AMENDED IN SENATE APRIL 1, 2013

AMENDED IN SENATE MARCH 21, 2013

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 10119.1, 10198.7, 10603, 10753, 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 add Sections 10127.21 and 10960.5 to, to add Chapter 9.9 (commencing with Section 10965) to Part 2 of 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 provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires 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 an insurer, on and after October 1, 2013, to offer, market, and sell all of the 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 insurer provides or arranges for the provision of health care services, as specified, but would require insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these insurers 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 insurer to consider the claims experience of all 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 insurer to establish a specified index rate for that market, and would authorize the insurer to vary premiums from the index rate based only on specified factors. The bill would authorize 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 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 an insurer from advertising or

marketing an individual grandfathered health plan for the purpose of enrolling a dependent of the policyholder in the plan and would also require insurers to annually issue a specified notice to 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 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 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 an insurer determines premium rates for a small employer health benefit plan, as specified. The bill would also require 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 insurer to establish a specified index rate for that market, and would authorize the insurer to vary premiums from the index rate based only on specified factors. The bill would make certain of these provisions inoperative, as specified, if, and 12 months after specified provisions of PPACA are repealed.

(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 insurers to the secretary for purposes of the risk adjustment program also be submitted to the Department of Insurance, in the same format. The bill would require the department to use that data for specified purposes.

(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 SB 2 of the 2013–14 First Extraordinary Session is enacted and becomes effective.

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

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

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

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

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

(c) On or before June 1, 2006, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, which means automatic declinable health

conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which individuals applying for coverage would be eligible. An insurer may comply with this section by submitting to the department underwriting materials or resource guides provided to agents and brokers, provided that those materials include the information required to be submitted by this section.

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

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

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

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

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

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer

apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative 12 months after the date of that repeal or amendment.

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

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

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

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

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

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

(1) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010

(Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

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

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

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

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

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

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

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

(c) The insurer shall establish, for the purposes of subdivision (b), a ranking of the individual health benefit plans it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The insurer shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The insurer shall notify in writing all insureds of the right to transfer to another individual health benefit plan pursuant to this section, at a minimum, when the insurer changes the insured's

premium rate. Posting this information on the insurer's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform insureds of the transfer rights provided under this section including information on the process to obtain details about the individual health benefit plans available to that insured and advising that the insured may be unable to return to his or her current individual health benefit plan if the insured transfers to another individual health benefit plan.

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

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

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

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

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

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

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

(g) (1) 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.

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

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

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

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

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

(d) Notwithstanding subdivisions (a) and (b), if an individual was subject to a preexisting condition provision or a waiting or affiliation period under the individual health benefit plan that was rescinded, the health insurer may apply the same preexisting condition provision or waiting or affiliation period in the new individual health benefit plan. The time period in the new individual health benefit plan for the preexisting condition provision or waiting or affiliation period shall not be longer than the one in the individual health benefit plan that was rescinded and the health insurer shall credit any time that the individual was covered under the rescinded individual health benefit plan.

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

(f) The insurer shall provide 60 days for insureds to accept the offered new individual health benefit plan and this plan shall be effective as of the effective date of the original individual health benefit plan and 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) (1) 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.

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

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

10119.2. (a) Every health insurer that offers, issues, or renews health insurance under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, shall offer to any individual, who was covered by the insurer under an individual health benefit plan that was rescinded, a new individual health benefit plan that provides the most equivalent benefits.

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

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

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

(e) The insurer shall provide 60 days for insureds to accept the offered new individual health benefit plan under subdivision (a),

and this plan shall be effective as of the effective date of the original health benefit plan and there shall be no lapse in coverage.

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

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

(h) (1) 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.

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

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

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

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

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

(b) (1) A nongrandfathered health benefit plan for individual coverage shall not impose any preexisting condition provision or waivered condition provision upon any individual.

(2) A grandfathered health benefit plan for individual coverage shall not exclude coverage on the basis of a waivered condition provision or preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor limit or exclude coverage for a specific insured by

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

(3) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the Public Health Service Act (42 U.S.C. Sec. 300gg-4), paragraph (1) shall become inoperative 12 months after the date of that repeal or amendment and thereafter paragraph (2) shall apply also to nongrandfathered health benefit plans for individual coverage.

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

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

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

However, if a person’s employment has ended, the availability of health coverage offered through employment or sponsored by

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

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

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

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

(2) On and after January 1, 2014, a disability insurer offering health insurance coverage subject to Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15) shall satisfy the requirements of this section and the implementing regulations by providing the uniform summary of benefits and coverage required under Section 2715 of the federal Public Health Service Act and any rules or regulations issued thereunder. An insurer that issues the federal uniform summary of benefits referenced in this paragraph shall ensure that all applicable disclosures required in this chapter and its implementing regulations are met in other documents provided to policyholders and insureds. An insurer subject to this paragraph shall provide the uniform summary of benefits and coverage to the commissioner together with the corresponding health insurance policy pursuant to Section 10290.

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

SEC. 9. Section 10753 of the Insurance Code is amended to read:

10753. (a) "Agent or broker" means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) "Benefit plan design" means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) "Carrier" means a health insurer or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder.

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

(e) "Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (s).

(f) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, in the small employer's regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business, and they are included as employees under a health benefit plan of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined

in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. A permanent employee who works at least 20 hours but not more than 29 hours is deemed to be an eligible employee if all four of the following apply:

(A) The employee otherwise meets the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employee health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The insurer may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (s).

(g) "Enrollee" means an eligible employee or dependent who receives health coverage through the program from a participating carrier.

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

(i) "Financially impaired" means, for the purposes of this chapter, a carrier that, on or after the effective date of this chapter, is not insolvent and is either:

(1) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations.

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(j) "Health benefit plan" means a policy of health insurance, as defined in Section 106, for the covered eligible employees of a small employer and their dependents. The term does not include coverage of Medicare services pursuant to contracts with the United States government, or coverage that provides excepted benefits, as described in Sections 2722 and 2791 of the federal Public Health Service Act, subject to Section 10701.

(k) "In force business" means an existing health benefit plan issued by the carrier to a small employer.

(*l*) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan consistent with the periods provided pursuant to Section 10753.05 and who subsequently requests enrollment in a health benefit plan of that small employer, except where the employee or dependent qualifies for a special enrollment period provided pursuant to Section 10753.05. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's health benefit plan consistent with the periods provided pursuant to Section 10753.05 and who subsequently requests enrollment in the plan, except where the employee or dependent qualifies for a special enrollment period provided pursuant to Section 10753.05.

(m) "New business" means a health benefit plan issued to a small employer that is not the carrier's in force business.

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

(o) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program, that is written or administered by a health insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or

without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

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

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

(5) 10 U.S.C. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

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

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

(10) Any other creditable coverage as defined by subdivision (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(p) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than 12 months from the date of issuance or renewal of the health benefit plan.

(q) (1) "Small employer" means either of the following:

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health benefit plans, and in which a bona fide

employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health benefit plans, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a carrier shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this chapter, provisions of this chapter that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this subparagraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association. This subparagraph shall be implemented to the extent consistent with PPACA, except that the minimum requirement of one employee shall be implemented only to the extent required by PPACA.

(B) Any guaranteed association, as defined in subdivision (r), that purchases health coverage for members of the association.

(2) For plan years commencing on or after January 1, 2014, the definition of an employer, for purposes of determining whether an employer with one employee shall include sole proprietors, certain owners of "S" corporations, or other individuals, shall be consistent with Section 1304 of PPACA.

(r) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its

membership criteria which (1) includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (q), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has been offering health insurance to its members for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any benefit plan design that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the carrier with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a master policy by an admitted insurer is delivered directly to the association or a trust formed for or sponsored by an association to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(s) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it may also include employees of association members,

association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include those persons as members of the guaranteed association, the association must so elect in advance of purchasing coverage from a plan. Health plans may require an association to adhere to the membership composition it selects for up to 12 months.

(t) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(u) "Nongrandfathered health benefit plan" means a health benefit plan that is not a grandfathered health plan.

(v) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

(w) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(x) "Waiting period" means a period that is required to pass with respect to the employee before the employee is eligible to be covered for benefits under the terms of the contract.

(y) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(z) "Family" means the policyholder and his or her dependents.

SEC. 10. Section 10753.05 of the Insurance Code is amended to read:

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

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

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

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

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

(5) A carrier which (A) effective January 1, 1992, and at least 20 years prior to that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer or sell any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits

shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers or sells any benefit plan design or any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits to those who are not members of the association it is subject to the requirements of this section.

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

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

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

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

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

(1) Prepare a brochure that summarizes all of its health benefit plans and make this summary available to small employers, agents, and brokers upon request. The summary shall include for each plan information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, an explanation of how creditable coverage is calculated if a waiting period is imposed, and a telephone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send copies to agents and brokers representing the carrier. Any entity that provides administrative services only with regard to a health benefit plan written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan.

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

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

(4) Notwithstanding subdivision (c) of Section 10753, for purposes of this subdivision, companies that are affiliated

companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

(k) (1) A carrier shall consider as a single risk pool for rating purposes in the small employer market the claims experience of all insureds in all nongrandfathered small employer health benefit

plans offered by the carrier in this state, whether offered as health care service plan contracts or health insurance policies, including those insureds and enrollees who enroll in coverage through the Exchange and insureds and enrollees covered by the carrier outside of the Exchange.

(2) Each calendar year, a carrier shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the carrier's nongrandfathered health benefit plans shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

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

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

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

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

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

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

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

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

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

SEC. 11. Section 10753.06.5 of the Insurance Code is amended to read:

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

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

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

(2) With respect to a small employer health benefit plan offered outside the Exchange for which an individual applies during a

special enrollment period described in paragraph (3) of subdivision (b) of Section 10753.05, the following provisions shall apply:

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

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

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

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

SEC. 12. Section 10753.11 of the Insurance Code is amended to read:

10753.11. (a) To the extent permitted by PPACA, a carrier shall not be required by the provisions of this chapter to do any of the following:

(1) Offer coverage to, or accept applications from, a small employer where the small employer is seeking coverage for eligible employees and dependents who do not live, work, or reside in a carrier's service areas.

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

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

(ii) The carrier is applying this paragraph uniformly to all employers without regard to the claims experience of those

employers, and their employees and dependents, or any health status-related factor relating to those employees and dependents.

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

(B) A carrier that cannot offer coverage to small employers in a specific service area because it is lacking sufficient capacity as described in this paragraph may not offer coverage in the applicable area to new employer groups until the later of the following dates:

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

(ii) The date the carrier notifies the commissioner that it has regained capacity to deliver services to small employers, and certifies to the commissioner that from the date of the notice it will enroll all small groups requesting coverage from the carrier until the carrier has met the requirements of subdivision (g) of Section 10753.05.

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 14. Section 10753.14 of the Insurance Code is amended to read:

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

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

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

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

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

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

(iv) Region 4 shall consist of the City and County of San Francisco.

(v) Region 5 shall consist of the County of Contra Costa.

(vi) Region 6 shall consist of the County of Alameda.

(vii) Region 7 shall consist of the County of Santa Clara.

(viii) Region 8 shall consist of the County of San Mateo.

(ix) Region 9 shall consist of the Counties of Monterey, San Benito, and Santa Cruz.

(x) Region 10 shall consist of the Counties of Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(xi) Region 11 shall consist of the Counties of Fresno, Kings, and Madera.

(xii) Region 12 shall consist of the Counties of San Luis Obispo, Santa Barbara, and Ventura.

(xiii) Region 13 shall consist of the Counties of Imperial, Inyo, and Mono.

(xiv) Region 14 shall consist of the County of Kern.

(xv) Region 15 shall consist of the ZIP Codes in the County of Los Angeles starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(xvi) Region 16 shall consist of the ZIP Codes in the County of Los Angeles other than those identified in clause (xv).

(xvii) Region 17 shall consist of the Counties of Riverside and San Bernardino.

(xviii) Region 18 shall consist of the County of Orange.

(xix) Region 19 shall consist of the County of San Diego.

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Health Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and submit a report to the appropriate policy committees of the Legislature. The requirement for submitting a report imposed under this subparagraph is inoperative June 1, 2021, pursuant to Section 10231.5 of the Government Code.

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

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

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

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

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

SEC. 15. Section 10902.4 of the Insurance Code is repealed.

SEC. 16. The heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of the Insurance Code is amended to read:

CHAPTER 9.7. CHILD ACCESS TO HEALTH INSURANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Information about the Medi-Cal program, information about the Healthy Families Program if the Healthy Families Program is accepting enrollment, and information about subsidies available through the California Health Benefit Exchange.

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

(3) The department shall adopt a uniform model notice to be used by carriers in order to comply with this subdivision, and shall consult with the Department of Managed Health Care in adopting that uniform model notice. Use of the model notice shall not require prior approval of the department. The adoption of the model notice by the department for purposes of this section shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 18. Section 10960.5 is added to the Insurance Code, to read:

10960.5. (a) This chapter 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.

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

SEC. 19. Chapter 9.9 (commencing with Section 10965) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.9. INDIVIDUAL ACCESS TO HEALTH INSURANCE

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

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

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

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

(d) "Family" means the policyholder and dependent or dependents.

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

(f) "Health benefit plan" means any individual or group policy of health insurance, as defined in Section 106. The term does not include a health insurance policy that provides excepted benefits, as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91), subject to Section 10965.01 a health insurance policy provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2, or Medicare supplement coverage, to the extent consistent with PPACA or a specified disease or hospital indemnity policy, subject to Section 10965.01.

(g) "Policy year" means the period from January 1 to December 31, inclusive.

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

(i) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a

specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(j) "Rating period" means the calendar year for which premium rates are in effect pursuant to subdivision (d) of Section 10965.9.

(k) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

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

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

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

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

"This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

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

(3) In the case of a policy or certificate that is described in this section and that is offered in this state on or after January 1, 2014, the carrier files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

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

(b) As used in this section, "policies or certificates of specified disease" and "policies or certificates of hospital confinement indemnity" mean policies or certificates of insurance sold to an insured to supplement other health insurance coverage as specified in this section.

10965.1. Except as provided in Section 10965.15, the provisions of this chapter shall only apply with respect to nongrandfathered individual health benefit plans offered by a health insurer, and shall apply in addition to other provisions of this chapter and the rules adopted thereunder.

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

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

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

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

(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar-year

individual health plan contracts, a plan shall provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

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

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

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

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

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

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

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

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

(E) His or her health coverage issuer substantially violated a material provision of the health coverage contract.

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

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

(H) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside

the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.

(I) He or she is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

~~(I)~~

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

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

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

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

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

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period

described in subdivision (c), when the policyholder submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

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

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

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

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

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

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

(h) (1) A health insurer shall consider as a single risk pool for rating purposes in the individual market the claims experience of all insureds and enrollees in all nongrandfathered individual health benefit plans offered by that insurer in this state, whether offered as health care service plan contracts or individual health insurance policies, including those insureds who enroll in individual coverage through the Exchange and insureds who enroll in individual coverage outside the Exchange. Student health insurance coverage, as such coverage is defined at Section 147.145(a) of Title 45 of

the Code of Federal Regulations, shall not be included in a health insurer's single risk pool for individual coverage.

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

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

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

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

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

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

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

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

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

(k) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), subdivisions (a), (b), and (g) shall become inoperative 12 months after the date of that repeal or amendment and individual health care benefit plans shall thereafter be subject to Sections 10901.2, 10951, and 10953.

10965.5. (a) Commencing on October 1, 2013, a health insurer or agent or broker shall not, directly or indirectly, engage in the following activities:

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

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

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

(b) Commencing on October 1, 2013, a health insurer shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a broker or agent that provides for or results in the compensation paid to a broker or agent for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision does not apply to a compensation arrangement that provides compensation to a broker or agent on the basis of percentage of premium, provided that the

percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

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

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

10965.7. (a) An individual health benefit plan shall be renewable at the option of the insured except as permitted to be canceled, rescinded, or not renewed pursuant to Section 155.430(b) of Title 45 of the Code of Federal Regulations.

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

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

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

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

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

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

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

(iv) Region 4 shall consist of the City and County of San Francisco.

(v) Region 5 shall consist of the County of Contra Costa.

(vi) Region 6 shall consist of the County of Alameda.

(vii) Region 7 shall consist of the County of Santa Clara.

(viii) Region 8 shall consist of the County of San Mateo.

(ix) Region 9 shall consist of the Counties of Monterey, San Benito, and Santa Cruz.

(x) Region 10 shall consist of the Counties of Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(xi) Region 11 shall consist of the Counties of Fresno, Kings, and Madera.

(xii) Region 12 shall consist of the Counties of San Luis Obispo, Santa Barbara, and Ventura.

(xiii) Region 13 shall consist of the Counties of Imperial, Inyo, and Mono.

(xiv) Region 14 shall consist of the County of Kern.

(xv) Region 15 shall consist of the ZIP Codes in the County of Los Angeles starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(xvi) Region 16 shall consist of the ZIP Codes in the County of Los Angeles other than those identified in clause (xv).

(xvii) Region 17 shall consist of the Counties of Riverside and San Bernardino.

(xviii) Region 18 shall consist of the County of Orange.

(xix) Region 19 shall consist of the County of San Diego.

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Heath Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and make a report to the appropriate policy committees of the Legislature.

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

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

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

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

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

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

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

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

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

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

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

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

(B) A health insurer that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service

area pursuant to subparagraph (A) shall not offer an individual health benefit plan in that area until the later of the following dates:

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

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

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

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

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

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

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

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

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

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

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

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

(c) Nothing in this chapter shall be construed to limit the commissioner's authority to develop and implement a plan of

rehabilitation for a health insurer whose financial viability or organizational and administrative capacity has become impaired, to the extent permitted by PPACA.

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

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

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

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

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

New improved health insurance options are available in California. You currently have health insurance that is not required to follow many of the new laws. For example, your policy may not provide preventive health services without you having to pay any cost sharing (copayments or coinsurance). Also your current policy may be allowed to increase your rates based on your health status while new policies cannot. You have the option to remain in your current policy or switch to a new policy. Under the new rules, a health insurance company cannot deny your application based on any health conditions you may have. For more information about your options, please contact ~~the California~~

~~Health Benefit Exchange,~~ *Covered California at* ____, the Office of Patient ~~Advocate,~~ *Advocate at* ____, your policy representative or ~~an~~ insurance ~~broker.~~ *agent, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.*

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

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

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

10965.17. (a) The commissioner may, no later than December 31, 2014, adopt emergency regulations implementing this chapter. The commissioner may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(b) The initial adoption of emergency regulations implementing this chapter and the one readoption of emergency regulation authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than one year, by which time final regulations may be adopted. The commissioner shall consult with the Director of the

Department of Managed Health Care prior to adopting any regulations pursuant to this subdivision for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to entities regulated by the commissioner and those regulated by the Department of Managed Health Care.

SEC. 20. The Insurance Commissioner may adopt regulations, to implement the changes made to the Insurance Code by this act, pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The commissioner shall consult with the Director of the Department of Managed Health Care prior to adopting any regulations pursuant to this subdivision for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to entities regulated by the commissioner and those regulated by the Department of Managed Health Care.

SEC. 21. This bill shall become operative only if Senate Bill 2 of the 2013–14 First Extraordinary Session is enacted and becomes effective.

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