~

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

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

22 ~~(3) Employ marketing practices or benefit designs that will have~~
23 ~~the effect of discouraging the enrollment of individuals with~~
24 ~~significant health needs.~~

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

36 ~~(e) This section shall only apply with respect to individual health~~
37 ~~benefit plans for policy years on or after January 1, 2014.~~

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 for policy years on or after January 1, 2014, a health care service
9 plan may use only the following characteristics of an individual,
10 and any dependent thereof, for purposes of establishing the rate
11 of the individual health benefit plan covering the individual and
12 the eligible dependents thereof, along with the health benefit plan
13 selected by the individual:

14 (1) Age, pursuant to the age bands established by the United
15 States Secretary of Health and Human Services and the age rating
16 curve established by the federal Centers for Medicare and Medicaid
17 Services pursuant to Section 2701(a)(3) of the federal Public Health
18 Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall
19 be determined using the individual's age as of the date of the plan
20 issuance or renewal, as applicable, and shall not vary by more than
21 three to one for like individuals of different age who are age 21 or
22 older as described in federal regulations adopted pursuant to
23 Section 2701(a)(3) of the federal Public Health Service Act (42
24 U.S.C. Sec. 300gg(a)(3)).

25 (2) (A) Geographic region. Except as provided in subparagraph
26 (B), the geographic regions for purposes of rating shall be the
27 following:

28 (i) Region 1 shall consist of the Counties of Alpine, Amador,
29 Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt,
30 Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,
31 Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou,
32 Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

33 (ii) Region 2 shall consist of the Counties of Fresno, Imperial,
34 Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin,
35 San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

36 (iii) Region 3 shall consist of the Counties of Alameda, Contra
37 Costa, Marin, San Francisco, San Mateo, and Santa Clara.

38 (iv) Region 4 shall consist of the Counties of Orange, Santa
39 Barbara, and Ventura.

40 (v) Region 5 shall consist of the County of Los Angeles.

1 ~~(vi) Region 6 shall consist of the Counties of Riverside, San~~
2 ~~Bernardino, and San Diego.~~
3 ~~(B) For the 2015 plan year and plan years thereafter, the~~
4 ~~geographic regions for purposes of rating shall be the following,~~
5 ~~subject to federal approval if required pursuant to Section 2701 of~~
6 ~~the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and~~
7 ~~obtained by the department and the Department of Insurance by~~
8 ~~July 1, 2014:~~
9 ~~(i) Region 1 shall consist of the Counties of Alpine, Amador,~~
10 ~~Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,~~
11 ~~Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,~~
12 ~~Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.~~
13 ~~(ii) Region 2 shall consist of the Counties of Marin, Napa,~~
14 ~~Solano, and Sonoma.~~
15 ~~(iii) Region 3 shall consist of the Counties of El Dorado, Placer,~~
16 ~~Sacramento, and Yolo.~~
17 ~~(iv) Region 4 shall consist of the Counties of Alameda, Contra~~
18 ~~Costa, San Francisco, San Mateo, and Santa Clara.~~
19 ~~(v) Region 5 shall consist of the Counties of Monterey, San~~
20 ~~Benito, and Santa Cruz.~~
21 ~~(vi) Region 6 shall consist of the Counties of Fresno, Kings,~~
22 ~~Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.~~
23 ~~(vii) Region 7 shall consist of the Counties of San Luis Obispo,~~
24 ~~Santa Barbara, and Ventura.~~
25 ~~(viii) Region 8 shall consist of the Counties of Imperial, Inyo,~~
26 ~~Kern, and Mono.~~
27 ~~(ix) Region 9 shall consist of the ZIP Codes in Los Angeles~~
28 ~~County starting with 906 to 912, inclusive, 915, 917, 918, and 935.~~
29 ~~(x) Region 10 shall consist of the ZIP Codes in Los Angeles~~
30 ~~County other than those identified in clause (ix).~~
31 ~~(xi) Region 11 shall consist of the Counties of Riverside and~~
32 ~~San Bernardino.~~
33 ~~(xii) Region 12 shall consist of the County of Orange.~~
34 ~~(xiii) Region 13 shall consist of the County of San Diego.~~
35 ~~(C) No later than June 1, 2017, the department, in collaboration~~
36 ~~with the Exchange and the Department of Insurance, shall review~~
37 ~~the geographic rating regions specified in this paragraph and the~~
38 ~~impacts of those regions on the health care coverage market in~~
39 ~~California, and make a report to the appropriate policy committees~~
40 ~~of the Legislature.~~

1 ~~(3) Whether the plan covers an individual or family, as described~~
2 ~~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) With respect to family coverage under an individual health~~
6 ~~benefit plan, the rating variation permitted under paragraph (1) of~~
7 ~~subdivision (a) shall be applied based on the portion of the~~
8 ~~premium attributable to each family member covered under the~~
9 ~~plan. The total premium for family coverage shall be determined~~
10 ~~by summing the premiums for each individual family member. In~~
11 ~~determining the total premium for family members, premiums for~~
12 ~~no more than the three oldest family members who are under age~~
13 ~~21 shall be taken into account.~~

14 ~~(d) The rating period for rates subject to this section shall be~~
15 ~~from January 1 to December 31, inclusive.~~

16 ~~(e) This section shall not apply to an individual health benefit~~
17 ~~plan that is a grandfathered health plan.~~

18 ~~(f) The requirement for submitting a report imposed under~~
19 ~~subparagraph (B) of paragraph (2) of subdivision (a) is inoperative~~
20 ~~on June 1, 2021, pursuant to Section 10231.5 of the Government~~
21 ~~Code.~~

22 ~~1399.857. (a) A health care service plan shall not be required~~
23 ~~to offer an individual health benefit plan or accept applications for~~
24 ~~the plan pursuant to Section 1399.849 in the case of any of the~~
25 ~~following:~~

26 ~~(1) To an individual who does not live or reside within the plan's~~
27 ~~approved service areas.~~

28 ~~(2) (A) Within a specific service area or portion of a service~~
29 ~~area, if the plan reasonably anticipates and demonstrates to the~~
30 ~~satisfaction of the director both of the following:~~

31 ~~(i) It will not have sufficient health care delivery resources to~~
32 ~~ensure that health care services will be available and accessible to~~
33 ~~the individual because of its obligations to existing enrollees.~~

34 ~~(ii) It is applying this subparagraph uniformly to all individuals~~
35 ~~without regard to the claims experience of those individuals or any~~
36 ~~health status-related factor relating to those individuals.~~

37 ~~(B) A health care service plan that cannot offer an individual~~
38 ~~health benefit plan to individuals because it is lacking in sufficient~~
39 ~~health care delivery resources within a service area or a portion of~~
40 ~~a service area pursuant to subparagraph (A) shall not offer a health~~

1 benefit plan in that area to individuals until the later of the
2 following dates:

3 (i) The 181st day after the date coverage is denied pursuant to
4 this paragraph.

5 (ii) The date the plan notifies the director that it has the ability
6 to deliver services to individuals, and certifies to the director that
7 from the date of the notice it will enroll all individuals requesting
8 coverage in that area from the plan.

9 (C) Subparagraph (B) shall not limit the plan's ability to renew
10 coverage already in force or relieve the plan of the responsibility
11 to renew that coverage as described in Section 1365.

12 (D) Coverage offered within a service area after the period
13 specified in subparagraph (B) shall be subject to this section.

14 (b) (1) A health care service plan may decline to offer an
15 individual health benefit plan to an individual if the plan
16 demonstrates to the satisfaction of the director both of the
17 following:

18 (A) It does not have the financial reserves necessary to
19 underwrite additional coverage. In determining whether this
20 subparagraph has been satisfied, the director shall consider, but
21 not be limited to, the plan's compliance with the requirements of
22 Section 1367, Article 6 (commencing with Section 1375), and the
23 rules adopted thereunder.

24 (B) It is applying this subdivision uniformly to all individuals
25 without regard to the claims experience of those individuals any
26 health status-related factor relating to those individuals.

27 (2) A plan that denies coverage to an individual under paragraph
28 (1) shall not offer coverage in the individual market before the
29 later of the following dates:

30 (A) The 181st day after the date that coverage is denied pursuant
31 to paragraph (1).

32 (B) The date the plan demonstrates to the satisfaction of the
33 director that the plan has sufficient financial reserves necessary to
34 underwrite additional coverage.

35 (3) Paragraph (2) shall not limit the plan's ability to renew
36 coverage already in force or relieve the plan of the responsibility
37 to renew that coverage as described in Section 1365.

38 (4) Coverage offered within a service area after the period
39 specified in paragraph (2) shall be subject to this section.

1 ~~(e) Nothing in this article shall be construed to limit the~~
2 ~~director's authority to develop and implement a plan of~~
3 ~~rehabilitation for a health care service plan whose financial viability~~
4 ~~or organizational and administrative capacity has become impaired~~
5 ~~to the extent permitted by PPACA.~~

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

8 ~~1399.859. (a) A health care service plan that receives an~~
9 ~~application for an individual health benefit plan outside the~~
10 ~~Exchange during the initial open enrollment period, an annual~~
11 ~~enrollment period, or a special enrollment period described in~~
12 ~~Section 1399.849 shall inform the applicant that he or she may be~~
13 ~~eligible for lower cost coverage through the Exchange and shall~~
14 ~~inform the applicant of the applicable enrollment period provided~~
15 ~~through the Exchange described in Section 1399.849.~~

16 ~~(b) On or before October 1, 2013, and annually thereafter, a~~
17 ~~health care service plan shall issue a notice to a subscriber enrolled~~
18 ~~in an individual health benefit plan offered outside the Exchange.~~
19 ~~The notice shall inform the subscriber that he or she may be eligible~~
20 ~~for lower cost coverage through the Exchange and shall inform~~
21 ~~the subscriber of the applicable open enrollment period provided~~
22 ~~through the Exchange described in Section 1399.849.~~

23 ~~(e) This section shall not apply where the individual health~~
24 ~~benefit plan described in subdivision (a) or (b) is a grandfathered~~
25 ~~health plan.~~

26 ~~1399.861. (a) On or before October 1, 2013, and annually~~
27 ~~thereafter, a health care service plan shall issue the following notice~~
28 ~~to all subscribers enrolled in an individual health benefit plan that~~
29 ~~is a grandfathered health plan:~~

30
31 ~~New improved health insurance options are available in~~
32 ~~California. You currently have health insurance that is exempt~~
33 ~~from many of the new requirements. For instance, your plan may~~
34 ~~not include certain consumer protections that apply to other plans,~~
35 ~~such as the requirement for the provision of preventive health~~
36 ~~services without any cost sharing and the prohibition against~~
37 ~~increasing your rates based on your health status. You have the~~
38 ~~option to remain in your current plan or switch to a new plan.~~
39 ~~Under the new rules, a health plan cannot deny your application~~
40 ~~based on any health conditions you may have. For more~~

1 information about your options, please contact the California
2 Health Benefit Exchange, the Office of Patient Advocate, your
3 plan representative, an insurance broker, or a health care navigator.
4

5 (b) Commencing October 1, 2013, a health care service plan
6 shall include the notice described in subdivision (a) in any renewal
7 material of the individual grandfathered health plan and in any
8 application for dependent coverage under the individual
9 grandfathered health plan.

10 (c) A health care service plan shall not advertise or market an
11 individual health benefit plan that is a grandfathered health plan
12 for purposes of enrolling a dependent of a subscriber into the plan
13 for policy years on or after January 1, 2014. Nothing in this
14 subdivision shall be construed to prohibit an individual enrolled
15 in an individual grandfathered health plan from adding a dependent
16 to that plan to the extent permitted by PPACA.

17 1399.862. Except as otherwise provided in this article, this
18 article shall only be implemented to the extent that it meets or
19 exceeds the requirements set forth in PPACA.

20 ~~SEC. 23:~~

21 *SECTION 1.* Section 10113.95 of the Insurance Code is
22 amended to read:

23 10113.95. (a) A health insurer that issues, renews, or amends
24 individual health insurance policies shall be subject to this section.

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

33 (c) On or before June 1, 2006, and annually thereafter, every
34 insurer shall file with the commissioner a general description of
35 the criteria, policies, procedures, or guidelines that the insurer uses
36 for rating and underwriting decisions related to individual health
37 insurance policies, which means automatic declinable health
38 conditions, health conditions that may lead to a coverage decline,
39 height and weight standards, health history, health care utilization,
40 lifestyle, or behavior that might result in a decline for coverage or

1 severely limit the health insurance products for which individuals
2 applying for coverage would be eligible. An insurer may comply
3 with this section by submitting to the department underwriting
4 materials or resource guides provided to agents and brokers,
5 provided that those materials include the information required to
6 be submitted by this section.

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

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

27
28 (e) Nothing in this section shall authorize public disclosure of
29 company-specific rating and underwriting criteria and practices
30 submitted to the commissioner.

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

33 (g) (1) This section shall become inoperative on November 1,
34 2013, or the 91st calendar day following the adjournment of the
35 2013–14 First Extraordinary Session, whichever date is later.

36 (2) *If Section 5000A of the Internal Revenue Code, as added by*
37 *Section 1501 of PPACA, is repealed or amended to no longer apply*
38 *to the individual market, as defined in Section 2791 of the federal*
39 *Public Health Services Act (42 U.S.C. Sec. 300gg-4), this section*

1 *shall become operative 12 months after the date of that repeal or*
2 *amendment.*

3 ~~SEC. 24.~~

4 *SEC. 2.* Section 10113.95 is added to the Insurance Code, to
5 read:

6 10113.95. (a) A health insurer that renews individual
7 grandfathered health *benefit* plans shall be subject to this section.

8 (b) An insurer subject to this section shall have written policies,
9 procedures, or underwriting guidelines establishing the criteria
10 and process whereby the insurer makes its decision to provide or
11 to deny coverage to ~~individuals dependents~~ applying for an
12 individual grandfathered health *benefit* plan and sets the rate for
13 that coverage. These guidelines, policies, or procedures shall ensure
14 that the plan rating and underwriting criteria comply with Sections
15 10140 and 10291.5 and all other applicable ~~provisions.~~ *provisions*
16 *of state and federal law.*

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

32 (d) Nothing in this section shall authorize public disclosure of
33 company-specific rating and underwriting criteria and practices
34 submitted to the commissioner.

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

37 ~~(f)~~

38 (e) For purposes of this section, the following definitions shall
39 apply:

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

6 (2) “Grandfathered health *benefit* plan” has the same meaning
7 as that term is defined in Section 1251 of PPACA.

8 ~~(g)~~

9 *(f) (1)* This section shall become operative on November 1,
10 2013, or the 91st calendar day following the adjournment of the
11 2013–14 First Extraordinary Session, whichever date is later.

12 *(2)* *If Section 5000A of the Internal Revenue Code, as added by*
13 *Section 1501 of PPACA, is repealed or amended to no longer apply*
14 *to the individual market, as defined in Section 2791 of the federal*
15 *Public Health Services Act (42 U.S.C. Sec. 300gg-4), this section*
16 *shall become inoperative 12 months after the date of that repeal*
17 *or amendment.*

18 ~~SEC. 25.~~

19 SEC. 3. Section 10119.1 of the Insurance Code is amended to
20 read:

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

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

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

37 (c) The insurer shall establish, for the purposes of subdivision
38 (b), a ranking of the individual health benefit plans it offers to
39 individual purchasers and post the ranking on its Internet Web site
40 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) (1) This section shall ~~remain in effect only until~~ *become*
35 *inoperative on* January 1, 2014, or the 91st calendar day following
36 the adjournment of the 2013–14 First Extraordinary Session,
37 whichever date is later, ~~and as of that date is repealed, unless a~~
38 ~~later enacted statute, that becomes operative on or before that date,~~
39 ~~deletes or extends the date on which it is repealed.~~ *later.*

1 (2) *If Section 5000A of the Internal Revenue Code, as added by*
2 *Section 1501 of PPACA, is repealed or amended to no longer apply*
3 *to the individual market, as defined in Section 2791 of the federal*
4 *Public Health Services Act (42 U.S.C. Sec. 300gg-4), this section*
5 *shall become operative 12 months after the date of that repeal or*
6 *amendment.*

7 ~~SEC. 26.~~

8 SEC. 4. Section 10119.2 of the Insurance Code is amended to
9 read:

10 10119.2. (a) Every health insurer that offers, issues, or renews
11 health insurance under an individual health benefit plan, as defined
12 in subdivision (a) of Section 10198.6, shall offer to any individual,
13 who was covered under an individual health benefit plan that was
14 rescinded, a new individual health benefit plan without medical
15 underwriting that provides equal benefits. A health insurer may
16 also permit an individual, who was covered under an individual
17 health benefit plan that was rescinded, to remain covered under
18 that individual health benefit plan, with a revised premium rate
19 that reflects the number of persons remaining on the health benefit
20 plan.

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

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

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

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

6 (f) The insurer shall provide 60 days for insureds to accept the
7 offered new individual health benefit plan and this plan shall be
8 effective as of the effective date of the original individual health
9 benefit plan and 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) (1) This section shall become inoperative on January 1,
14 2014, or the 91st calendar day following the adjournment of the
15 2013–14 First Extraordinary Session, whichever date is later.

16 (2) *If Section 5000A of the Internal Revenue Code, as added by*
17 *Section 1501 of PPACA, is repealed or amended to no longer apply*
18 *to the individual market, as defined in Section 2791 of the federal*
19 *Public Health Services Act (42 U.S.C. Sec. 300gg-4), this section*
20 *shall become operative 12 months after the date of that repeal or*
21 *amendment.*

22 ~~SEC. 27.~~

23 SEC. 5. Section 10119.2 is added to the Insurance Code, to
24 read:

25 10119.2. (a) Every health insurer that offers, issues, or renews
26 health insurance under an individual health benefit plan, as defined
27 in subdivision (a) of Section 10198.6, through the California Health
28 Benefit Exchange shall offer to any individual, who was covered
29 by the insurer under an individual health benefit plan that was
30 rescinded, a new individual health benefit plan through the
31 Exchange that provides the most equivalent benefits.

32 (b) A health insurer that offers, issues, or renews individual
33 health benefit plans inside or outside the California Health Benefit
34 Exchange may also permit an individual, who was covered by the
35 insurer under an individual health benefit plan that was rescinded,
36 to remain covered under that individual health benefit plan, with
37 a revised premium rate that reflects the number of persons
38 remaining on the health benefit plan consistent with Section
39 10965.9.

1 (c) If a new individual health benefit plan is issued under
2 subdivision (a), the insurer may revise the premium rate to reflect
3 only the number of persons covered on the new individual health
4 benefit plan consistent with Section 10965.9.

5 (d) The insurer shall notify in writing all insureds of the right
6 to coverage under an individual health benefit plan pursuant to
7 this section, at a minimum, when the insurer rescinds the individual
8 health benefit plan. The notice shall adequately inform insureds
9 of the right to coverage provided under this section.

10 (e) The insurer shall provide 60 days for insureds to accept the
11 offered new individual health benefit plan under subdivision (a),
12 and this plan shall be effective as of the effective date of the
13 original health benefit plan and there shall be no lapse in coverage.

14 (f) This section shall not apply to any individual whose
15 information in the application for coverage and related
16 communications led to the rescission.

17 (g) This section shall apply notwithstanding subdivision (a) or
18 (d) of Section 10965.3.

19 (h) (1) This section shall become operative on January 1, 2014,
20 or the 91st calendar day following the adjournment of the 2013–14
21 First Extraordinary Session, whichever date is later.

22 (2) *If Section 5000A of the Internal Revenue Code, as added by*
23 *Section 1501 of PPACA, is repealed or amended to no longer apply*
24 *to the individual market, as defined in Section 2791 of the federal*
25 *Public Health Services Act (42 U.S.C. Sec. 300gg-4), this section*
26 *shall become inoperative 12 months after the date of that repeal*
27 *or amendment.*

28 ~~SEC. 28.~~

29 SEC. 6. Section 10127.21 is added to the Insurance Code, to
30 read:

31 10127.21. Any data submitted by a health insurer to the United
32 States Secretary of Health and Human Services, or his or her
33 designee, for purposes of the risk adjustment program described
34 in Section 1343 of the federal Patient Protection and Affordable
35 Care Act (42 U.S.C. Sec. 18063) shall be concurrently submitted
36 to the ~~department.~~ *department and in the same format. The*
37 *department shall use the information to monitor federal*
38 *implementation of risk adjustment in the state and to ensure that*
39 *insurers are in compliance with federal requirements related to*
40 *risk adjustment.*

1 ~~SEC. 29.~~

2 *SEC. 7.* Section 10198.7 of the Insurance Code is amended to
3 read:

4 10198.7. (a) A health benefit plan for group coverage shall
5 not impose any preexisting condition provision or waived
6 condition provision upon any individual.

7 (b) A nongrandfathered health benefit plan for individual
8 coverage shall not impose any preexisting condition provision or
9 waived condition provision upon any individual. A grandfathered
10 health benefit plan for individual coverage shall not exclude
11 coverage on the basis of a waived condition provision or
12 preexisting condition provision for a period greater than 12 months
13 following the individual's effective date of coverage, nor limit or
14 exclude coverage for a specific insured by type of illness, treatment,
15 medical condition, or accident, except for satisfaction of a
16 preexisting condition provision or waived condition provision
17 pursuant to this article. Waivered condition provisions or
18 preexisting condition provisions contained in health benefit plans
19 may relate only to conditions for which medical advice, diagnosis,
20 care, or treatment, including use of prescription drugs, was
21 recommended or received from a licensed health practitioner during
22 the 12 months immediately preceding the effective date of
23 coverage.

24 (c) (1) A health benefit plan for group coverage may apply a
25 waiting period of up to 60 days as a condition of employment if
26 applied equally to all eligible employees and dependents and if
27 consistent with PPACA. A waiting period shall not be based on a
28 preexisting condition of an employee or dependent, the health
29 status of an employee or dependent, or any other factor listed in
30 Section 10198.9. During the waiting period, the health benefit plan
31 is not required to provide health care services and no premium
32 shall be charged to the policyholder or insureds.

33 (2) A health benefit plan for individual coverage shall not
34 impose a waiting period.

35 (d) In determining whether a preexisting condition provision,
36 a waived condition provision, or a waiting period applies to a
37 person, a health benefit plan shall credit the time the person was
38 covered under creditable coverage, provided that the person
39 becomes eligible for coverage under the succeeding health benefit
40 plan within 62 days of termination of prior coverage, exclusive of

1 any waiting period, and applies for coverage under the succeeding
2 plan within the applicable enrollment period. A plan shall also
3 credit any time that an eligible employee must wait before enrolling
4 in the plan, including any postenrollment or employer-imposed
5 waiting period. However, if a person's employment has ended, the
6 availability of health coverage offered through employment or
7 sponsored by an employer has terminated, or an employer's
8 contribution toward health coverage has terminated, a carrier shall
9 credit the time the person was covered under creditable coverage
10 if the person becomes eligible for health coverage offered through
11 employment or sponsored by an employer within 180 days,
12 exclusive of any waiting period, and applies for coverage under
13 the succeeding plan within the applicable enrollment period.

14 (e) An individual's period of creditable coverage shall be
15 certified pursuant to Section 2704(e) of Title XXVII of the federal
16 Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

17 *SEC. 8. Section 10603 of the Insurance Code is amended to*
18 *read:*

19 10603. (a) (1) On or before April 1, 1975, the commissioner
20 shall promulgate a standard supplemental disclosure form for all
21 disability insurance policies. Upon the appropriate disclosure form
22 as prescribed by the commissioner, each insurer shall provide, in
23 easily understood language and in a uniform, clearly organized
24 manner, as prescribed and required by the commissioner, ~~such~~ *the*
25 summary information about each disability insurance policy offered
26 by the insurer as the commissioner finds is necessary to provide
27 for full and fair disclosure of the provisions of the policy.

28 (2) *On and after January 1, 2014, a disability insurer offering*
29 *health insurance coverage subject to Section 2715 of the federal*
30 *Public Health Service Act (42 U.S.C. Sec. 300gg-15) shall satisfy*
31 *the requirements of this section and the implementing regulations*
32 *by providing the uniform summary of benefits and coverage*
33 *required under Section 2715 of the federal Public Health Service*
34 *Act and any rules or regulations issued thereunder. An insurer*
35 *that issues the federal uniform summary of benefits referenced in*
36 *this paragraph shall ensure that all applicable disclosures required*
37 *in this chapter and its implementing regulations are met in other*
38 *documents provided to policyholders and insureds. An insurer*
39 *subject to this paragraph shall provide the uniform summary of*

1 *benefits and coverage to the commissioner together with the*
2 *corresponding health insurance policy pursuant to Section 10290.*

3 (b) Nothing in this section shall preclude the disclosure form
4 from being included with the evidence of coverage or certificate
5 of coverage or policy.

6 ~~SEC. 30.~~

7 *SEC. 9.* Section 10753.05 of the Insurance Code is amended
8 to read:

9 10753.05. (a) No group or individual policy or contract or
10 certificate of group insurance or statement of group coverage
11 providing benefits to employees of small employers as defined in
12 this chapter shall be issued or delivered by a carrier subject to the
13 jurisdiction of the commissioner regardless of the situs of the
14 contract or master policyholder or of the domicile of the carrier
15 nor, except as otherwise provided in Sections 10270.91 and
16 10270.92, shall a carrier provide coverage subject to this chapter
17 until a copy of the form of the policy, contract, certificate, or
18 statement of coverage is filed with and approved by the
19 commissioner in accordance with Sections 10290 and 10291, and
20 the carrier has complied with the requirements of Section 10753.17.

21 (b) (1) On and after October 1, 2013, each carrier shall fairly
22 and affirmatively offer, market, and sell all of the carrier's health
23 benefit plans that are sold to, offered through, or sponsored by,
24 small employers or associations that include small employers for
25 plan years on or after January 1, 2014, to all small employers in
26 each geographic region in which the carrier makes coverage
27 available or provides benefits.

28 (2) A carrier that offers qualified health plans through the
29 Exchange shall be deemed to be in compliance with paragraph (1)
30 with respect to health benefit plans offered through the Exchange
31 in those geographic regions in which the carrier offers plans
32 through the Exchange.

33 (3) A carrier shall provide enrollment periods consistent with
34 PPACA and described in Section 155.725 of Title 45 of the Code
35 of Federal Regulations. Commencing January 1, 2014, a carrier
36 shall provide special enrollment periods consistent with the special
37 enrollment periods described in Section 10965.3, except for the
38 triggering events identified in paragraphs (d)(3) and (d)(6) of
39 Section 155.420 of Title 45 of the Code of Federal Regulations
40 with respect to health benefit plans offered through the Exchange.

1 (4) Nothing in this section shall be construed to require an
2 association, or a trust established and maintained by an association
3 to receive a master insurance policy issued by an admitted insurer
4 and to administer the benefits thereof solely for association
5 members, to offer, market or sell a benefit plan design to those
6 who are not members of the association. However, if the
7 association markets, offers or sells a benefit plan design to those
8 who are not members of the association it is subject to the
9 requirements of this section. This shall apply to an association that
10 otherwise meets the requirements of paragraph (8) formed by
11 merger of two or more associations after January 1, 1992, if the
12 predecessor organizations had been in active existence on January
13 1, 1992, and for at least five years prior to that date and met the
14 requirements of paragraph (5).

15 (5) A carrier which (A) effective January 1, 1992, and at least
16 20 years prior to that date, markets, offers, or sells benefit plan
17 designs only to all members of one association and (B) does not
18 market, offer or sell any other individual, selected group, or group
19 policy or contract providing medical, hospital and surgical benefits
20 shall not be required to market, offer, or sell to those who are not
21 members of the association. However, if the carrier markets, offers
22 or sells any benefit plan design or any other individual, selected
23 group, or group policy or contract providing medical, hospital and
24 surgical benefits to those who are not members of the association
25 it is subject to the requirements of this section.

26 (6) Each carrier that sells health benefit plans to members of
27 one association pursuant to paragraph (5) shall submit an annual
28 statement to the commissioner which states that the carrier is selling
29 health benefit plans pursuant to paragraph (5) and which, for the
30 one association, lists all the information required by paragraph (7).

31 (7) Each carrier that sells health benefit plans to members of
32 any association shall submit an annual statement to the
33 commissioner which lists each association to which the carrier
34 sells health benefit plans, the industry or profession which is served
35 by the association, the association's membership criteria, a list of
36 officers, the state in which the association is organized, and the
37 site of its principal office.

38 (8) For purposes of paragraphs (4) and (6), an association is a
39 nonprofit organization comprised of a group of individuals or
40 employers who associate based solely on participation in a

1 specified profession or industry, accepting for membership any
2 individual or small employer meeting its membership criteria,
3 which do not condition membership directly or indirectly on the
4 health or claims history of any person, which uses membership
5 dues solely for and in consideration of the membership and
6 membership benefits, except that the amount of the dues shall not
7 depend on whether the member applies for or purchases insurance
8 offered by the association, which is organized and maintained in
9 good faith for purposes unrelated to insurance, which has been in
10 active existence on January 1, 1992, and at least five years prior
11 to that date, which has a constitution and bylaws, or other
12 analogous governing documents which provide for election of the
13 governing board of the association by its members, which has
14 contracted with one or more carriers to offer one or more health
15 benefit plans to all individual members and small employer
16 members in this state. *Health coverage through an association*
17 *that is not related to employment shall be considered individual*
18 *coverage pursuant to Section 144.102(c) of Title 45 of the Code*
19 *of Federal Regulations.*

20 (c) On and after October 1, 2013, each carrier shall make
21 available to each small employer all health benefit plans that the
22 carrier offers or sells to small employers or to associations that
23 include small employers for plan years on or after January 1, 2014.
24 Notwithstanding subdivision (d) of Section 10753, for purposes
25 of this subdivision, companies that are affiliated companies or that
26 are eligible to file a consolidated income tax return shall be treated
27 as one carrier.

28 (d) Each carrier shall do all of the following:

29 (1) Prepare a brochure that summarizes all of its health benefit
30 plans and make this summary available to small employers, agents,
31 and brokers upon request. The summary shall include for each
32 plan information on benefits provided, a generic description of the
33 manner in which services are provided, such as how access to
34 providers is limited, benefit limitations, required copayments and
35 deductibles, an explanation of how creditable coverage is calculated
36 if a waiting period is imposed, and a telephone number that can
37 be called for more detailed benefit information. Carriers are
38 required to keep the information contained in the brochure accurate
39 and up to date, and, upon updating the brochure, send copies to
40 agents and brokers representing the carrier. Any entity that provides

1 administrative services only with regard to a health benefit plan
2 written or issued by another carrier shall not be required to prepare
3 a summary brochure which includes that benefit plan.

4 (2) For each health benefit plan, prepare a more detailed
5 evidence of coverage and make it available to small employers,
6 agents and brokers upon request. The evidence of coverage shall
7 contain all information that a prudent buyer would need to be aware
8 of in making selections of benefit plan designs. An entity that
9 provides administrative services only with regard to a health benefit
10 plan written or issued by another carrier shall not be required to
11 prepare an evidence of coverage for that health benefit plan.

12 (3) Provide copies of the current summary brochure to all agents
13 or brokers who represent the carrier and, upon updating the
14 brochure, send copies of the updated brochure to agents and brokers
15 representing the carrier for the purpose of selling health benefit
16 plans.

17 (4) Notwithstanding subdivision (c) of Section 10753, for
18 purposes of this subdivision, companies that are affiliated
19 companies or that are eligible to file a consolidated income tax
20 return shall be treated as one carrier.

21 (e) Every agent or broker representing one or more carriers for
22 the purpose of selling health benefit plans to small employers shall
23 do all of the following:

24 (1) When providing information on a health benefit plan to a
25 small employer but making no specific recommendations on
26 particular benefit plan designs:

27 (A) Advise the small employer of the carrier's obligation to sell
28 to any small employer any of the health benefit plans it offers to
29 small employers, consistent with PPACA, and provide them, upon
30 request, with the actual rates that would be charged to that
31 employer for a given health benefit plan.

32 (B) Notify the small employer that the agent or broker will
33 procure rate and benefit information for the small employer on
34 any health benefit plan offered by a carrier for whom the agent or
35 broker sells health benefit plans.

36 (C) Notify the small employer that, upon request, the agent or
37 broker will provide the small employer with the summary brochure
38 required in paragraph (1) of subdivision (d) for any benefit plan
39 design offered by a carrier whom the agent or broker represents.

1 (D) Notify the small employer of the availability of coverage
2 and the availability of tax credits for certain employers consistent
3 with PPACA and state law, including any rules, regulations, or
4 guidance issued in connection therewith.

5 (2) When recommending a particular benefit plan design or
6 designs, advise the small employer that, upon request, the agent
7 will provide the small employer with the brochure required by
8 paragraph (1) of subdivision (d) containing the benefit plan design
9 or designs being recommended by the agent or broker.

10 (3) Prior to filing an application for a small employer for a
11 particular health benefit plan:

12 (A) For each of the health benefit plans offered by the carrier
13 whose health benefit plan the agent or broker is presenting, provide
14 the small employer with the benefit summary required in paragraph
15 (1) of subdivision (d) and the premium for that particular employer.

16 (B) Notify the small employer that, upon request, the agent or
17 broker will provide the small employer with an evidence of
18 coverage brochure for each health benefit plan the carrier offers.

19 (C) Obtain a signed statement from the small employer
20 acknowledging that the small employer has received the disclosures
21 required by this paragraph and Section 10753.16.

22 (f) No carrier, agent, or broker shall induce or otherwise
23 encourage a small employer to separate or otherwise exclude an
24 eligible employee from a health benefit plan which, in the case of
25 an eligible employee meeting the definition in paragraph (1) of
26 subdivision (f) of Section 10753, is provided in connection with
27 the employee's employment or which, in the case of an eligible
28 employee as defined in paragraph (2) of subdivision (f) of Section
29 10753, is provided in connection with a guaranteed association.

30 (g) No carrier shall reject an application from a small employer
31 for a health benefit plan provided:

32 (1) The small employer as defined by subparagraph (A) of
33 paragraph (1) of subdivision (q) of Section 10753 offers health
34 benefits to 100 percent of its eligible employees as defined in
35 paragraph (1) of subdivision (f) of Section 10753. Employees who
36 waive coverage on the grounds that they have other group coverage
37 shall not be counted as eligible employees.

38 (2) The small employer agrees to make the required premium
39 payments.

1 (h) No carrier or agent or broker shall, directly or indirectly,
2 engage in the following activities:

3 (1) Encourage or direct small employers to refrain from filing
4 an application for coverage with a carrier because of the health
5 status, claims experience, industry, occupation, or geographic
6 location within the carrier's approved service area of the small
7 employer or the small employer's employees.

8 (2) Encourage or direct small employers to seek coverage from
9 another carrier because of the health status, claims experience,
10 industry, occupation, or geographic location within the carrier's
11 approved service area of the small employer or the small
12 employer's employees.

13 (3) Employ marketing practices or benefit designs that will have
14 the effect of discouraging the enrollment of individuals with
15 significant health needs *or discriminate based on the individual's*
16 *race, color, national origin, present or predicted disability, age,*
17 *sex, gender identity, sexual orientation, expected length of life,*
18 *degree of medical dependency, quality of life, or other health*
19 *conditions.*

20 *This subdivision shall be enforced in the same manner as Section*
21 *790.03, including through Sections 790.035 and 790.05.*

22 (i) No carrier shall, directly or indirectly, enter into any contract,
23 agreement, or arrangement with an agent or broker that provides
24 for or results in the compensation paid to an agent or broker for a
25 health benefit plan to be varied because of the health status, claims
26 experience, industry, occupation, or geographic location of the
27 small employer or the small employer's employees. This
28 subdivision shall not apply with respect to a compensation
29 arrangement that provides compensation to an agent or broker on
30 the basis of percentage of premium, provided that the percentage
31 shall not vary because of the health status, claims experience,
32 industry, occupation, or geographic area of the small employer.

33 (j) (1) A health benefit plan offered to a small employer, as
34 defined in Section 1304(b) of PPACA and in Section 10753, shall
35 not establish rules for eligibility, including continued eligibility,
36 of an individual, or dependent of an individual, to enroll under the
37 terms of the plan based on any of the following health status-related
38 factors:

39 (A) Health status.

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

- 1 (C) Claims experience.
- 2 (D) Receipt of health care.
- 3 (E) Medical history.
- 4 (F) Genetic information.
- 5 (G) Evidence of insurability, including conditions arising out
- 6 of acts of domestic violence.
- 7 (H) Disability.
- 8 (I) Any other health status-related factor as determined by any
- 9 federal regulations, rules, or guidance issued pursuant to Section
- 10 2705 of the federal Public Health Service Act.

11 (2) Notwithstanding Section 10291.5, a carrier shall not require
 12 an eligible employee or dependent to fill out a health assessment
 13 or medical questionnaire prior to enrollment under a health benefit
 14 plan. A carrier shall not acquire or request information that relates
 15 to a health status-related factor from the applicant or his or her
 16 dependent or any other source prior to enrollment of the individual.

17 ~~(k) (1) A carrier shall consider the claims experience of all~~
 18 ~~insureds in all nongrandfathered health benefit plans offered in~~
 19 ~~the state that are subject to subdivision (a), including those insureds~~
 20 ~~who do not enroll in the plans through the Exchange, to be~~
 21 ~~members of a single risk pool.~~

22 *(k) (1) A carrier shall consider as a single risk pool for rating*
 23 *purposes in the small employer market the claims experience of*
 24 *all insureds in all nongrandfathered small employer health benefit*
 25 *plans offered by the carrier in this state, whether offered as health*
 26 *care service plan contracts or health insurance policies, including*
 27 *those insureds and enrollees who enroll in coverage through the*
 28 *Exchange and insureds and enrollees covered by the carrier*
 29 *outside of the Exchange.*

30 (2) Each ~~plan~~ calendar year, a carrier shall establish an index
 31 rate for the small employer market in the state based on the total
 32 combined claims costs for providing essential health benefits, as
 33 defined pursuant to Section 1302 of PPACA and Section 10112.27,
 34 within the single risk pool required under paragraph (1). The index
 35 rate shall be adjusted on a marketwide basis based on the total
 36 expected marketwide payments and charges under the risk
 37 adjustment and reinsurance programs established for the state
 38 pursuant to Sections 1343 and 1341 of PPACA. The premium rate
 39 for all of the carrier’s nongrandfathered health benefit plans shall
 40 use the applicable index rate, as adjusted for total expected

1 marketwide payments and charges under the risk adjustment and
2 reinsurance programs established for the state pursuant to Sections
3 1343 and 1341 of PPACA, subject only to the adjustments
4 permitted under paragraph (3).

5 (3) A carrier may vary ~~premiums~~ *premium* rates for a particular
6 nongrandfathered health benefit plan from its index rate based
7 only on the following actuarially justified plan-specific factors:

8 (A) The actuarial value and cost-sharing design of the health
9 benefit plan.

10 (B) The health benefit plan’s provider network, delivery system
11 characteristics, and utilization management practices.

12 (C) The benefits provided under the health benefit plan that are
13 in addition to the essential health benefits, as defined pursuant to
14 Section 1302 of PPACA. These additional benefits shall be pooled
15 with similar benefits within the single risk pool required under
16 paragraph (1) and the claims experience from those benefits shall
17 be utilized to determine rate variations for health benefit plans that
18 offer those benefits in addition to essential health benefits.

19 (D) *Administrative costs, excluding any user fees required by*
20 *the Exchange.*

21 ~~(E)~~

22 (E) With respect to catastrophic plans, as described in subsection
23 (e) of Section 1302 of PPACA, the expected impact of the specific
24 eligibility categories for those plans.

25 (I) If a carrier enters into a contract, agreement, or other
26 arrangement with a third-party administrator or other entity to
27 provide administrative, marketing, or other services related to the
28 offering of health benefit plans to small employers in this state,
29 the third-party administrator shall be subject to this chapter.

30 (m) (1) Except as provided in paragraph (2), this section shall
31 become inoperative if Section 2702 of the federal Public Health
32 Service Act (42 U.S.C. Sec. ~~300gg-1~~; *300gg-4*), as added by
33 Section 1201 of PPACA, is repealed, in which case, *12 months*
34 *after the repeal*, carriers subject to this section shall instead be
35 governed by Section 10705 to the extent permitted by federal law,
36 and all references in this chapter to this section shall instead refer
37 to Section 10705, except for purposes of paragraph (2).

38 (2) Paragraph (3) of subdivision (b) of this section shall remain
39 operative as it relates to health benefit plans offered through the
40 Exchange.

1 ~~SEC. 31.~~

2 ~~SEC. 10.~~ Section 10753.06.5 of the Insurance Code is amended
3 to read:

4 10753.06.5. (a) With respect to health benefit plans offered
5 outside the Exchange, after a small employer submits a completed
6 application, the carrier shall, within 30 days, notify the employer
7 of the employer's actual rates in accordance with Section 10753.14.
8 The employer shall have 30 days in which to exercise the right to
9 buy coverage at the quoted rates.

10 (b) Except as required under subdivision (c), when a small
11 employer submits a premium payment, based on the quoted rates,
12 and that payment is delivered or postmarked, whichever occurs
13 earlier, within the first 15 days of a month, coverage shall become
14 effective no later than the first day of the following month. When
15 that payment is neither delivered nor postmarked until after the
16 15th day of a month, coverage shall become effective no later than
17 the first day of the second month following delivery or postmark
18 of the payment.

19 (c) (1) With respect to a *small employer* health benefit plan
20 offered through the Exchange, a carrier shall apply coverage
21 effective dates consistent with those required under Section
22 155.720 of Title 45 of the Code of Federal Regulations and
23 paragraph (2) of subdivision (e) of Section 10965.3.

24 (2) With respect to a *small employer* health benefit plan offered
25 outside the Exchange for which an individual applies during a
26 special enrollment period described in paragraph (3) of subdivision
27 (b) of Section 10753.05, the following provisions shall apply:

28 (A) Coverage under the plan shall become effective no later
29 than the first day of the first calendar month beginning after the
30 date the carrier receives the request for special enrollment.

31 (B) Notwithstanding subparagraph (A), in the case of a birth,
32 adoption, or placement for adoption, coverage under the plan shall
33 become effective on the date of birth, adoption, or placement for
34 adoption.

35 (d) During the first 30 days of coverage, the small employer
36 shall have the option of changing coverage to a different health
37 benefit plan offered by the same carrier. If a small employer
38 notifies the carrier of the change within the first 15 days of a month,
39 coverage under the new health benefit plan shall become effective
40 no later than the first day of the following month. If a small

1 employer notifies the carrier of the change after the 15th day of a
2 month, coverage under the new health benefit plan shall become
3 effective no later than the first day of the second month following
4 notification.

5 (e) All eligible employees and dependents listed on the small
6 employer's completed application shall be covered on the effective
7 date of the health benefit plan.

8 ~~SEC. 32.~~

9 *SEC. 11.* Section 10753.11 of the Insurance Code is amended
10 to read:

11 10753.11. (a) To the extent permitted by PPACA, no carrier
12 shall be required by the provisions of this chapter to do ~~any~~ *either*
13 of the following:

14 (1) To offer coverage to or accept applications from a small
15 employer where the small employer is seeking coverage for eligible
16 employees *and dependents* who do not live, work, or reside in a
17 carrier's ~~approved~~ service areas.

18 (2) (A) To offer coverage to, or accept applications from, a
19 small employer for a benefits plan design within an area if the
20 commissioner has found all of the following:

21 (i) The carrier will not have the capacity within the area in its
22 network of providers to deliver service adequately to the eligible
23 employees and dependents of that employee because of its
24 obligations to existing group contractholders and enrollees.

25 (ii) The carrier is applying this paragraph uniformly to all
26 employers without regard to the claims experience of those
27 employers, and their employees and dependents, or any health
28 status-related factor relating to those employees and dependents.

29 (iii) The action is not unreasonable or clearly inconsistent with
30 the intent of this chapter.

31 (B) A carrier that cannot offer coverage to small employers in
32 a specific service area because it is lacking sufficient capacity as
33 described in this paragraph may not offer coverage in the applicable
34 area to new employer groups ~~with more than 50 eligible employees~~
35 until the later of the following dates:

36 (i) The 181st day after the date that coverage is denied pursuant
37 to this paragraph.

38 (ii) The date the carrier notifies the commissioner that it has
39 regained capacity to deliver services to small employers, and
40 certifies to the commissioner that from the date of the notice it will

1 enroll all small groups requesting coverage from the carrier until
2 the carrier has met the requirements of subdivision (g) of Section
3 10753.05.

4 (C) Subparagraph (B) shall not limit the carrier's ability to renew
5 coverage already in force or relieve the carrier of the responsibility
6 to renew that coverage as described in Sections 10273.4 and
7 10753.13.

8 (D) Coverage offered within a service area after the period
9 specified in subparagraph (B) shall be subject to the requirements
10 of this section.

11 ~~SEC. 33.~~

12 *SEC. 12.* Section 10753.12 of the Insurance Code is amended
13 to read:

14 10753.12. (a) A carrier shall not be required to offer coverage
15 or accept applications for benefit plan designs pursuant to this
16 chapter where the carrier demonstrates to the satisfaction of the
17 commissioner both of the following:

18 (1) The acceptance of an application or applications would place
19 the carrier in a financially impaired condition.

20 (2) The carrier is applying this subdivision uniformly to all
21 employers without regard to the claims experience of those
22 employers and their employees and dependents or any health
23 status-related factor relating to those employees and dependents.

24 (b) The commissioner's determination under subdivision (a)
25 shall follow an evaluation that includes a certification by the
26 commissioner that the acceptance of an application or applications
27 would place the carrier in a financially impaired condition.

28 (c) A carrier that has not offered coverage or accepted
29 applications pursuant to this chapter shall not offer coverage or
30 accept applications for any individual or group health benefit plan
31 until the later of the following dates:

32 (1) The 181st day after the date that coverage is denied pursuant
33 to this section.

34 (2) The date on which the carrier ceases to be financially
35 impaired, as determined by the commissioner.

36 (d) Subdivision (c) shall not limit the carrier's ability to renew
37 coverage already in force or relieve the carrier of the responsibility
38 to renew that coverage as described in Sections 10273.4, 10273.6,
39 and 10753.13.

1 (e) Coverage offered within a service area after the period
2 specified in subdivision (c) shall be subject to the requirements of
3 this section.

4 ~~SEC. 34.~~

5 *SEC. 13.* Section 10753.14 of the Insurance Code is amended
6 to read:

7 10753.14. (a) The premium rate for a health benefit plan
8 issued, amended, or renewed on or after January 1, 2014, shall
9 vary with respect to the particular coverage involved only by the
10 following:

11 (1) Age, pursuant to the age bands established by the United
12 States Secretary of Health and Human Services and the age rating
13 curve established by the Centers for Medicare and Medicaid
14 Services pursuant to Section 2701(a)(3) of the federal Public Health
15 Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall
16 be determined using the individual's age as of the date of the plan
17 issuance or renewal, as applicable, and shall not vary by more than
18 three to one for like individuals of different age who are 21 years
19 of age or older as described in federal regulations adopted pursuant
20 to Section 2701(a)(3) of the federal Public Health Service Act (42
21 U.S.C. Sec. 300gg(a)(3)).

22 (2) (A) Geographic region. ~~Except as provided in subparagraph~~
23 ~~(B), the~~ *The* geographic regions for purposes of rating shall be the
24 following:

25 ~~(i) Region 1 shall consist of the Counties of Alpine, Amador,~~
26 ~~Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt,~~
27 ~~Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,~~
28 ~~Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou,~~
29 ~~Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.~~

30 ~~(ii) Region 2 shall consist of the Counties of Fresno, Imperial,~~
31 ~~Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin,~~
32 ~~San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.~~

33 ~~(iii) Region 3 shall consist of the Counties of Alameda, Contra~~
34 ~~Costa, Marin, San Francisco, San Mateo, and Santa Clara.~~

35 ~~(iv) Region 4 shall consist of the Counties of Orange, Santa~~
36 ~~Barbara, and Ventura.~~

37 ~~(v) Region 5 shall consist of the County of Los Angeles.~~

38 ~~(vi) Region 6 shall consist of the Counties of Riverside, San~~
39 ~~Bernardino, and San Diego.~~

1 ~~(B) For the 2015 plan year and plan years thereafter, the~~
 2 ~~geographic regions for purposes of rating shall be the following,~~
 3 ~~subject to federal approval if required pursuant to Section 2701 of~~
 4 ~~the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and~~
 5 ~~obtained by the department and the Department of Managed Health~~
 6 ~~Care by July 1, 2014:~~

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

11 ~~(ii) Region 2 shall consist of the Counties of Marin, Napa,~~
 12 ~~Solano, and Sonoma.~~

13 ~~(iii) Region 3 shall consist of the Counties of El Dorado, Placer,~~
 14 ~~Sacramento, and Yolo.~~

15 ~~(iv) Region 4 shall consist of the Counties of Alameda, Contra~~
 16 ~~Costa, San Francisco, San Mateo, and Santa Clara.~~

17 ~~(v) Region 5 shall consist of the Counties of Monterey, San~~
 18 ~~Benito, and Santa Cruz.~~

19 ~~(vi) Region 6 shall consist of the Counties of Fresno, Kings,~~
 20 ~~Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.~~

21 ~~(vii) Region 7 shall consist of the Counties of San Luis Obispo,~~
 22 ~~Santa Barbara, and Ventura.~~

23 ~~(viii) Region 8 shall consist of the Counties of Imperial, Inyo,~~
 24 ~~Kern, and Mono.~~

25 ~~(ix) Region 9 shall consist of the ZIP Codes in Los Angeles~~
 26 ~~County starting with 906 to 912, inclusive, 915, 917, 918, and 935.~~

27 ~~(x) Region 10 shall consist of the ZIP Codes in Los Angeles~~
 28 ~~County other than those identified in clause (ix).~~

29 ~~(xi) Region 11 shall consist of the Counties of San Bernardino~~
 30 ~~and Riverside.~~

31 ~~(xii) Region 12 shall consist of the County of Orange.~~

32 ~~(xiii) Region 13 shall consist of the County of San Diego.~~

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

37 *(ii) Region 2 shall consist of the Counties of Marin, Napa,*
 38 *Solano, and Sonoma.*

39 *(iii) Region 3 shall consist of the Counties of El Dorado, Placer,*
 40 *Sacramento, and Yolo.*

- 1 (iv) *Region 4 shall consist of the City and County of San*
- 2 *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 9 shall consist of the Counties of Monterey, San*
- 8 *Benito, and Santa Cruz.*
- 9 (x) *Region 10 shall consist of the Counties of Mariposa, Merced,*
- 10 *San Joaquin, Stanislaus, and Tulare.*
- 11 (xi) *Region 11 shall consist of the Counties of Fresno, Kings,*
- 12 *and Madera.*
- 13 (xii) *Region 12 shall consist of the Counties of San Luis Obispo,*
- 14 *Santa Barbara, and Ventura.*
- 15 (xiii) *Region 13 shall consist of the Counties of Imperial, Inyo,*
- 16 *and Mono.*
- 17 (xiv) *Region 14 shall consist of the County of Kern.*
- 18 (xv) *Region 15 shall consist of the ZIP Codes in the County of*
- 19 *Los Angeles starting with 906 to 912, inclusive, 915, 917, 918,*
- 20 *and 935.*
- 21 (xvi) *Region 16 shall consist of the ZIP Codes in the County of*
- 22 *Los Angeles other than those identified in clause (xv).*
- 23 (xvii) *Region 17 shall consist of the Counties of Riverside and*
- 24 *San Bernardino.*
- 25 (xviii) *Region 18 shall consist of the County of Orange.*
- 26 (xix) *Region 19 shall consist of the County of San Diego.*
- 27 ~~(C)~~
- 28 (B) (i) No later than June 1, 2017, the department, in
- 29 collaboration with the Exchange and the Department of Managed
- 30 Health Care, shall review the geographic rating regions specified
- 31 in this paragraph and the impacts of those regions on the health
- 32 care coverage market in California, and make a report to the
- 33 appropriate policy committees of the Legislature.
- 34 (ii) *The requirement for submitting a report imposed under this*
- 35 *subparagraph is inoperative June 1, 2021, pursuant to Section*
- 36 *10231.5 of the Government Code.*
- 37 (3) Whether the health benefit plan covers an individual or
- 38 family, as described in PPACA.
- 39 (b) The rate for a health benefit plan subject to this section shall
- 40 not vary by any factor not described in this section.

1 (c) The total premium charged to a small employer pursuant to
2 this section shall be determined by summing the premiums of
3 covered employees and dependents in accordance with Section
4 147.102(c)(1) of Title 45 of the Code of Federal Regulations.

5 (d) The rating period for rates subject to this section shall be no
6 less than 12 months from the date of issuance or renewal of the
7 health benefit plan.

8 (e) *This section shall become inoperative if Section 2701 of the*
9 *federal Public Health Services Act (42 U.S.C. Sec. 300gg), as*
10 *added by Section 1201 of PPACA, is repealed, in which case, 12*
11 *months after the repeal, rates for health benefit plans subject to*
12 *this section shall instead be subject to Section 10714, to the extent*
13 *permitted by federal law, and all references to this section shall*
14 *be deemed to be references to Section 10714.*

15 ~~SEC. 35. Section 10901.3 of the Insurance Code is amended~~
16 ~~to read:~~

17 ~~10901.3. (a) (1) After the federally eligible defined individual~~
18 ~~submits a completed application form for a health benefit plan,~~
19 ~~the carrier shall, within 30 days, notify the individual of the~~
20 ~~individual's actual premium charges for that health benefit plan~~
21 ~~design. In no case shall the premium charged for any health benefit~~
22 ~~plan identified in subdivision (d) of Section 10785 exceed the~~
23 ~~following amounts:~~

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

34 ~~(B) For health benefit plans identified in subdivision (d) of~~
35 ~~Section 10785 that do not offer services through a preferred~~
36 ~~provider arrangement, 170 percent of the standard premium charged~~
37 ~~to an individual who is of the same age and resides in the same~~
38 ~~geographic area as the federally eligible defined individual.~~
39 ~~However, for federally qualified individuals who are between the~~
40 ~~ages of 60 and 64, inclusive, the premium shall not exceed 170~~

1 percent of the standard premium charged to an individual who is
2 59 years of age and resides in the same geographic area as the
3 federally eligible defined individual. The individual shall have 30
4 days in which to exercise the right to buy coverage at the quoted
5 premium rates.

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

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

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

18 ~~(b) When a federally eligible defined individual submits a
19 premium payment, based on the quoted premium charges, and that
20 payment is delivered or postmarked, whichever occurs earlier,
21 within the first 15 days of the month, coverage shall begin no later
22 than the first day of the following month. When that payment is
23 neither delivered or postmarked until after the 15th day of a month,
24 coverage shall become effective no later than the first day of the
25 second month following delivery or postmark of the payment.~~

26 ~~(c) During the first 30 days after the effective date of the health
27 benefit plan, the individual shall have the option of changing
28 coverage to a different health benefit plan design offered by the
29 same carrier. If the individual notified the plan of the change within
30 the first 15 days of a month, coverage under the new health benefit
31 plan shall become effective no later than the first day of the
32 following month. If an enrolled individual notified the carrier of
33 the change after the 15th day of a month, coverage under the health
34 benefit plan shall become effective no later than the first day of
35 the second month following notification.~~

36 ~~(d) This section shall remain in effect only until January 1, 2014,
37 or the 91st calendar day following the adjournment of the 2013-14
38 First Extraordinary Session, whichever date is later, and as of that
39 date is repealed, unless a later enacted statute, that becomes~~

1 ~~operative on or before that date, deletes or extends the date on~~
2 ~~which it is repealed.~~

3 ~~SEC. 36.— Section 10901.3 is added to the Insurance Code, to~~
4 ~~read:~~

5 ~~10901.3.— (a) 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 ~~premium for the second lowest cost silver plan of the individual~~
12 ~~market in the rating area in which the individual resides which is~~
13 ~~offered through the California Health Benefit Exchange established~~
14 ~~under Title 22 (commencing with Section 100500) of the~~
15 ~~Government Code, as described in Section 36B(b)(3)(B) of Title~~
16 ~~26 of the United States Code.~~

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

25 ~~(c) During the first 30 days after the effective date of the health~~
26 ~~benefit plan, the individual shall have the option of changing~~
27 ~~coverage to a different health benefit plan design offered by the~~
28 ~~same carrier. If the individual notified the plan of the change within~~
29 ~~the first 15 days of a month, coverage under the new health benefit~~
30 ~~plan shall become effective no later than the first day of the~~
31 ~~following month. If an enrolled individual notified the carrier of~~
32 ~~the change after the 15th day of a month, coverage under the health~~
33 ~~benefit plan shall become effective no later than the first day of~~
34 ~~the second month following notification.~~

35 ~~(d) This section shall become operative on January 1, 2014, or~~
36 ~~the 91st calendar day following the adjournment of the 2013–14~~
37 ~~First Extraordinary Session, whichever date is later.~~

38 ~~SEC. 37.— Section 10901.9 of the Insurance Code is amended~~
39 ~~to read:~~

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

4 (a) The premium for new business for a federally eligible defined
5 individual shall not exceed the following amounts:

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

17 (2) For health benefit plans identified in subdivision (d) of
18 Section 10785 that do not offer services through a preferred
19 provider arrangement, 170 percent of the standard premium charged
20 to an individual who is of the same age and resides in the same
21 geographic area as the federally eligible defined individual.
22 However, for federally qualified individuals who are between the
23 ages of 60 to 64, inclusive, the premium shall not exceed 170
24 percent of the standard premium charged to an individual who is
25 59 years of age and resides in the same geographic area as the
26 federally eligible defined individual.

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

29 (1) For health benefit plans identified in subdivision (d) of
30 Section 10785 that offer services through a preferred provider
31 arrangement, the average premium paid by a subscriber of the
32 Major Risk Medical Insurance Program who is of the same age
33 and resides in the same geographic area as the federally eligible
34 defined individual. However, for federally qualified individuals
35 who are between the ages of 60 and 64, inclusive, the premium
36 shall not exceed the average premium paid by a subscriber of the
37 Major Risk Medical Insurance Program who is 59 years of age
38 and resides in the same geographic area as the federally eligible
39 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, 170 percent of the standard premium charged~~
4 ~~to an individual who is of the same age and resides in the same~~
5 ~~geographic area as the federally eligible defined individual.~~
6 ~~However, for federally qualified individuals who are between the~~
7 ~~ages of 60 and 64, inclusive, the premium shall not exceed 170~~
8 ~~percent of the standard premium charged to an individual who is~~
9 ~~59 years of age and resides in the same geographic area as the~~
10 ~~federally eligible defined individual. The premium effective on~~
11 ~~January 1, 2001, shall apply to in force business at the earlier of~~
12 ~~either the time of renewal or July 1, 2001.~~

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

15 ~~(1) For health benefit plans identified in subdivision (d) of~~
16 ~~Section 10785 that offer services through a preferred provider~~
17 ~~arrangement, the average increase in the premiums charged to a~~
18 ~~subscriber of the Major Risk Medical Insurance Program who is~~
19 ~~of the same age and resides in the same geographic area as the~~
20 ~~federally eligible 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, the increase in premiums charged to a~~
24 ~~nonfederally qualified individual who is of the same age and resides~~
25 ~~in the same geographic area as the federally defined eligible~~
26 ~~individual. The premium for an eligible individual may not be~~
27 ~~modified more frequently than every 12 months.~~

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

33 ~~(d) This section shall remain in effect only until January 1, 2014,~~
34 ~~or the 91st calendar day following the adjournment of the 2013-14~~
35 ~~First Extraordinary Session, whichever date is later, and as of that~~
36 ~~date is repealed, unless a later enacted statute, that becomes~~
37 ~~operative on or before that date, deletes or extends the date on~~
38 ~~which it is repealed.~~

39 ~~SEC. 38. Section 10901.9 is added to the Insurance Code, to~~
40 ~~read:~~

1 ~~10901.9.~~ (a) ~~Commencing on the date on which the act adding~~
2 ~~this section becomes operative, premiums for health benefit plans~~
3 ~~offered, delivered, amended, or renewed by carriers shall be subject~~
4 ~~to the following requirements:~~

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

13 ~~(2) For a contract that a carrier has discontinued offering, the~~
14 ~~premium applied to the first rating period of the new contract that~~
15 ~~the federally eligible defined individual elects to purchase shall~~
16 ~~be no greater than the premium applied in the prior rating period~~
17 ~~to the discontinued contract.~~

18 ~~(b) This section shall become operative on January 1, 2014, or~~
19 ~~the 91st calendar day following the adjournment of the 2013–14~~
20 ~~First Extraordinary Session, whichever date is later.~~

21 ~~SEC. 39.~~

22 ~~SEC. 14.~~ Section 10902.4 of the Insurance Code is repealed.

23 ~~SEC. 40.~~

24 ~~SEC. 15.~~ The heading of Chapter 9.7 (commencing with Section
25 10950) of Part 2 of Division 2 of the Insurance Code is amended
26 to read:

27
28 CHAPTER 9.7. CHILD ACCESS TO HEALTH INSURANCE

29
30 ~~SEC. 41.~~

31 ~~SEC. 16.~~ Section 10954 of the Insurance Code is amended to
32 read:

33 10954. (a) A carrier may use the following characteristics of
34 an eligible child for purposes of establishing the rate of the health
35 benefit plan for that child, where consistent with federal regulations
36 under PPACA: age, geographic region, and family composition,
37 plus the health benefit plan selected by the child or the responsible
38 party for a child.

1 (b) From the effective date of this chapter to December 31,
2 2013, inclusive, rates for a child applying for coverage shall be
3 subject to the following limitations:

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

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

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

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

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

28
29 "Please consider your options carefully before failing to maintain
30 or renewing coverage for a child for whom you are responsible.
31 If you attempt to obtain new individual coverage for that child,
32 the premium for the same coverage may be higher than the
33 premium you pay now."
34

35 (d) A child who applied for coverage between September 23,
36 2010, and the end of the initial enrollment period shall be deemed
37 to have maintained coverage during that period.

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

1 (e)
2 (f) Carriers shall not require documentation from applicants
3 relating to their coverage history.

4 (f)
5 (g) (1) On and after the operative date of the act adding this
6 subdivision, and until January 1, 2014, a carrier shall provide ~~a~~
7 *the model* notice, *as provided in paragraph (3)*, to all applicants
8 for coverage under this chapter and to all insureds, or the
9 responsible party for an insured, renewing coverage under this
10 chapter that contains the following information:

11 (A) Information about the open enrollment period provided
12 under Section 10965.3.

13 (B) An explanation that obtaining coverage during the open
14 enrollment period described in Section 10965.3 will not affect the
15 effective dates of coverage for coverage purchased pursuant to
16 this chapter unless the applicant cancels that coverage.

17 (C) An explanation that coverage purchased pursuant to this
18 chapter shall be effective as required under subdivision (d) of
19 Section 10951 and that such coverage shall not prevent an applicant
20 from obtaining new coverage during the open enrollment period
21 described in Section 10965.3.

22 (D) Information about the Medi-Cal program and the Healthy
23 Families Program and about subsidies available through the
24 California Health Benefit Exchange.

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

27 (3) The department ~~may~~ *shall* adopt a *uniform* model notice to
28 be used by carriers in order to comply with this subdivision, and
29 shall consult with the Department of Managed Health Care in
30 adopting that *uniform* model notice. Use of the model notice shall
31 not require prior approval of the department. ~~Any~~ *The* model notice
32 ~~designated~~ *adopted* by the department for purposes of this section
33 shall not be subject to the Administrative Procedure Act (Chapter
34 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
35 Title 2 of the Government Code).

36 ~~SEC. 42.~~

37 *SEC. 17.* Section 10960.5 is added to the Insurance Code, to
38 read:

1 10960.5. (a) This chapter shall become inoperative on January
 2 1, 2014, or the 91st calendar day following the adjournment of the
 3 2013–14 First Extraordinary Session, whichever date is later.

4 (b) *If Section 5000A of the Internal Revenue Code, as added by*
 5 *Section 1501 of PPACA, is repealed or amended to no longer apply*
 6 *to the individual market, as defined in Section 2791 of the federal*
 7 *Public Health Services Act (42 U.S.C. Sec. 300gg-4), this section*
 8 *shall become operative 12 months after the date of that repeal or*
 9 *amendment.*

10 ~~SEC. 43.~~

11 *SEC. 18.* Chapter 9.9 (commencing with Section 10965) is
 12 added to Part 2 of Division 2 of the Insurance Code, to read:

13

14 CHAPTER 9.9. INDIVIDUAL ACCESS TO HEALTH INSURANCE

15

16 10965. For purposes of this chapter, the following definitions
 17 shall apply:

18 (a) “Child” means a child described in Section 22775 of the
 19 Government Code and subdivisions (n) to (p), inclusive, of Section
 20 599.500 of Title 2 of the California Code of Regulations.

21 (b) “Dependent” means the spouse or registered domestic
 22 partner, or child, of an individual, subject to applicable terms of
 23 the health benefit plan.

24 (c) “Exchange” means the California Health Benefit Exchange
 25 created by Section 100500 of the Government Code.

26 (d) *“Family” means the policyholder and dependent or*
 27 *dependents.*

28 ~~(d)~~

29 (e) “Grandfathered health plan” has the same meaning as that
 30 term is defined in Section 1251 of PPACA.

31 ~~(e)~~

32 (f) “Health benefit plan” means any individual or group policy
 33 of health insurance, as defined in Section 106. The term does not
 34 include a health insurance policy that provides excepted benefits,
 35 as described in Sections 2722 and 2791 of the federal Public Health
 36 Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91),
 37 subject to Section 10965.01, ~~a health insurance conversion policy~~
 38 ~~offered pursuant to Section 12682.1~~, a health insurance policy
 39 provided in the Medi-Cal program (Chapter 7 (commencing with
 40 Section 14000) of Part 3 of Division 9 of the Welfare and

1 Institutions Code), the Healthy Families Program (Part 6.2
 2 (commencing with Section 12693) of Division 2), the Access for
 3 Infants and Mothers Program (Part 6.3 (commencing with Section
 4 12695) of Division 2), or the program under Part 6.4 (commencing
 5 with Section 12699.50) of Division 2, ~~or a health insurance policy~~
 6 ~~offered to a federally eligible defined individual under Chapter~~
 7 ~~8.5 (commencing with Section 10785);~~ to the extent consistent
 8 with PPACA *or a specified disease or hospital indemnity policy,*
 9 *subject to Section 10965.01.*

10 (f)

11 (g) “Policy year” has the meaning set forth in Section 144.103
 12 of Title 45 of the Code of Federal Regulations.

13 (g)

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

19 (h)

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

26 (i)

27 (j) “Rating period” means ~~the period~~ *calendar year* for which
 28 premium rates ~~established by an insurer~~ are in effect *pursuant to*
 29 *subdivision (d) of Section 10965.9.*

30 (j)

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

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

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

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

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

10
11 “This is a supplement to health insurance. It is not a substitute
12 for essential health benefits or minimum essential coverage as
13 defined in federal law.”

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 *issued or delivered* 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~~, 2014, 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 (4) *The carrier issuing a policy or certificate of specified disease*
27 *or a policy or certificate of hospital confinement indemnity requires*
28 *that the person to be insured is covered by an individual or group*
29 *policy or contract that arranges or provides medical, hospital,*
30 *and surgical coverage not designed to supplement other private*
31 *or governmental plans.*

32 (b) As used in this section, “policies or certificates of specified
33 disease” and “policies or certificates of hospital confinement
34 indemnity” mean policies or certificates of insurance sold to an
35 insured to supplement other health insurance coverage as specified
36 in this section.

37 10965.1. Every health insurer offering individual health benefit
38 plans shall, in addition to complying with the provisions of this
39 part and rules adopted thereunder, comply with the provisions of
40 this chapter.

1 10965.3. (a) (1) On and after October 1, 2013, a health insurer
2 shall fairly and affirmatively offer, market, and sell all of the
3 insurer's health benefit plans that are sold in the individual market
4 for policy years on or after January 1, 2014, to all individuals and
5 dependents in each service area in which the insurer provides or
6 arranges for the provision of health care services. A health insurer
7 shall limit enrollment in individual health benefit plans to open
8 enrollment periods and special enrollment periods as provided in
9 subdivisions (c) and (d).

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

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

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

22 (c) (1) A health insurer shall provide an initial open enrollment
23 period from October 1, 2013, to March 31, 2014, inclusive, and
24 annual enrollment periods for plan years on or after January 1,
25 2015, from October 15 to December 7, inclusive, of the preceding
26 calendar year.

27 (2) *For individuals enrolled in noncalendar-year individual*
28 *health plan contracts, a plan shall provide a limited open*
29 *enrollment period beginning on the date that is 30 calendar days*
30 *prior to the date the policy year ends in 2014 pursuant to Section*
31 *147.104(b)(2) of Title 45 of the Code of Federal Regulations.*

32 (d) (1) Subject to paragraph (2), commencing January 1, 2014,
33 a health insurer shall allow an individual to enroll in or change
34 individual health benefit plans as a result of the following triggering
35 events:

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

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

4 (ii) “Loss of minimum essential coverage” includes, but is not
5 limited to, loss of that coverage due to the circumstances described
6 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
7 Code of Federal Regulations and the circumstances described in
8 Section 1163 of Title 29 of the United States Code. “Loss of
9 minimum essential coverage” also includes loss of that coverage
10 for a reason that is not due to the fault of the individual.

11 (iii) “Loss of minimum essential coverage” does not include
12 loss of that coverage due to the individual’s failure to pay
13 premiums on a timely basis or situations allowing for a rescission,
14 subject to clause (ii) and Sections 10119.2 and 10384.17.

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

16 (C) He or she is mandated to be covered *as a dependent* pursuant
17 to a valid state or federal court order.

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

19 (E) His or her health-benefit plan *coverage issuer* substantially
20 violated a material provision of the ~~policy~~ *health coverage contract*.

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

23 (G) He or she was receiving services from a contracting provider
24 under another health benefit plan, as defined in Section 10965 or
25 Section 1399.845 of the Health and Safety Code for one of the
26 conditions described in subdivision (a) of Section 10133.56 and
27 that provider is no longer participating in the health benefit plan.

28 (H) He or she demonstrates to the Exchange, with respect to
29 health benefit plans offered through the Exchange, or to the
30 department, with respect to health benefit plans offered outside
31 the Exchange, that he or she did not enroll in a health benefit plan
32 during the immediately preceding enrollment period available to
33 the individual because he or she was misinformed that he or she
34 was covered under minimum essential coverage.

35 (I) With respect to individual health benefit plans offered
36 through the Exchange, in addition to the triggering events listed
37 in this paragraph, any other events listed in Section 155.420(d) of
38 Title 45 of the Code of Federal Regulations.

39 (2) With respect to individual health benefit plans offered
40 outside the Exchange, an individual shall have ~~63~~ 60 days from

1 the date of a triggering event identified in paragraph (1) to apply
2 for coverage from a health care service plan subject to this section.
3 With respect to individual health benefit plans offered through the
4 Exchange, an individual shall have ~~63~~ 60 days from the date of a
5 triggering event identified in paragraph (1) to select a plan offered
6 through the Exchange, unless a longer period is provided in Part
7 155 (commencing with Section 155.10) of Subchapter B of Subtitle
8 A of Title 45 of the Code of Federal Regulations.

9 (e) With respect to individual health benefit plans offered
10 through the Exchange, ~~the following provisions shall apply:~~

11 ~~(1) The~~ *the* effective date of coverage ~~selected~~ *required* pursuant
12 to this section shall be consistent with the dates specified in Section
13 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.
14 *A dependent that is a registered domestic partner pursuant to*
15 *Section 297 of the Family Code shall have the same effective date*
16 *of coverage as a spouse.*

17 ~~(2) Notwithstanding paragraph (1), in the case where an~~
18 ~~individual acquires a dependent or becomes a dependent by~~
19 ~~entering into a registered domestic partnership pursuant to Section~~
20 ~~297 of the Family Code and applies for coverage of that domestic~~
21 ~~partner consistent with subdivision (d), the coverage effective date~~
22 ~~shall be the first day of the month following the date he or she~~
23 ~~selects a plan through the Exchange, unless an earlier date is agreed~~
24 ~~to under Section 155.420(b)(3) of Title 45 of the Code of Federal~~
25 ~~Regulations.~~

26 (f) With respect to an individual health benefit plan offered
27 outside the Exchange, the following provisions shall apply:

28 (1) After an individual submits a completed application form
29 for a plan, the insurer shall, within 30 days, notify the individual
30 of the individual's actual premium charges for that plan established
31 in accordance with Section 10965.9. The individual shall have 30
32 days in which to exercise the right to buy coverage at the quoted
33 premium charges.

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

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

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

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

26 (A) When the individual submits a premium payment, based
27 on the quoted premium charges, and that payment is delivered or
28 postmarked, whichever occurs earlier, within the first 15 days of
29 the month, coverage under the plan shall become effective no later
30 than the first day of the following month. When the premium
31 payment is neither delivered nor postmarked until after the 15th
32 day of the month, coverage shall become effective no later than
33 the first day of the second month following delivery or postmark
34 of the payment.

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

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

1 coverage effective date shall be the first day of the month following
2 the date the insurer receives the request for special enrollment.

3 (g) (1) A health insurer shall not establish rules for eligibility,
4 including continued eligibility, of any individual to enroll under
5 the terms of an individual health benefit plan based on any of the
6 following factors:

7 (A) Health status.

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

9 (C) Claims experience.

10 (D) Receipt of health care.

11 (E) Medical history.

12 (F) Genetic information.

13 (G) Evidence of insurability, including conditions arising out
14 of acts of domestic violence.

15 (H) Disability.

16 (I) Any other health status-related factor as determined by any
17 federal regulations, rules, or guidance issued pursuant to Section
18 2705 of the federal Public Health Service Act.

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

26 ~~(h) (1) A health insurer shall consider the claims experience of
27 all insureds in all individual health benefit plans offered in the
28 state that are subject to subdivision (a), including those insureds
29 who do not enroll in the plans through the Exchange, to be
30 members of a single risk pool.~~

31 *(h) (1) A health insurer shall consider as a single risk pool for
32 rating purposes in the individual market the claims experience of
33 all insureds and enrollees in all nongrandfathered individual health
34 benefit plans offered by that insurer in this state, whether offered
35 as health care service plan contracts or individual health insurance
36 policies, including those insureds who enroll in individual coverage
37 through the Exchange and insureds who enroll in individual
38 coverage outside the Exchange.*

39 (2) Each ~~policy~~ calendar year, a health insurer shall establish
40 an index rate for the individual market in the state based on the

1 total combined claims costs for providing essential health benefits,
2 as defined pursuant to Section 1302 of PPACA, within the single
3 risk pool required under paragraph (1). The index rate shall be
4 adjusted on a marketwide basis based on the total expected
5 marketwide payments and charges under the risk adjustment and
6 reinsurance programs established for the state pursuant to Sections
7 1343 and 1341 of PPACA. The premium rate for all of the health
8 insurer's health benefit plans in the individual market shall use the
9 applicable index rate, as adjusted for total expected marketwide
10 payments and charges under the risk adjustment and reinsurance
11 programs established for the state pursuant to Sections 1343 and
12 1341 of PPACA, subject only to the adjustments permitted under
13 paragraph (3).

14 (3) A health insurer may vary ~~premiums~~ *premium* rates for a
15 particular health benefit plan from its index rate based only on the
16 following actuarially justified plan-specific factors:

17 (A) The actuarial value and cost-sharing design of the health
18 benefit plan.

19 (B) The health benefit plan's provider network, delivery system
20 characteristics, and utilization management practices.

21 (C) The benefits provided under the health benefit plan that are
22 in addition to the essential health benefits, as defined pursuant to
23 Section 1302 of PPACA *and Section 10112.27*. These additional
24 benefits shall be pooled with similar benefits within the single risk
25 pool required under paragraph (1) and the claims experience from
26 those benefits shall be utilized to determine rate variations for
27 plans that offer those benefits in addition to essential health
28 benefits.

29 (D) With respect to catastrophic plans, as described in subsection
30 (e) of Section 1302 of PPACA *and Section 10112.3*, the expected
31 impact of the specific eligibility categories for those plans.

32 (E) *Administrative costs, excluding any user fees required by*
33 *the Exchange.*

34 (i) This section shall only apply with respect to individual health
35 benefit plans for policy years on or after January 1, 2014.

36 (j) This section shall not apply to an individual health benefit
37 plan that is a grandfathered health plan.

38 (k) *If Section 5000A of the Internal Revenue Code, as added by*
39 *Section 1501 of PPACA, is repealed or amended to no longer apply*
40 *to the individual market, as defined in Section 2791 of the federal*

1 *Public Health Services Act (42 U.S.C. Sec. 300gg-4), subdivisions*
2 *(a), (b), and (g) shall become inoperative 12 months after the date*
3 *of that repeal or amendment and individual health care benefit*
4 *plans shall thereafter be subject to Sections 10901.2, 10951, and*
5 *10953.*

6 10965.5. (a) ~~No~~ *Commencing on October 1, 2013, no health*
7 *insurer or agent or broker shall, directly or indirectly, engage in*
8 *the following activities:*

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

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

19 (3) *Employ marketing practices or benefit designs that will have*
20 *the effect of discouraging the enrollment of individuals with*
21 *significant health needs or discriminate based on an individual's*
22 *race, color, national origin, present or predicted disability, age,*
23 *sex, gender identity, sexual orientation, expected length of life,*
24 *degree of medical dependency, quality of life, or other health*
25 *conditions.*

26 (b) ~~A~~ *Commencing on October 1, 2013, a health insurer shall*
27 *not, directly or indirectly, enter into any contract, agreement, or*
28 *arrangement with a broker or agent that provides for or results in*
29 *the compensation paid to a broker or agent for the sale of an*
30 *individual health benefit plan to be varied because of the health*
31 *status, claims experience, industry, occupation, or geographic*
32 *location of the individual. This subdivision does not apply to a*
33 *compensation arrangement that provides compensation to a broker*
34 *or agent on the basis of percentage of premium, provided that the*
35 *percentage shall not vary because of the health status, claims*
36 *experience, industry, occupation, or geographic area of the*
37 *individual.*

38 (c) *This section shall only apply with respect to individual health*
39 *benefit plans for policy years on or after January 1, 2014.*

1 (d) This section shall be enforced in the same manner as Section
2 790.03, including through Sections 790.05 and 790.035.

3 10965.7. (a) All individual health benefit plans shall conform
4 to the requirements of Sections 10112.1, 10127.18, 10273.6, and
5 12682.1, and any other requirements imposed by this code, and
6 shall be renewable at the option of the insured except as permitted
7 to be canceled, rescinded, or not renewed pursuant to Section
8 10273.6.

9 (b) Any insurer that ceases to offer for sale new individual health
10 benefit plans pursuant to Section 10273.6 shall continue to be
11 governed by this chapter with respect to business conducted under
12 this chapter.

13 10965.9. (a) With respect to individual health benefit plans
14 issued, amended, or renewed on or after January 1, 2014, a health
15 insurer may use only the following characteristics of an individual,
16 and any dependent thereof, for purposes of establishing the rate
17 of the individual health benefit plan covering the individual and
18 the eligible dependents thereof, along with the health benefit plan
19 selected by the individual:

20 (1) Age, pursuant to the age bands established by the United
21 States Secretary of Health and Human Services and the age rating
22 curve established by the federal Centers for Medicare and Medicaid
23 Services pursuant to Section 2701(a)(3) of the federal Public Health
24 Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall
25 be determined using the individual's age as of the date of the plan
26 issuance or renewal, as applicable, and shall not vary by more than
27 three to one for like individuals of different age who are ~~age 21~~
28 *21 years of age* or older as described in federal regulations adopted
29 pursuant to Section 2701(a)(3) of the federal Public Health Service
30 Act (42 U.S.C. Sec. 300gg(a)(3)).

31 (2) (A) Geographic region. ~~Except as provided in subparagraph~~
32 ~~(B), the~~ *The* geographic regions for purposes of rating shall be the
33 following:

34 ~~(i) Region 1 shall consist of the Counties of Alpine, Amador,~~
35 ~~Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt,~~
36 ~~Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,~~
37 ~~Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou,~~
38 ~~Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.~~

- 1 (ii) ~~Region 2 shall consist of the Counties of Fresno, Imperial,~~
2 ~~Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin,~~
3 ~~San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.~~
4 (iii) ~~Region 3 shall consist of the Counties of Alameda, Contra~~
5 ~~Costa, Marin, San Francisco, San Mateo, and Santa Clara.~~
6 (iv) ~~Region 4 shall consist of the Counties of Orange, Santa~~
7 ~~Barbara, and Ventura.~~
8 (v) ~~Region 5 shall consist of the County of Los Angeles.~~
9 (vi) ~~Region 6 shall consist of the Counties of Riverside, San~~
10 ~~Bernardino, and San Diego.~~
11 (B) ~~For the 2015 plan year and plan years thereafter, the~~
12 ~~geographic regions for purposes of rating shall be the following,~~
13 ~~subject to federal approval if required pursuant to Section 2701 of~~
14 ~~the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and~~
15 ~~obtained by the department and the Department of Managed Health~~
16 ~~Care by July 1, 2014:~~
17 (i) ~~Region 1 shall consist of the Counties of Alpine, Amador,~~
18 ~~Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,~~
19 ~~Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,~~
20 ~~Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.~~
21 (ii) ~~Region 2 shall consist of the Counties of Marin, Napa,~~
22 ~~Solano, and Sonoma.~~
23 (iii) ~~Region 3 shall consist of the Counties of El Dorado, Placer,~~
24 ~~Sacramento, and Yolo.~~
25 (iv) ~~Region 4 shall consist of the Counties of Alameda, Contra~~
26 ~~Costa, San Francisco, San Mateo, and Santa Clara.~~
27 (v) ~~Region 5 shall consist of the Counties of Monterey, San~~
28 ~~Benito, and Santa Cruz.~~
29 (vi) ~~Region 6 shall consist of the Counties of Fresno, Kings,~~
30 ~~Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.~~
31 (vii) ~~Region 7 shall consist of the Counties of San Luis Obispo,~~
32 ~~Santa Barbara, and Ventura.~~
33 (viii) ~~Region 8 shall consist of the Counties of Imperial, Inyo,~~
34 ~~Kern, and Mono.~~
35 (ix) ~~Region 9 shall consist of the ZIP Codes in Los Angeles~~
36 ~~County starting with 906 to 912, inclusive, 915, 917, 918, and 935.~~
37 (x) ~~Region 10 shall consist of the ZIP Codes in Los Angeles~~
38 ~~County other than those identified in clause (ix).~~
39 (xi) ~~Region 11 shall consist of the Counties of San Bernardino~~
40 ~~and Riverside.~~

- 1 ~~(xii) Region 12 shall consist of the County of Orange.~~
- 2 ~~(xiii) Region 13 shall consist of the County of San Diego.~~
- 3 (i) Region 1 shall consist of the Counties of Alpine, Amador,
- 4 Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake,
- 5 Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra,
- 6 Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.
- 7 (ii) Region 2 shall consist of the Counties of Marin, Napa,
- 8 Solano, and Sonoma.
- 9 (iii) Region 3 shall consist of the Counties of El Dorado, Placer,
- 10 Sacramento, and Yolo.
- 11 (iv) Region 4 shall consist of the City and County of San
- 12 Francisco.
- 13 (v) Region 5 shall consist of the County of Contra Costa.
- 14 (vi) Region 6 shall consist of the County of Alameda.
- 15 (vii) Region 7 shall consist of the County of Santa Clara.
- 16 (viii) Region 8 shall consist of the County of San Mateo.
- 17 (ix) Region 9 shall consist of the Counties of Monterey, San
- 18 Benito, and Santa Cruz.
- 19 (x) Region 10 shall consist of the Counties of Mariposa, Merced,
- 20 San Joaquin, Stanislaus, and Tulare.
- 21 (xi) Region 11 shall consist of the Counties of Fresno, Kings,
- 22 and Madera.
- 23 (xii) Region 12 shall consist of the Counties of San Luis Obispo,
- 24 Santa Barbara, and Ventura.
- 25 (xiii) Region 13 shall consist of the Counties of Imperial, Inyo,
- 26 and Mono.
- 27 (xiv) Region 14 shall consist of the County of Kern.
- 28 (xv) Region 15 shall consist of the ZIP Codes in the County of
- 29 Los Angeles starting with 906 to 912, inclusive, 915, 917, 918,
- 30 and 935.
- 31 (xvi) Region 16 shall consist of the ZIP Codes in the County of
- 32 Los Angeles other than those identified in clause (xv).
- 33 (xvii) Region 17 shall consist of the Counties of Riverside and
- 34 San Bernardino.
- 35 (xviii) Region 18 shall consist of the County of Orange.
- 36 (xix) Region 19 shall consist of the County of San Diego.
- 37 ~~(C)~~
- 38 (B) No later than June 1, 2017, the department, in collaboration
- 39 with the Exchange and the Department of Managed Health Care,
- 40 shall review the geographic rating regions specified in this

1 paragraph and the impacts of those regions on the health care
2 coverage market in California, and make a report to the appropriate
3 policy committees of the Legislature.

4 (3) Whether the plan covers an individual or family, as described
5 in PPACA.

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

8 (c) With respect to family coverage under an individual health
9 benefit plan, the rating variation permitted under paragraph (1) of
10 subdivision (a) shall be applied based on the portion of the
11 premium attributable to each family member covered under the
12 plan. The total premium for family coverage shall be determined
13 by summing the premiums for each individual family member. In
14 determining the total premium for family members, premiums for
15 no more than the three oldest family members who are under-age
16 ~~21~~ 21 years of age shall be taken into account.

17 (d) The rating period for rates subject to this section shall be
18 from January 1 to December 31, inclusive.

19 (e) This section shall not apply to an individual health benefit
20 plan that is a grandfathered health plan.

21 (f) The requirement for submitting a report imposed under
22 subparagraph (B) of paragraph (2) of subdivision (a) is inoperative
23 on June 1, 2021, pursuant to Section 10231.5 of the Government
24 Code.

25 (g) *If Section 5000A of the Internal Revenue Code, as added by*
26 *Section 1501 of PPACA, is repealed or amended to no longer apply*
27 *to the individual market, as defined in Section 2791 of the federal*
28 *Public Health Services Act (42 U.S.C. Sec. 300gg-4), this section*
29 *shall become inoperative 12 months after the date of that repeal*
30 *or the amendment.*

31 10965.11. (a) A health insurer shall not be required to offer
32 an individual health benefit plan or accept applications for the plan
33 pursuant to Section 10965.3 in the case of any of the following:

34 (1) To an individual who does not live or reside within the
35 insurer's approved service areas.

36 (2) (A) Within a specific service area or portion of a service
37 area, if the insurer reasonably anticipates and demonstrates to the
38 satisfaction of the commissioner both of the following:

1 (i) It will not have sufficient health care delivery resources to
2 ensure that health care services will be available and accessible to
3 the individual because of its obligations to existing insureds.

4 (ii) It is applying this subparagraph uniformly to all individuals
5 without regard to the claims experience of those individuals or any
6 health status-related factor relating to those individuals.

7 (B) A health insurer that cannot offer ~~an individual~~ a health
8 benefit plan to individuals because it is lacking in sufficient health
9 care delivery resources within a service area or a portion of a
10 service area pursuant to subparagraph (A) shall not offer ~~an~~
11 ~~individual~~ a health benefit plan in that area until the later of the
12 following dates:

13 (i) The 181st day after the date coverage is denied pursuant to
14 this paragraph.

15 (ii) The date the insurer notifies the commissioner that it has
16 the ability to deliver services to individuals, and certifies to the
17 commissioner that from the date of the notice it will enroll all
18 individuals requesting coverage in that area from the insurer.

19 (C) Subparagraph (B) shall not limit the insurer's ability to
20 renew coverage already in force or relieve the insurer of the
21 responsibility to renew that coverage as described in Section
22 10273.6.

23 (D) Coverage offered within a service area after the period
24 specified in subparagraph (B) shall be subject to this section.

25 (b) (1) A health insurer may decline to offer an individual health
26 benefit plan to an individual if the insurer demonstrates to the
27 satisfaction of the commissioner both of the following:

28 (A) It does not have the financial reserves necessary to
29 underwrite additional coverage. In determining whether this
30 subparagraph has been satisfied, the commissioner shall consider,
31 but not be limited to, the insurer's compliance with the
32 requirements of this part and the rules adopted under those
33 provisions.

34 (B) It is applying this subdivision uniformly to all individuals
35 without regard to the claims experience of those individuals or any
36 health status-related factor relating to those individuals.

37 (2) A health insurer that denies coverage to an individual under
38 paragraph (1) shall not offer coverage ~~in the individual market~~
39 before the later of the following dates:

1 (A) The 181st day after the date coverage is denied pursuant to
2 this subdivision.

3 (B) The date the insurer demonstrates to the satisfaction of the
4 commissioner that the insurer has sufficient financial reserves
5 necessary to underwrite additional coverage.

6 (3) Paragraph (2) shall not limit the insurer's ability to renew
7 coverage already in force or relieve the insurer of the responsibility
8 to renew that coverage as described in Section 10273.6.

9 (C) Coverage offered within a service area after the period
10 specified in paragraph (2) shall be subject to this section.

11 (c) Nothing in this chapter shall be construed to limit the
12 commissioner's authority to develop and implement a plan of
13 rehabilitation for a health insurer whose financial viability or
14 organizational and administrative capacity has become ~~impaired~~
15 *impaired*, to the extent permitted by PPACA.

16 10965.13. (a) A health insurer that receives an application for
17 an individual health benefit plan outside the Exchange during the
18 initial open enrollment period, an annual enrollment period, or a
19 special enrollment period described in Section 10965.3 shall inform
20 the applicant that he or she may be eligible for lower cost coverage
21 through the Exchange and shall inform the applicant of the
22 applicable enrollment period provided through the Exchange
23 described in Section 10965.3.

24 (b) On or before October 1, 2013, and annually thereafter, a
25 health insurer shall issue a notice to a policyholder enrolled in an
26 individual health benefit plan offered outside the Exchange. The
27 notice shall inform the policyholder that he or she may be eligible
28 for lower cost coverage through the Exchange and shall inform
29 the policyholder of the applicable open enrollment period provided
30 through the Exchange described in Section 10965.3.

31 (c) This section shall not apply where the individual health
32 benefit plan described in subdivision (a) or (b) is a grandfathered
33 health plan.

34 10965.15. (a) On or before October 1, 2013, and annually
35 thereafter, a health insurer shall issue the following notice to all
36 policyholders enrolled in an individual health benefit plan that is
37 a grandfathered health plan:

38
39 ~~New improved health insurance options are available in~~
40 ~~California. You currently have health insurance that is exempt~~

1 from many of the new requirements. For instance, your policy may
2 not include certain consumer protections that apply to other
3 policies, such as the requirement for the provision of preventive
4 health services without any cost sharing and the prohibition against
5 increasing your rates based on your health status. You have the
6 option to remain in your current policy or switch to a new policy.
7 Under the new rules, a health insurance company cannot deny your
8 application based on any health conditions you may have. For
9 more information about your options, please contact the California
10 Health Benefit Exchange, the Office of Patient Advocate, your
11 policy representative, an insurance broker, or a health care
12 navigator.

13 *New improved health insurance options are available in*
14 *California. You currently have health insurance that is not required*
15 *to follow many of the new laws. For example, your policy may not*
16 *provide preventive health services without you having to pay any*
17 *cost sharing (copayments or coinsurance). Also your current policy*
18 *may be allowed to increase your rates based on your health status*
19 *while new policies cannot. You have the option to remain in your*
20 *current policy or switch to a new policy. Under the new rules, a*
21 *health insurance company cannot deny your application based on*
22 *any health conditions you may have. For more information about*
23 *your options, please contact the California Health Benefit*
24 *Exchange, the Office of Patient Advocate, your policy*
25 *representative, an insurance broker, or a health care navigator.*

26
27 (b) Commencing October 1, 2013, a health insurer shall include
28 the notice described in subdivision (a) in any renewal material of
29 the individual grandfathered health plan and in any application for
30 dependent coverage under the individual grandfathered health
31 plan.

32 (c) A health insurer shall not advertise or market an individual
33 health benefit plan that is a grandfathered health plan for purposes
34 of enrolling a dependent of a policyholder into the plan for policy
35 years on or after January 1, 2014. Nothing in this subdivision shall
36 be construed to prohibit an individual enrolled in an individual
37 grandfathered health plan from adding a dependent to that plan to
38 the extent permitted by PPACA.

1 10965.16. Except as otherwise provided in this chapter, this
2 chapter shall be implemented to the extent that it meets or exceeds
3 the requirements set forth in PPACA.

4 ~~SEC. 44. Part 6.25 (commencing with Section 12694.50) is~~
5 ~~added to Division 2 of the Insurance Code, to read:~~

6
7 ~~PART 6.25. CHIP CONTINUATION COVERAGE~~

8
9 ~~12694.50. For purposes of this part, the following definitions~~
10 ~~shall apply:~~

11 ~~(a) "Board" means the Managed Risk Medical Insurance Board.~~

12 ~~(b) "Department" means the State Department of Health Care~~
13 ~~Services.~~

14 ~~(c) "Participating dental plan" means any of the following plans~~
15 ~~that is lawfully engaged in providing, arranging, paying for, or~~
16 ~~reimbursing the cost of personal dental services under insurance~~
17 ~~policies or health care service plan contracts, or membership~~
18 ~~contracts, in consideration of premiums or other periodic charges~~
19 ~~payable to it, and that, on or after January 1, 2012, has or had a~~
20 ~~contract with the board or the department to provide coverage to~~
21 ~~program subscribers:~~

22 ~~(1) A dental insurer holding a valid outstanding certificate of~~
23 ~~authority from the commissioner.~~

24 ~~(2) A specialized health care service plan as defined under~~
25 ~~subdivision (o) of Section 1345 of the Health and Safety Code.~~

26 ~~(d) "Participating health plan" means any of the following plans~~
27 ~~that is lawfully engaged in providing, arranging, paying for, or~~
28 ~~reimbursing the cost of personal health care services under~~
29 ~~insurance policies or health care service plan contracts, medical~~
30 ~~and hospital service arrangements, or membership contracts, in~~
31 ~~consideration of premiums or other periodic charges payable to it,~~
32 ~~and that, on or after January 1, 2012, has or had a contract with~~
33 ~~the board or the department to provide coverage to program~~
34 ~~subscribers:~~

35 ~~(1) A private health insurer holding a valid outstanding~~
36 ~~certificate of authority from the commissioner.~~

37 ~~(2) A health care service plan as defined under subdivision (f)~~
38 ~~of Section 1345 of the Health and Safety Code, including a plan~~
39 ~~operating as a geographic managed care plan pursuant to a contract~~
40 ~~entered into under Article 2.91 (commencing with Section 14089)~~

1 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions
2 Code.
3 (3) ~~A county organized health system.~~
4 (e) ~~“Participating vision care plan” means any of the following~~
5 ~~plans that is lawfully engaged in providing, arranging, paying for,~~
6 ~~or reimbursing the cost of personal vision services under insurance~~
7 ~~policies or health care service plan contracts, or membership~~
8 ~~contracts, in consideration of premiums or other periodic charges~~
9 ~~payable to it, and that, on or after January 1, 2012, has or had a~~
10 ~~contract with the board or the department to provide coverage to~~
11 ~~program subscribers:~~
12 ~~(1) A vision insurer holding a valid outstanding certificate of~~
13 ~~authority from the commissioner.~~
14 ~~(2) A specialized health care service plan as defined under~~
15 ~~subdivision (e) of Section 1345 of the Health and Safety Code.~~
16 (f) ~~“Program” means the federal Children’s Health Insurance~~
17 ~~Program established in the state pursuant to Title XXI of the federal~~
18 ~~Social Security Act and includes the program established under~~
19 ~~Part 6.2 (commencing with Section 12693) and the transition of~~
20 ~~the enrollees in that program pursuant to Section 14005.26 of the~~
21 ~~Welfare and Institutions Code.~~
22 (g) ~~“Qualified beneficiary” means an individual who meets all~~
23 ~~of the following requirements:~~
24 ~~(1) On or after January 1, 2012, received or receives coverage~~
25 ~~under a participating dental, health, or vision plan under the~~
26 ~~program.~~
27 ~~(2) Was disenrolled or will be disenrolled from the program~~
28 ~~due to loss of eligibility because of his or her age.~~
29 ~~(3) Is not eligible for full scope benefits under the Medi-Cal~~
30 ~~program.~~
31 (h) ~~“Subscriber” means an individual who is eligible for and~~
32 ~~enrolled in the program.~~
33 12694.52. (a) ~~Until January 1, 2014, or the date that is six~~
34 ~~months following the operative date of this part, whichever date~~
35 ~~is later, every participating health, dental, and vision plan shall~~
36 ~~offer coverage to a qualified beneficiary. The plan shall offer the~~
37 ~~qualified beneficiary the same coverage that the beneficiary had~~
38 ~~immediately prior to disenrollment from the program or coverage~~
39 ~~with benefits that are most equivalent to the coverage that the~~

1 beneficiary had immediately prior to disenrollment from the
2 program.

3 (b) Except as otherwise provided in this part, coverage provided
4 pursuant to this part shall be provided under the same terms and
5 conditions that apply to similarly situated subscribers in the
6 program under the applicable participating plan.

7 (c) (1) For a qualified beneficiary who was disenrolled from
8 the program prior to the operative date of this part, the participating
9 health, dental, or vision plan shall provide written notification of
10 eligibility for coverage pursuant to this section to the qualified
11 beneficiary within 30 days of the operative date of this part.

12 (2) For a qualified beneficiary who is disenrolled from the
13 program on or after the operative date of this part, the participating
14 health, dental, or vision plan shall provide written notification of
15 eligibility for coverage pursuant to this section to the qualified
16 beneficiary no less than 30 days prior to disenrollment from the
17 program.

18 (3) The notice required under this subdivision shall state that
19 the qualified beneficiary must elect the coverage in writing and
20 deliver the written request, by first-class mail, or other reliable
21 means of delivery, including personal delivery, express mail, or
22 private courier company, to the participating plan within 60 days
23 of the mailing of the notice. The notice shall also state that a
24 qualified beneficiary electing coverage pursuant to this part shall
25 pay to the participating plan the amount of the required premium
26 payment, as set forth in Section 12694.54.

27 (d) A qualified beneficiary shall have 60 days from the mailing
28 of the notice required under subdivision (c) to elect coverage
29 pursuant to this section. The election shall be in writing and shall
30 be delivered by first-class mail, or other reliable means of delivery,
31 including personal delivery, express mail, or private courier
32 company, to the participating plan.

33 (e) A qualified beneficiary receiving coverage pursuant to this
34 part shall continue to receive that coverage until the coverage is
35 terminated at his or her election or pursuant to Section 12694.56,
36 whichever occurs first.

37 (f) A qualified beneficiary receiving coverage pursuant to this
38 part shall be considered part of the participating plan and treated
39 as similarly situated subscribers for contract purposes, unless
40 otherwise specified in this part.

1 ~~12694.54.~~ (a) ~~A qualified beneficiary who elects coverage~~
 2 ~~pursuant to this part shall make the following premium payments~~
 3 ~~to the participating health, dental, or vision plan, as applicable:~~

4 ~~(1) To the participating health plan: not more than 110 percent~~
 5 ~~of the average per subscriber payment made by the board or the~~
 6 ~~department to all participating health plans for coverage provided~~
 7 ~~under the program to subscribers who are one year of age or older.~~

8 ~~(2) To the participating dental plan: not more than 110 percent~~
 9 ~~of the average per subscriber payment made by the board or the~~
 10 ~~department to all participating dental plans for coverage provided~~
 11 ~~under the program to subscribers who are one year of age or older.~~

12 ~~(3) To the participating vision plan: not more than 110 percent~~
 13 ~~of the average per subscriber payment made by the board or the~~
 14 ~~department to all participating vision plans for coverage provided~~
 15 ~~under the program to subscribers who are one year of age or older.~~

16 ~~(b) The premium payments required by this section shall be~~
 17 ~~made before the due date of each payment but not more frequently~~
 18 ~~than on a monthly basis.~~

19 ~~12694.56.~~ ~~The continuation coverage provided pursuant to this~~
 20 ~~part shall terminate at the first to occur of the following:~~

21 ~~(a) The date 18 months after the effective date of coverage~~
 22 ~~elected pursuant to this part.~~

23 ~~(b) The end of the period for which premium payments were~~
 24 ~~made, if the qualified beneficiary ceases to make payments or fails~~
 25 ~~to make timely payments of a required premium, in accordance~~
 26 ~~with Section 12694.54 and the terms and conditions of the policy~~
 27 ~~or contract. In the case of nonpayment of premiums, reinstatement~~
 28 ~~shall be governed by the terms and conditions of the policy or~~
 29 ~~contract.~~

30 ~~(c) The qualified beneficiary moves out of the plan's service~~
 31 ~~area or the qualified beneficiary, or applicant acting on his or her~~
 32 ~~behalf, commits fraud or deception in the use of plan services.~~

33 ~~SEC. 45.~~

34 *SEC. 19.* (a) The Insurance Commissioner may adopt
 35 *regulations* ~~regulations~~, to implement the changes made to the
 36 Insurance Code by this ~~act~~ *act*, pursuant to the Administrative
 37 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
 38 Part 1 of Division 3 of Title 2 of the Government Code). The
 39 commissioner shall consult with the Director of the Department
 40 of Managed Health Care prior to adopting any regulations pursuant

1 to this ~~section~~ *subdivision* for the specific purpose of ensuring, to
2 the extent practical, that there is consistency of regulations
3 applicable to entities regulated by the commissioner and those
4 regulated by the Director of the Department of Managed Health
5 Care.

6 *(b) (1) The commissioner may adopt emergency regulations*
7 *implementing the changes made to the Insurance Code by this act*
8 *no later than December 31, 2014. The commissioner may readopt*
9 *any emergency regulation authorized by this section that is the*
10 *same as or substantially equivalent to an emergency regulation*
11 *previously adopted under this section.*

12 *(2) The initial adoption of emergency regulations implementing*
13 *this section and the one readoption of emergency regulations*
14 *authorized by this section shall be deemed an emergency and*
15 *necessary for the immediate preservation of the public peace,*
16 *health, safety, or general welfare. The initial emergency*
17 *regulations and, notwithstanding Section 11346.1 of the*
18 *Government Code, the one readoption of emergency regulations*
19 *authorized by this section shall be submitted to the Office of*
20 *Administrative Law for filing with the Secretary of State and each*
21 *shall remain in effect for no more than 180 days, by which time*
22 *final regulations may be adopted. The commissioner shall consult*
23 *with the Director of the Department of Managed Health Care prior*
24 *to adopting any regulations pursuant to this subdivision for the*
25 *specific purpose of ensuring, to the extent practical, that there is*
26 *consistency of regulations applicable to entities regulated by the*
27 *commissioner and those regulated by the Department of Managed*
28 *Health Care.*

29 ~~SEC. 46. — No reimbursement is required by this act pursuant~~
30 ~~to Section 6 of Article XIII B of the California Constitution because~~
31 ~~the only costs that may be incurred by a local agency or school~~
32 ~~district will be incurred because this act creates a new crime or~~
33 ~~infraction, eliminates a crime or infraction, or changes the penalty~~
34 ~~for a crime or infraction, within the meaning of Section 17556 of~~
35 ~~the Government Code, or changes the definition of a crime within~~
36 ~~the meaning of Section 6 of Article XIII B of the California~~
37 ~~Constitution.~~

38 *SEC. 20. This bill shall become operative only if Senate Bill 2*
39 *of the 2013–14 First Extraordinary Session is enacted and becomes*
40 *effective.*

O