

AMENDED IN ASSEMBLY MARCH 21, 2013

AMENDED IN ASSEMBLY MARCH 7, 2013

CALIFORNIA LEGISLATURE—2013–14 FIRST EXTRAORDINARY SESSION

**SENATE BILL**

**No. 2**

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

January 28, 2013

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An act to amend Sections 1357.51, *1357.500*, 1357.503, 1357.504, 1357.509, 1357.512, 1363, 1389.5, and 1399.829 of, to amend the heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of, to amend and add Sections 1389.4 and 1389.7 of, to add Sections 1348.96 and 1399.836 to, to add Article 11.8 (commencing with Section 1399.845) to Chapter 2.2 of Division 2 of, and to repeal Section 1399.816 of, the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 2, as amended, Hernandez. Health care coverage.

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

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

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires plans offering coverage in the individual market to offer coverage for a child subject to specified requirements. Existing law establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014.

This bill would require a *health care service* plan on and after October 1, 2013, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services, as specified, but would require plans to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these ~~health benefit~~ *health care service* plans from imposing any preexisting condition exclusion upon any individual and from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified. The bill would require a health care service plan to consider the claims experience of all enrollees of its nongrandfathered individual health benefit plans offered in the state to be part of a single risk pool, as specified, would require the plan to establish a specified index rate for that market, and would authorize the plan to vary premiums from the index rate based only on specified factors. The bill would authorize plans to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans, as specified. The bill would require plans to provide specified information regarding

the Exchange to applicants for and subscribers of individual health benefit plans offered outside the Exchange. The bill would prohibit a plan from advertising or marketing an individual grandfathered health plan for the purpose of enrolling a dependent of the subscriber in the plan and would also require plans to annually issue a specified notice to subscribers enrolled in a grandfathered plan. The bill would authorize the director to require a plan to discontinue offering individual plan contracts if the director determines the plan does not have sufficient financial viability or organizational capacity, as specified. The bill would make certain of these ~~provisions~~, *provisions* inoperative if, and 12 months after, ~~certain~~ *specified* provisions of PPACA are repealed or amended, as specified.

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

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

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

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

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

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

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

This bill would require that certain health care service plan contracts satisfy these requirements by providing a uniform summary of benefits and coverage required by federal law.

(6)

(4) This bill would become operative only if AB 2 of the 2013–14 First Extraordinary Session is enacted and ~~takes effect~~. *becomes effective*.

(7)

(5) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

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

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

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

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

3 1348.96. Any data submitted by a health care service plan to  
4 the United States Secretary of Health and Human Services, or his  
5 or her designee, for purposes of the risk adjustment program  
6 described in Section 1343 of the federal Patient Protection and  
7 Affordable Care Act (42 U.S.C. Sec. 18063) shall be concurrently  
8 submitted to the department in the same format. The department  
9 shall use the information to monitor federal implementation of risk  
10 adjustment in the state and to ensure that health care service plans  
11 are in compliance with federal requirements related to risk  
12 adjustment.

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

15 1357.51. (a) A health benefit plan for group coverage shall  
16 not impose any preexisting condition provision or waived  
17 condition provision upon any enrollee.

18 (b) (1) A nongrandfathered health benefit plan for individual  
19 coverage shall not impose any preexisting condition provision or  
20 waived condition provision upon any enrollee.

21 (2) A grandfathered health benefit plan for individual coverage  
22 shall not exclude coverage on the basis of a waived condition  
23 provision or preexisting condition provision for a period greater  
24 than 12 months following the enrollee's effective date of coverage,  
25 nor limit or exclude coverage for a specific enrollee by type of  
26 illness, treatment, medical condition, or accident, except for  
27 satisfaction of a preexisting condition provision or waived  
28 condition provision pursuant to this article. Waivered condition  
29 provisions or preexisting condition provisions contained in  
30 individual grandfathered health benefit plans may relate only to  
31 conditions for which medical advice, diagnosis, care, or treatment,  
32 including use of prescription drugs, was recommended or received  
33 from a licensed health practitioner during the 12 months  
34 immediately preceding the effective date of coverage.

35 (3) *If Section 5000A of the Internal Revenue Code, as added by*  
36 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
37 *to the individual market, as defined in Section 2791 of the Public*  
38 *Health Service Act (42 U.S.C. Sec. 300gg-4), paragraph (1) shall*

1 *become inoperative 12 months after the date of that repeal or*  
2 *amendment and thereafter paragraph (2) shall apply also to*  
3 *nongrandfathered health benefit plans for individual coverage.*

4 (c) (1) A health benefit plan for group coverage may apply a  
5 waiting period of up to 60 days as a condition of employment if  
6 applied equally to all eligible employees and dependents and if  
7 consistent with PPACA. A health benefit plan for group coverage  
8 through a health maintenance organization, as defined in Section  
9 2791 of the federal Public Health Service Act (42 U.S.C. Sec.  
10 300gg-3(e)), shall not impose any affiliation period that exceeds  
11 60 days. A waiting or affiliation period shall not be based on a  
12 preexisting condition of an employee or dependent, the health  
13 status of an employee or dependent, or any other factor listed in  
14 Section 1357.52. An affiliation period shall run concurrently with  
15 a waiting period. During the waiting or affiliation period, the plan  
16 is not required to provide health care services and no premium  
17 shall be charged to the subscriber or enrollees.

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

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

31 However, if a person's employment has ended, the availability  
32 of health coverage offered through employment or sponsored by  
33 an employer has terminated, or an employer's contribution toward  
34 health coverage has terminated, a plan shall credit the time the  
35 person was covered under creditable coverage if the person  
36 becomes eligible for health coverage offered through employment  
37 or sponsored by an employer within 180 days, exclusive of any  
38 waiting or affiliation period, and applies for coverage under the  
39 succeeding plan contract within the applicable enrollment period.

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

4 *SEC. 3. Section 1357.500 of the Health and Safety Code is*  
5 *amended to read:*

6 1357.500. As used in this article, the following definitions shall  
7 apply:

8 (a) “Child” means a child described in Section 22775 of the  
9 Government Code and subdivisions (n) to (p), inclusive, of Section  
10 599.500 of Title 2 of the California Code of Regulations.

11 (b) “Dependent” means the spouse or registered domestic  
12 partner, or child, of an eligible employee, subject to applicable  
13 terms of the health care service plan contract covering the  
14 employee, and includes dependents of guaranteed association  
15 members if the association elects to include dependents under its  
16 health coverage at the same time it determines its membership  
17 composition pursuant to subdivision (m).

18 (c) “Eligible employee” means either of the following:

19 (1) Any permanent employee who is actively engaged on a  
20 full-time basis in the conduct of the business of the small employer  
21 with a normal workweek of an average of 30 hours per week over  
22 the course of a month, at the small employer’s regular places of  
23 business, who has met any statutorily authorized applicable waiting  
24 period requirements. The term includes sole proprietors or partners  
25 of a partnership, if they are actively engaged on a full-time basis  
26 in the small employer’s business and included as employees under  
27 a health care service plan contract of a small employer, but does  
28 not include employees who work on a part-time, temporary, or  
29 substitute basis. It includes any eligible employee, as defined in  
30 this paragraph, who obtains coverage through a guaranteed  
31 association. Employees of employers purchasing through a  
32 guaranteed association shall be deemed to be eligible employees  
33 if they would otherwise meet the definition except for the number  
34 of persons employed by the employer. Permanent employees who  
35 work at least 20 hours but not more than 29 hours are deemed to  
36 be eligible employees if all four of the following apply:

37 (A) They otherwise meet the definition of an eligible employee  
38 except for the number of hours worked.

39 (B) The employer offers the employees health coverage under  
40 a health benefit plan.

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

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

9 (2) Any member of a guaranteed association as defined in  
10 subdivision (m).

11 (d) “Exchange” means the California Health Benefit Exchange  
12 created by Section 100500 of the Government Code.

13 (e) “In force business” means an existing health benefit plan  
14 contract issued by the plan to a small employer.

15 (f) “Late enrollee” means an eligible employee or dependent  
16 who has declined enrollment in a health benefit plan offered by a  
17 small employer at the time of the initial enrollment period provided  
18 under the terms of the health benefit plan consistent with the  
19 periods provided pursuant to Section 1357.503 and who  
20 subsequently requests enrollment in a health benefit plan of that  
21 small employer, except where the employee or dependent qualifies  
22 for a special enrollment period provided pursuant to Section  
23 1357.503. It also means any member of an association that is a  
24 guaranteed association as well as any other person eligible to  
25 purchase through the guaranteed association when that person has  
26 failed to purchase coverage during the initial enrollment period  
27 provided under the terms of the guaranteed association’s plan  
28 contract consistent with the periods provided pursuant to Section  
29 1357.503 and who subsequently requests enrollment in the plan,  
30 except where that member or person qualifies for a special  
31 enrollment period provided pursuant to Section 1357.503.

32 (g) “New business” means a health care service plan contract  
33 issued to a small employer that is not the plan’s in force business.

34 (h) “Preexisting condition provision” means a contract provision  
35 that excludes coverage for charges or expenses incurred during a  
36 specified period following the enrollee’s effective date of coverage,  
37 as to a condition for which medical advice, diagnosis, care, or  
38 treatment was recommended or received during a specified period  
39 immediately preceding the effective date of coverage. No health  
40 care service plan shall limit or exclude coverage for any individual



1 based on a preexisting condition whether or not any medical advice,  
2 diagnosis, care, or treatment was recommended or received before  
3 that date.

4 (i) “Creditable coverage” means:

5 (1) Any individual or group policy, contract, or program that is  
6 written or administered by a disability insurer, health care service  
7 plan, fraternal benefits society, self-insured employer plan, or any  
8 other entity, in this state or elsewhere, and that arranges or provides  
9 medical, hospital, and surgical coverage not designed to supplement  
10 other private or governmental plans. The term includes continuation  
11 or conversion coverage but does not include accident only, credit,  
12 coverage for onsite medical clinics, disability income, Medicare  
13 supplement, long-term care, dental, vision, coverage issued as a  
14 supplement to liability insurance, insurance arising out of a  
15 workers’ compensation or similar law, automobile medical payment  
16 insurance, or insurance under which benefits are payable with or  
17 without regard to fault and that is statutorily required to be  
18 contained in any liability insurance policy or equivalent  
19 self-insurance.

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

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

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

26 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
27 (Civilian Health and Medical Program of the Uniformed Services  
28 (CHAMPUS)).

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

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

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

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

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

4 (j) “Rating period” means the period for which premium rates  
5 established by a plan are in effect and shall be no less than 12  
6 months from the date of issuance or renewal of the plan contract.

7 (k) (1) “Small employer” means any of the following:

8 (A) For plan years commencing on or after January 1, 2014,  
9 and on or before December 31, 2015, any person, firm, proprietary  
10 or nonprofit corporation, partnership, public agency, or association  
11 that is actively engaged in business or service, that, on at least 50  
12 percent of its working days during the preceding calendar quarter  
13 or preceding calendar year, employed at least one, but no more  
14 than 50, eligible employees, the majority of whom were employed  
15 within this state, that was not formed primarily for purposes of  
16 buying health care service plan contracts, and in which a bona fide  
17 employer-employee relationship exists. For plan years commencing  
18 on or after January 1, 2016, any person, firm, proprietary or  
19 nonprofit corporation, partnership, public agency, or association  
20 that is actively engaged in business or service, that, on at least 50  
21 percent of its working days during the preceding calendar quarter  
22 or preceding calendar year, employed at least one, but no more  
23 than 100, eligible employees, the majority of whom were employed  
24 within this state, that was not formed primarily for purposes of  
25 buying health care service plan contracts, and in which a bona fide  
26 employer-employee relationship exists. In determining whether  
27 to apply the calendar quarter or calendar year test, a health care  
28 service plan shall use the test that ensures eligibility if only one  
29 test would establish eligibility. In determining the number of  
30 eligible employees, companies that are affiliated companies and  
31 that are eligible to file a combined tax return for purposes of state  
32 taxation shall be considered one employer. Subsequent to the  
33 issuance of a health care service plan contract to a small employer  
34 pursuant to this article, and for the purpose of determining  
35 eligibility, the size of a small employer shall be determined  
36 annually. Except as otherwise specifically provided in this article,  
37 provisions of this article that apply to a small employer shall  
38 continue to apply until the plan contract anniversary following the  
39 date the employer no longer meets the requirements of this  
40 definition. It includes any small employer as defined in this

1 paragraph who purchases coverage through a guaranteed  
2 association, and any employer purchasing coverage for employees  
3 through a guaranteed association. This subparagraph shall be  
4 implemented to the extent consistent with PPACA, except that the  
5 minimum requirement of one employee shall be implemented only  
6 to the extent required by PPACA.

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

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

14 (l) “Guaranteed association” means a nonprofit organization  
15 comprised of a group of individuals or employers who associate  
16 based solely on participation in a specified profession or industry,  
17 accepting for membership any individual or employer meeting its  
18 membership criteria, and that (1) includes one or more small  
19 employers as defined in subparagraph (A) of paragraph (1) of  
20 subdivision (k), (2) does not condition membership directly or  
21 indirectly on the health or claims history of any person, (3) uses  
22 membership dues solely for and in consideration of the membership  
23 and membership benefits, except that the amount of the dues shall  
24 not depend on whether the member applies for or purchases  
25 insurance offered to the association, (4) is organized and  
26 maintained in good faith for purposes unrelated to insurance, (5)  
27 has been in active existence on January 1, 1992, and for at least  
28 five years prior to that date, (6) has included health insurance as  
29 a membership benefit for at least five years prior to January 1,  
30 1992, (7) has a constitution and bylaws, or other analogous  
31 governing documents that provide for election of the governing  
32 board of the association by its members, (8) offers any plan contract  
33 that is purchased to all individual members and employer members  
34 in this state, (9) includes any member choosing to enroll in the  
35 plan contracts offered to the association provided that the member  
36 has agreed to make the required premium payments, and (10)  
37 covers at least 1,000 persons with the health care service plan with  
38 which it contracts. The requirement of 1,000 persons may be met  
39 if component chapters of a statewide association contracting

1 separately with the same carrier cover at least 1,000 persons in the  
2 aggregate.

3 This subdivision applies regardless of whether a contract issued  
4 by a plan is with an association, or a trust formed for or sponsored  
5 by an association, to administer benefits for association members.

6 For purposes of this subdivision, an association formed by a  
7 merger of two or more associations after January 1, 1992, and  
8 otherwise meeting the criteria of this subdivision shall be deemed  
9 to have been in active existence on January 1, 1992, if its  
10 predecessor organizations had been in active existence on January  
11 1, 1992, and for at least five years prior to that date and otherwise  
12 met the criteria of this subdivision.

13 (m) “Members of a guaranteed association” means any  
14 individual or employer meeting the association’s membership  
15 criteria if that person is a member of the association and chooses  
16 to purchase health coverage through the association. At the  
17 association’s discretion, it also may include employees of  
18 association members, association staff, retired members, retired  
19 employees of members, and surviving spouses and dependents of  
20 deceased members. However, if an association chooses to include  
21 these persons as members of the guaranteed association, the  
22 association shall make that election in advance of purchasing a  
23 plan contract. Health care service plans may require an association  
24 to adhere to the membership composition it selects for up to 12  
25 months.

26 (n) “Affiliation period” means a period that, under the terms of  
27 the health care service plan contract, must expire before health  
28 care services under the contract become effective.

29 (o) “Grandfathered health plan” has the meaning set forth in  
30 Section 1251 of PPACA.

31 (p) “Nongrandfathered small employer health care service plan  
32 contract” means a small employer health care service plan contract  
33 that is not a grandfathered health plan.

34 (q) “Plan year” has the meaning set forth in Section 144.103 of  
35 Title 45 of the Code of Federal Regulations.

36 (r) “PPACA” means the federal Patient Protection and  
37 Affordable Care Act (Public Law 111-148), as amended by the  
38 federal Health Care and Education Reconciliation Act of 2010  
39 (Public Law 111-152), and any rules, regulations, or guidance  
40 issued thereunder.

1 (s) “Small employer health care service plan contract” means  
2 a health care service plan contract issued to a small employer.

3 (t) “Waiting period” means a period that is required to pass with  
4 respect to an employee before the employee is eligible to be  
5 covered for benefits under the terms of the contract.

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

9 (v) “Family” means the subscriber and his or her dependent  
10 or dependents.

11 ~~SEC. 3.~~

12 *SEC. 4.* Section 1357.503 of the Health and Safety Code is  
13 amended to read:

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

20 (2) On and after October 1, 2013, a plan shall make available  
21 to each small employer all small employer health care service plan  
22 contracts that the plan offers and sells to small employers or to  
23 associations that include small employers in this state for plan  
24 years on or after January 1, 2014. Health coverage through an  
25 association that is not related to employment shall be considered  
26 individual coverage pursuant to Section 144.102(c) of Title 45 of  
27 the Code of *Federal* Regulations.

28 (3) A plan that offers qualified health plans through the  
29 Exchange shall be deemed to be in compliance with paragraphs  
30 (1) and (2) with respect to small employer health care service plan  
31 contracts offered through the Exchange in those geographic regions  
32 in which the plan offers plan contracts through the Exchange.

33 (b) A plan shall provide enrollment periods consistent with  
34 PPACA and described in Section 155.725 of Title 45 of the Code  
35 of Federal Regulations. Commencing January 1, 2014, a plan shall  
36 provide special enrollment periods consistent with the special  
37 enrollment periods described in Section 1399.849, *to the extent*  
38 *permitted by PPACA*, except for the triggering events identified  
39 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of

1 the Code of Federal Regulations with respect to plan contracts  
2 offered through the Exchange.

3 (c) No plan or solicitor shall induce or otherwise encourage a  
4 small employer to separate or otherwise exclude an eligible  
5 employee from a health care service plan contract that is provided  
6 in connection with employee's employment or membership in a  
7 guaranteed association.

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

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

32 (1) The small employer offers health benefits to 100 percent of  
33 its eligible employees. Employees who waive coverage on the  
34 grounds that they have other group coverage shall not be counted  
35 as eligible employees.

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

38 (3) The small employer agrees to inform the small employer's  
39 employees of the availability of coverage and the provision that  
40 those not electing coverage must wait until the next open

1 enrollment or a special enrollment period to obtain coverage  
2 through the group if they later decide they would like to have  
3 coverage.

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

8 (f) No plan or solicitor shall, directly or indirectly, engage in  
9 the following activities:

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

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

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

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

37 (h) (1) A policy or contract that covers a small employer, as  
38 defined in Section 1304(b) of PPACA and in Section 1357.500,  
39 shall not establish rules for eligibility, including continued  
40 eligibility, of an individual, or dependent of an individual, to enroll

1 under the terms of the policy or contract based on any of the  
2 following health status-related factors:

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

15 (2) Notwithstanding Section 1389.1, a health care service plan  
16 shall not require an eligible employee or dependent to fill out a  
17 health assessment or medical questionnaire prior to enrollment  
18 under a small employer health care service plan contract. A health  
19 care service plan shall not acquire or request information that  
20 relates to a health status-related factor from the applicant or his or  
21 her dependent or any other source prior to enrollment of the  
22 individual.

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

31 (2) Each calendar year, a health care service plan shall establish  
32 an index rate for the small employer market in the state based on  
33 the total combined claims costs for providing essential health  
34 benefits, as defined pursuant to Section 1302 of PPACA and  
35 Section 1367.005, within the single risk pool required under  
36 paragraph (1). The index rate shall be adjusted on a marketwide  
37 basis based on the total expected marketwide payments and charges  
38 under the risk adjustment and reinsurance programs established  
39 for the state pursuant to Sections 1343 and 1341 of PPACA. The  
40 premium rate for all of the health care service plan's



1 nongrandfathered small employer health care service plan contracts  
2 shall use the applicable index rate, as adjusted for total expected  
3 marketwide payments and charges under the risk adjustment and  
4 reinsurance programs established for the state pursuant to Sections  
5 1343 and 1341 of PPACA, subject only to the adjustments  
6 permitted under paragraph (3).

7 (3) A health care service plan may vary premium rates for a  
8 particular nongrandfathered small employer health care service  
9 plan contract from its index rate based only on the following  
10 actuarially justified plan-specific factors:

11 (A) The actuarial value and cost-sharing design of the plan  
12 contract.

13 (B) The plan contract’s provider network, delivery system  
14 characteristics, and utilization management practices.

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

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

25 (E) Administrative costs, excluding any user fees—~~regulated~~  
26 *required* by the Exchange.

27 (j) A plan shall comply with the requirements of Section 1374.3.

28 (k) (1) Except as provided in paragraph (2), if Section 2702 of  
29 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1),  
30 as added by Section 1201 of PPACA, is repealed, this section shall  
31 become inoperative 12 months after the repeal date, in which case  
32 health care service plans subject to this section shall instead be  
33 governed by Section 1357.03 to the extent permitted by federal  
34 law, and all references in this article to this section shall instead  
35 refer to Section 1357.03 except for purposes of paragraph—~~(3)~~: (2).

36 (2) Subdivision (b) shall remain operative with respect to health  
37 care service plan contracts offered through the Exchange.

38 ~~SEC. 4.~~

39 *SEC. 5.* Section 1357.504 of the Health and Safety Code is  
40 amended to read:

1 1357.504. (a) With respect to small employer health care  
2 service plan contracts offered outside the Exchange, after a small  
3 employer submits a completed application form for a plan contract,  
4 the health care service plan shall, within 30 days, notify the  
5 employer of the employer's actual premium charges for that plan  
6 contract established in accordance with Section 1357.512. The  
7 employer shall have 30 days in which to exercise the right to buy  
8 coverage at the quoted premium charges.

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

18 (c) (1) With respect to a small employer health care service  
19 plan contract offered through the Exchange, a plan shall apply  
20 coverage effective dates consistent with those required under  
21 Section 155.720 of Title 45 of the Code of Federal Regulations  
22 and paragraph (2) of subdivision (e) of Section 1399.849.

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

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

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

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

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

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

8 ~~SEC. 5.~~

9 *SEC. 6.* Section 1357.509 of the Health and Safety Code is  
10 amended to read:

11 1357.509. (a) To the extent permitted by PPACA, a plan shall  
12 not be required to offer a health care service plan contract or accept  
13 applications for the contract pursuant to this article in the case of  
14 any of the following:

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

18 (2) (A) Within a specific service area or portion of a service  
19 area, if a plan reasonably anticipates and demonstrates to the  
20 satisfaction of the director ~~both~~ *all* of the following:

21 (i) It will not have sufficient health care delivery resources to  
22 ensure that health care services will be available and accessible to  
23 the eligible employee and dependents of the employee because of  
24 its obligations to existing enrollees.

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

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

31 (B) A plan that cannot offer a health care service plan contract  
32 to small employers because it is lacking in sufficient health care  
33 delivery resources within a service area or a portion of a service  
34 area pursuant to subparagraph (A) may not offer a contract in the  
35 area in which the plan is not offering coverage to small employers  
36 to new employer groups until the later of the following dates:

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

39 (ii) The date the plan notifies the director that it has the ability  
40 to deliver services to small employer groups, and certifies to the

1 director that from the date of the notice it will enroll all small  
2 employer groups requesting coverage in that area from the plan .

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

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

9 (b) (1) A health care service plan may decline to offer a health  
10 care service plan contract to a small employer if the plan  
11 demonstrates to the satisfaction of the director both of the  
12 following:

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

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

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

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

28 (B) The date the plan demonstrates to the satisfaction of the  
29 director that the plan has sufficient financial reserves necessary to  
30 underwrite additional coverage.

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

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

37 (c) Nothing in this article shall be construed to limit the  
38 director's authority to develop and implement a plan of  
39 rehabilitation for a health care service plan whose financial viability

1 or organizational and administrative capacity has become impaired,  
2 to the extent permitted by PPACA.

3 ~~SEC. 6.~~

4 *SEC. 7.* Section 1357.512 of the Health and Safety Code is  
5 amended to read:

6 1357.512. (a) The premium rate for a small employer health  
7 care service plan contract *issued, amended, or renewed on or after*  
8 *January 1, 2014*, shall vary with respect to the particular coverage  
9 involved only by the following:

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

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

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

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

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

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

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

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

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

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

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

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

- 1 (xi) Region 11 shall consist of the Counties of Fresno, Kings,
- 2 and Madera.
- 3 (xii) Region 12 shall consist of the Counties of San Luis Obispo,
- 4 Santa Barbara, and Ventura.
- 5 (xiii) Region 13 shall consist of the Counties of Imperial, Inyo,
- 6 and Mono.
- 7 (xiv) Region 14 shall consist of the County of Kern.
- 8 (xv) Region 15 shall consist of the ZIP Codes in the County of
- 9 Los Angeles starting with 906 to 912, inclusive, 915, 917, 918,
- 10 and 935.
- 11 (xvi) Region 16 shall consist of the ZIP Codes in the County of
- 12 Los Angeles other than those identified in clause (xv).
- 13 (xvii) Region 17 shall consist of the Counties of Riverside and
- 14 San Bernardino.
- 15 (xviii) Region 18 shall consist of the County of Orange.
- 16 (xix) Region 19 shall consist of the County of San Diego.
- 17 (B) No later than June 1, 2017, the department, in collaboration
- 18 with the Exchange and the Department of Insurance, shall review
- 19 the geographic rating regions specified in this paragraph and the
- 20 impacts of those regions on the health care coverage market in
- 21 California, and submit a report to the appropriate policy committees
- 22 of the Legislature. The requirement for submitting a report under
- 23 this subparagraph is inoperative June 1, 2021, pursuant to Section
- 24 10231.5 of the Government Code.
- 25 (3) Whether the contract covers an individual or family, as
- 26 described in PPACA.
- 27 (b) The rate for a health care service plan contract subject to
- 28 this section shall not vary by any factor not described in this
- 29 section.
- 30 (c) The total premium charged to a small employer pursuant to
- 31 this section shall be determined by summing the premiums of
- 32 covered employees and dependents in accordance with Section
- 33 147.102(c)(1) of Title 45 of the Code of Federal Regulations.
- 34 (d) The rating period for rates subject to this section shall be no
- 35 less than 12 months from the date of issuance or renewal of the
- 36 plan contract.
- 37 (e) If Section 2701 of the federal Public Health Service Act (42
- 38 U.S.C. Sec. 300gg), as added by Section 1201 of PPACA, is
- 39 repealed, this section shall become inoperative 12 months after
- 40 the repeal date, in which case rates for health care service plan

1 contracts subject to this section shall instead be subject to Section  
2 1357.12, to the extent permitted by federal law, and all references  
3 to this section shall be deemed to be references to Section 1357.12.

4 ~~SEC. 7.~~

5 *SEC. 8.* Section 1363 of the Health and Safety Code is amended  
6 to read:

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

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

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

25 (2) The exceptions, reductions, and limitations that apply to the  
26 plan.

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

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

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

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

39 (A) (i) States that the evidence of coverage discloses the terms  
40 and conditions of coverage.

1 (ii) States, with respect to individual plan contracts, small group  
2 plan contracts, and any other group plan contracts for which health  
3 care services are not negotiated, that the applicant has a right to  
4 view the evidence of coverage prior to enrollment, and, if the  
5 evidence of coverage is not combined with the disclosure form,  
6 the notice shall specify where the evidence of coverage can be  
7 obtained prior to enrollment.

8 (B) Includes a statement that the disclosure and the evidence of  
9 coverage should be read completely and carefully and that  
10 individuals with special health care needs should read carefully  
11 those sections that apply to them.

12 (C) Includes the plan’s telephone number or numbers that may  
13 be used by an applicant to receive additional information about  
14 the benefits of the plan or a statement where the telephone number  
15 or numbers are located in the disclosure form.

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

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

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

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

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

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

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

39 (12) A description of any limitations on the patient’s choice of  
40 primary care physician, specialty care physician, or nonphysician



1 health care practitioner, based on service area and limitations on  
2 the patient's choice of acute care hospital care, subacute or  
3 transitional inpatient care, or skilled nursing facility.

4 (13) General authorization requirements for referral by a primary  
5 care physician to a specialty care physician or a nonphysician  
6 health care practitioner.

7 (14) Conditions and procedures for disenrollment.

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

11 (16) Information concerning the right of an enrollee to request  
12 an independent review in accordance with Article 5.55  
13 (commencing with Section 1374.30).

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

15 (b) (1) As of July 1, 1999, the director shall require each plan  
16 offering a contract to an individual or small group to provide with  
17 the disclosure form for individual and small group plan contracts  
18 a uniform health plan benefits and coverage matrix containing the  
19 plan's major provisions in order to facilitate comparisons between  
20 plan contracts. The uniform matrix shall include the following  
21 category descriptions together with the corresponding copayments  
22 and limitations in the following sequence:

23 (A) Deductibles.

24 (B) Lifetime maximums.

25 (C) Professional services.

26 (D) Outpatient services.

27 (E) Hospitalization services.

28 (F) Emergency health coverage.

29 (G) Ambulance services.

30 (H) Prescription drug coverage.

31 (I) Durable medical equipment.

32 (J) Mental health services.

33 (K) Chemical dependency services.

34 (L) Home health services.

35 (M) Other.

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

38

39 **THIS MATRIX IS INTENDED TO BE USED TO HELP YOU**  
40 **COMPARE COVERAGE BENEFITS AND IS A SUMMARY**

1 ONLY. THE EVIDENCE OF COVERAGE AND PLAN  
2 CONTRACT SHOULD BE CONSULTED FOR A DETAILED  
3 DESCRIPTION OF COVERAGE BENEFITS AND  
4 LIMITATIONS.

5

6 (3) (A) A health care service plan contract subject to Section  
7 2715 of the federal Public Health Service Act (42 U.S.C. *Sec.*  
8 300gg-15), shall satisfy the requirements of this subdivision by  
9 providing the uniform summary of benefits and coverage required  
10 under Section 2715 of the federal Public Health Service Act (42  
11 U.S.C. *Sec.* 300gg-15) and any rules or regulations issued  
12 thereunder. A health care service plan that issues the uniform  
13 summary of benefits referenced in this paragraph shall do both of  
14 the following:

15 (i) Ensure that all applicable benefit disclosure requirements  
16 specified in this chapter and in Title 28 of the California Code of  
17 Regulations are met in other health plan documents provided to  
18 enrollees under the provisions of this chapter.

19 (ii) Consistent with applicable law, advise applicants and  
20 enrollees, in a prominent place in the plan documents referenced  
21 in subdivision (a), that enrollees are not financially responsible in  
22 payment of emergency care services, in any amount that the health  
23 care service plan is obligated to pay, beyond the enrollee's  
24 copayments, coinsurance, and deductibles as provided in the  
25 enrollee's health care service plan contract.

26 (B) Subdivision (c) shall not apply to a health care service plan  
27 contract subject to subparagraph (A).

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

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

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

1 (f) Group contractholders shall disseminate copies of the  
2 completed disclosure form to all persons eligible to be a subscriber  
3 under the group contract at the time those persons are offered the  
4 plan. If the individual group members are offered a choice of plans,  
5 separate disclosure forms shall be supplied for each plan available.  
6 Each group contractholder shall also disseminate or cause to be  
7 disseminated copies of the evidence of coverage to all applicants,  
8 upon request, prior to enrollment and to all subscribers enrolled  
9 under the group contract.

10 (g) In the case of conflicts between the group contract and the  
11 evidence of coverage, the provisions of the evidence of coverage  
12 shall be binding upon the plan notwithstanding any provisions in  
13 the group contract that may be less favorable to subscribers or  
14 enrollees.

15 (h) In addition to the other disclosures required by this section,  
16 every health care service plan and any agent or employee of the  
17 plan shall, when presenting a plan for examination or sale to any  
18 individual purchaser or the representative of a group consisting of  
19 25 or fewer individuals, disclose in writing the ratio of premium  
20 costs to health services paid for plan contracts with individuals  
21 and with groups of the same or similar size for the plan's preceding  
22 fiscal year. A plan may report that information by geographic area,  
23 provided the plan identifies the geographic area and reports  
24 information applicable to that geographic area.

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

28 ~~SEC. 8.~~

29 *SEC. 9.* Section 1389.4 of the Health and Safety Code is  
30 amended to read:

31 1389.4. (a) A full service health care service plan that issues,  
32 renews, or amends individual health plan contracts shall be subject  
33 to this section.

34 (b) A health care service plan subject to this section shall have  
35 written policies, procedures, or underwriting guidelines establishing  
36 the criteria and process whereby the plan makes its decision to  
37 provide or to deny coverage to ~~dependents~~ *individuals* applying  
38 for coverage and sets the rate for that coverage. These guidelines,  
39 policies, or procedures shall ~~assure~~ *ensure* that the plan rating and

1 underwriting criteria comply with Sections 1365.5 and 1389.1 and  
2 all other applicable provisions of state and federal law.

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

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

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

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

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

1 (g) (1) This section shall become inoperative on November 1,  
2 2013, or the 91st calendar day following the adjournment of the  
3 2013–14 First Extraordinary Session, whichever date is later.

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

10 ~~SEC. 9.~~

11 *SEC. 10.* Section 1389.4 is added to the Health and Safety  
12 Code, to read:

13 1389.4. (a) A full service health care service plan that renews  
14 individual grandfathered health *benefit* plans shall be subject to  
15 this section.

16 (b) A health care service plan subject to this section shall have  
17 written policies, procedures, or underwriting guidelines establishing  
18 the criteria and process whereby the plan makes its decision to  
19 provide or to deny coverage to dependents applying for an  
20 individual grandfathered health plan and sets the rate for that  
21 coverage. These guidelines, policies, or procedures shall ensure  
22 that the plan rating and underwriting criteria comply with Sections  
23 1365.5 and 1389.1 and all other applicable provisions of state and  
24 federal law.

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

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

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

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

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

13 (f) (1) This section shall become operative on November 1,  
 14 2013, or the 91st calendar day following the adjournment of the  
 15 2013–14 First Extraordinary Session, whichever date is later.

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

22 ~~SEC. 10.~~

23 *SEC. 11.* Section 1389.5 of the Health and Safety Code is  
 24 amended to read:

25 1389.5. (a) This section shall apply to a health care service  
 26 plan that provides coverage under an individual plan contract that  
 27 is issued, amended, delivered, or renewed on or after January 1,  
 28 2007.

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

35 “Without medical underwriting” means that the health care  
 36 service plan shall not decline to offer coverage to, or deny  
 37 enrollment of, the individual or impose any preexisting condition  
 38 exclusion on the individual who transfers to another individual  
 39 plan contract pursuant to this section.

1 (c) The plan shall establish, for the purposes of subdivision (b),  
2 a ranking of the individual plan contracts it offers to individual  
3 purchasers and post the ranking on its Internet Web site or make  
4 the ranking available upon request. The plan shall update the  
5 ranking whenever a new benefit design for individual purchasers  
6 is approved.

7 (d) The plan shall notify in writing all enrollees of the right to  
8 transfer to another individual plan contract pursuant to this section,  
9 at a minimum, when the plan changes the enrollee's premium rate.  
10 Posting this information on the plan's Internet Web site shall not  
11 constitute notice for purposes of this subdivision. The notice shall  
12 adequately inform enrollees of the transfer rights provided under  
13 this section, including information on the process to obtain details  
14 about the individual plan contracts available to that enrollee and  
15 advising that the enrollee may be unable to return to his or her  
16 current individual plan contract if the enrollee transfers to another  
17 individual plan contract.

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

20 (1) A federally eligible defined individual, as defined in  
21 subdivision (c) of Section 1399.801, who is enrolled in an  
22 individual health benefit plan contract offered pursuant to Section  
23 1366.35.

24 (2) An individual offered conversion coverage pursuant to  
25 Section 1373.6.

26 (3) Individual coverage under a specialized health care service  
27 plan contract.

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

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

34 (6) An individual enrolled in the Healthy Families Program  
35 pursuant to Part 6.2 (commencing with Section 12693) of Division  
36 2 of the Insurance Code.

37 (f) It is the intent of the Legislature that individuals shall have  
38 more choice in their health coverage when health care service plans  
39 guarantee the right of an individual to transfer to another product  
40 based on the plan's own ranking system. The Legislature does not

1 intend for the department to review or verify the plan’s ranking  
2 for actuarial or other purposes.

3 (g) (1) This section shall become inoperative January 1, 2014,  
4 or the 91st calendar day following the adjournment of the 2013–14  
5 First Extraordinary Session, whichever date is later.

6 (2) If Section 5000A of the Internal Revenue Code, as added  
7 by Section 1501 of PPACA, is repealed or amended to no longer  
8 apply to the individual market, as defined in Section 2791 of the  
9 federal Public Health—~~Services~~ *Service* Act (42 U.S.C. Sec.  
10 300gg-4), this section shall become operative 12 months after the  
11 date of ~~such~~ *that* repeal or amendment.

12 ~~SEC. 11.~~

13 *SEC. 12.* Section 1389.7 of the Health and Safety Code is  
14 amended to read:

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

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

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

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



1 individual plan contract that was rescinded and the health care  
2 service plan shall credit any time that the individual was covered  
3 under the rescinded individual plan contract.

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

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

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

16 (h) (1) This section shall become inoperative on January 1,  
17 2014, or the 91st calendar day following the adjournment of the  
18 2013–14 First Extraordinary Session, whichever date is later.

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

25 ~~SEC. 12.~~

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

28 1389.7. (a) Every health care service plan that offers, issues,  
29 or renews individual plan contracts shall offer to any individual,  
30 who was covered by the plan under an individual plan contract  
31 that was rescinded, a new individual plan contract that provides  
32 the most equivalent benefits.

33 (b) ~~If a new individual plan contract is issued under subdivision~~  
34 ~~(a), the plan may revise the~~ *A health care service plan that offers,*  
35 *issues, or renews individual plan contracts inside or outside the*  
36 *California Health Benefit Exchange may also permit an individual,*  
37 *who was covered by the plan under an individual plan contract*  
38 *that was rescinded, to remain covered under that individual plan*  
39 *contract, with a revised premium rate to reflect only that reflects*

1 the number of persons ~~covered~~ *remaining* on the ~~new~~ individual  
2 plan contract consistent with Section 1399.855.

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

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

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

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

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

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

26 ~~SEC. 13.~~

27 *SEC. 14.* Section 1399.816 of the Health and Safety Code is  
28 repealed.

29 ~~SEC. 14.~~

30 *SEC. 15.* The heading of Article 11.7 (commencing with  
31 Section 1399.825) of Chapter 2.2 of Division 2 of the Health and  
32 Safety Code is amended to read:

33  
34 Article 11.7. Child Access to Health Care Coverage  
35

36 ~~SEC. 15.~~

37 *SEC. 16.* Section 1399.829 of the Health and Safety Code is  
38 amended to read:

39 1399.829. (a) A health care service plan may use the following  
40 characteristics of an eligible child for purposes of establishing the

1 rate of the plan contract for that child, where consistent with federal  
2 regulations under PPACA: age, geographic region, and family  
3 composition, plus the health care service plan contract selected by  
4 the child or the responsible party for the child.

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

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

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

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

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

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

33  
34 “Please consider your options carefully before failing to maintain  
35 or renewing coverage for a child for whom you are responsible.  
36 If you attempt to obtain new individual coverage for that child,  
37 the premium for the same coverage may be higher than the  
38 premium you pay now.”  
39

1 (d) A child who applied for coverage between September 23,  
2 2010, and the end of the initial open enrollment period shall be  
3 deemed to have maintained coverage during that period.

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

7 (f) Health care service plans shall not require documentation  
8 from applicants relating to their coverage history.

9 (g) (1) On and after the operative date of the act adding this  
10 subdivision, and until January 1, 2014, a health care service plan  
11 shall provide the model notice, as provided in paragraph (3), to all  
12 applicants for coverage under this article and to all enrollees, or  
13 the responsible party for an enrollee, renewing coverage under this  
14 article that contains the following information:

15 (A) Information about the open enrollment period provided  
16 under Section 1399.849.

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

21 (C) An explanation that coverage purchased pursuant to this  
22 article shall be effective as required under subdivision (d) of  
23 Section 1399.826 and that such coverage shall not prevent an  
24 applicant from obtaining new coverage during the open enrollment  
25 period described in Section 1399.849.

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

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

32 (3) The department shall adopt a uniform model notice to be  
33 used by health care service plans in order to comply with this  
34 subdivision, and shall consult with the Department of Insurance  
35 in adopting that uniform model notice. Use of the model notice  
36 shall not require prior approval of the department. The model  
37 notice adopted by the department for purposes of this section shall  
38 not be subject to the Administrative Procedure Act (Chapter 3.5  
39 (commencing with Section 11340) of Part 1 of Division 3 of Title  
40 2 of the Government Code).

1 ~~SEC. 16.~~

2 *SEC. 17.* Section 1399.836 is added to the Health and Safety  
3 Code, to read:

4 1399.836. (a) This article shall become inoperative on January  
5 1, 2014, or the 91st calendar day following the adjournment of the  
6 2013–14 First Extraordinary Session, whichever date is later.

7 (b) If Section 5000A of the Internal Revenue Code, as added  
8 by Section 1501 of PPACA, is repealed or amended to no longer  
9 apply to the individual market, as defined in Section 2791 of the  
10 federal Public Health–~~Services~~ *Service* Act (42 U.S.C. Sec.  
11 300gg-4), this article shall become operative 12 months after the  
12 date of ~~the~~ *that* repeal or amendment.

13 ~~SEC. 17.~~

14 *SEC. 18.* Article 11.8 (commencing with Section 1399.845) is  
15 added to Chapter 2.2 of Division 2 of the Health and Safety Code,  
16 to read:

17

18 Article 11.8. Individual Access to Health Care Coverage

19

20 1399.845. For purposes of this article, the following definitions  
21 shall apply:

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

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

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

30 (d) “Family” means the subscriber and his or her dependent or  
31 dependents.

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

34 (f) “Health benefit plan” means any individual or group health  
35 care service plan contract that provides medical, hospital, and  
36 surgical benefits. The term does not include a specialized health  
37 care service plan contract, a health care service plan contract  
38 provided in the Medi-Cal program (Chapter 7 (commencing with  
39 Section 14000) of Part 3 of Division 9 of the Welfare and  
40 Institutions Code), the Healthy Families Program (Part 6.2

1 (commencing with Section 12693) of Division 2 of the Insurance  
2 Code), the Access for Infants and Mothers Program (Part 6.3  
3 (commencing with Section 12695) of Division 2 of the Insurance  
4 Code), or the program under Part 6.4 (commencing with Section  
5 12699.50) of Division 2 of the Insurance Code, or Medicare  
6 supplement coverage, to the extent consistent with PPACA.

7 (g) “Policy year” means the period from January 1 to December  
8 31, inclusive.

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

14 (i) “Preexisting condition provision” means a contract provision  
15 that excludes coverage for charges or expenses incurred during a  
16 specified period following the enrollee’s effective date of coverage,  
17 as to a condition for which medical advice, diagnosis, care, or  
18 treatment was recommended or received during a specified period  
19 immediately preceding the effective date of coverage.

20 (j) “Rating period” means the calendar year for which premium  
21 rates are in effect pursuant to subdivision (d) of Section ~~1399.85-~~  
22 ~~1399.855.~~

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

26 1399.847. Except as provided in Sections ~~1399.858, 1399.859,~~  
27 ~~1399.858~~ and 1399.861, the provisions of this article shall only  
28 apply with respect to nongrandfathered individual health benefit  
29 plans offered by a health care service plan, and shall apply in  
30 addition to the other provisions of this chapter and the rules adopted  
31 thereunder.

32 1399.849. (a) (1) On and after October 1, 2013, a plan shall  
33 fairly and affirmatively offer, market, and sell all of the plan’s  
34 health benefit plans that are sold in the individual market for policy  
35 years on or after January 1, 2014, to all individuals and dependents  
36 in each service area in which the plan provides or arranges for the  
37 provision of health care services. A plan shall limit enrollment in  
38 individual health benefit plans to open enrollment periods and  
39 special enrollment periods as provided in subdivisions (c) and (d).

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

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

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

14 (2) Pursuant to Section ~~147.140(b)(2)~~ *147.104(b)(2)* of Title 45  
15 of the Code of Federal Regulations, for individuals enrolled in  
16 noncalendar year individual health plan contracts, a plan shall  
17 provide a limited open enrollment period beginning on the date  
18 that is 30 calendar days prior to the date the policy year ends in  
19 2014.

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (2) With respect to individual health benefit plans offered  
25 outside the Exchange, an individual shall have 60 days from the  
26 date of a triggering event identified in paragraph (1) to apply for  
27 coverage from a health care service plan subject to this section.  
28 With respect to individual health benefit plans offered through the  
29 Exchange, an individual shall have 60 days from the date of a  
30 triggering event identified in paragraph (1) to select a plan offered  
31 through the Exchange, unless a longer period is provided in Part  
32 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
33 A of Title 45 of the Code of Federal Regulations.

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



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

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

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

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

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

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

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

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

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

22 (A) Health status.

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

24 (C) Claims experience.

25 (D) Receipt of health care.

26 (E) Medical history.

27 (F) Genetic information.

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

30 (H) Disability.

31 (I) Any other health status-related factor as determined by any  
32 federal regulations, rules, or guidance issued pursuant to Section  
33 2705 of the federal Public Health Service Act.

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

1 (h) (1) A health care service plan shall consider as a single risk  
2 pool for rating purposes in the individual market the claims  
3 experience of all *insureds and enrollees* in all nongrandfathered  
4 individual health benefit plans offered by ~~the~~ *that* health care  
5 service plan in this state, whether offered as health care service  
6 plan contracts or individual health insurance policies, including  
7 *those insureds and enrollees* who enroll in *individual coverage*  
8 through the Exchange and *insureds and enrollees who enroll in*  
9 *individual coverage* outside of the Exchange. *Student health*  
10 *insurance coverage, as that coverage is defined in Section*  
11 *147.145(a) of Title 45 of the Code of Federal Regulations, shall*  
12 *not be included in a health care service plan's single risk pool for*  
13 *individual coverage.*

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

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

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

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

36 (C) The benefits provided under the health benefit plan that are  
37 in addition to the essential health benefits, as defined pursuant to  
38 Section 1302 of PPACA and Section 1367.005. These additional  
39 benefits shall be pooled with similar benefits within the single risk  
40 pool required under paragraph (1) and the claims experience from

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

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

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

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

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

13 (k) If Section 5000A of the Internal Revenue Code, as added  
14 by Section 1501 of PPACA, is repealed or amended to no longer  
15 apply to the individual market, as defined in Section 2791 of the  
16 federal Public Health—~~Services~~ *Service* Act (42 U.S.C. Sec.  
17 300gg-4), subdivisions (a), (b), and (g) shall become inoperative  
18 12 months after ~~the~~ *that* repeal or amendment.

19 1399.851. (a) Commencing October 1, 2013, a health care  
20 service plan or solicitor shall not, directly or indirectly, engage in  
21 the following activities:

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

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

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

39 (b) Commencing October 1, 2013, a health care service plan  
40 shall not, directly or indirectly, enter into any contract, agreement,

1 or arrangement with a solicitor that provides for or results in the  
2 compensation paid to a solicitor for the sale of an individual health  
3 benefit plan to be varied because of the health status, claims  
4 experience, industry, occupation, or geographic location of the  
5 individual. This subdivision does not apply to a compensation  
6 arrangement that provides compensation to a solicitor on the basis  
7 of percentage of premium, provided that the percentage shall not  
8 vary because of the health status, claims experience, industry,  
9 occupation, or geographic area of the individual.

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

12 1399.853. (a) An individual health benefit plan shall be  
13 renewable at the option of the enrollee except as permitted to be  
14 canceled, rescinded, or not renewed pursuant to Section 1365 and  
15 Section 155.430(b) of Title 45 of the Code of Federal Regulations.

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

20 1399.855. (a) With respect to individual health benefit plans  
21 for policy years on or after January 1, 2014, a health care service  
22 plan may use only the following characteristics of an individual,  
23 and any dependent thereof, for purposes of establishing the rate  
24 of the individual health benefit plan covering the individual and  
25 the eligible dependents thereof, along with the health benefit plan  
26 selected by the individual:

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

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

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

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

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

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

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

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

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

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

28 1399.857. (a) A health care service plan shall not be required  
29 to offer an individual health benefit plan or accept applications for  
30 the plan pursuant to Section 1399.849 in the case of any of the  
31 following:

32 (1) To an individual who does not live or reside within the plan’s  
33 approved service areas.

34 (2) (A) Within a specific service area or portion of a service  
35 area, if the plan reasonably anticipates and demonstrates to the  
36 satisfaction of the director both of the following:

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

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

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

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

12 (ii) The date the plan notifies the director that it has the ability  
13 to deliver services to individuals, and certifies to the director that  
14 from the date of the notice it will enroll all individuals requesting  
15 coverage in that area from the plan.

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

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

21 (b) (1) A health care service plan may decline to offer an  
22 individual health benefit plan to an individual if the plan  
23 demonstrates to the satisfaction of the director both of the  
24 following:

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

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

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

36 (A) The 181st day after the date that coverage is denied pursuant  
37 to ~~paragraph (1)~~. *this subdivision*.

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



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

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

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

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

13 1399.858. The director may require a plan to discontinue the  
14 offering of contracts or acceptance of applications from any  
15 individual, or responsible party for an individual, upon a  
16 determination by the director that the plan does not have sufficient  
17 financial viability, or organizational and administrative capacity  
18 to ensure the delivery of health care services to its enrollees. In  
19 determining whether the conditions of this section have been met,  
20 the director shall consider, but not be limited to, the plan's  
21 compliance with the requirements of Section 1367, Article 6  
22 (commencing with Section 1375), and the rules adopted thereunder.

23 1399.859. (a) A health care service plan that receives an  
24 application for an individual health benefit plan outside the  
25 Exchange during the initial open enrollment period, an annual  
26 enrollment period, or a special enrollment period described in  
27 Section 1399.849 shall inform the applicant that he or she may be  
28 eligible for lower cost coverage through the Exchange and shall  
29 inform the applicant of the applicable enrollment period provided  
30 through the Exchange described in Section 1399.849.

31 (b) On or before October 1, 2013, and annually every October  
32 1 thereafter, a health care service plan shall issue a notice to a  
33 subscriber enrolled in an individual health benefit plan offered  
34 outside the Exchange. The notice shall inform the subscriber that  
35 he or she may be eligible for lower cost coverage through the  
36 Exchange and shall inform the subscriber of the applicable open  
37 enrollment period provided through the Exchange described in  
38 Section 1399.849.

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

4 1399.861. (a) On or before October 1, 2013, and annually  
5 every October 1 thereafter, a health care service plan shall issue  
6 the following notice to all subscribers enrolled in an individual  
7 health benefit plan that is a grandfathered health plan:

8  
9 New improved health insurance options are available in  
10 California. You currently have health insurance that is not required  
11 to follow many of the new laws. For example, your plan may not  
12 provide preventive health services without you having to pay any  
13 cost sharing (copayments or coinsurance). Also, your current plan  
14 may be allowed to increase your rates based on your health status  
15 while new plans and policies cannot. You have the option to remain  
16 in your current plan or switch to a new plan. Under the new rules,  
17 a health plan cannot deny your application based on any health  
18 conditions you may have. For more information about your options,  
19 please contact the California Health Benefit Exchange, the Office  
20 of Patient Advocate, your plan representative, or an insurance  
21 broker.

22  
23 (b) Commencing October 1, 2013, a health care service plan  
24 shall include the notice described in subdivision (a) in any renewal  
25 material of the individual grandfathered health plan and in any  
26 application for dependent coverage under the individual  
27 grandfathered health plan.

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

35 1399.862. Except as otherwise provided in this article, this  
36 article shall only be implemented to the extent that it meets or  
37 exceeds the requirements set forth in PPACA.

38 1399.863. (a) The department may adopt emergency  
39 regulations implementing this ~~section~~ *article* no later than  
40 December 31, 2014. The department may readopt any emergency

1 regulation authorized by this ~~subdivision~~ *section* that is the same  
2 as or substantially equivalent to an emergency regulation previously  
3 adopted under this section.

4 (b) The initial adoption of emergency regulations implementing  
5 this ~~section~~ *article* and the one readoption of emergency regulations  
6 authorized by this ~~subdivision~~ *section* shall be deemed an  
7 emergency and necessary for the immediate preservation of the  
8 public peace, health, safety, or general welfare. Initial emergency  
9 regulations and the one readoption of emergency regulations  
10 authorized by this ~~subdivision~~ *section* shall be exempt from review  
11 by the Office of Administrative Law. The initial emergency  
12 regulations and the one readoption of emergency regulations  
13 authorized by this ~~subdivision~~ *section* shall be submitted to the  
14 Office of Administrative Law for filing with the Secretary of State  
15 and each shall remain in effect for no more than one year, by which  
16 time final regulations may be adopted. *The department shall consult*  
17 *with the Insurance Commissioner prior to adopting any regulations*  
18 *pursuant to this section for the specific purpose of ensuring, to the*  
19 *extent practical, that there is consistency of regulations applicable*  
20 *to entities regulated by the department and those regulated by the*  
21 *Insurance Commissioner.*

22 ~~SEC. 18:~~

23 *SEC. 19.* This act shall become operative only if Assembly  
24 Bill 2 of the 2013–14 First Extraordinary Session is enacted and  
25 becomes effective.

26 ~~SEC. 19:~~

27 *SEC. 20.* No reimbursement is required by this act pursuant  
28 to Section 6 of Article XIII B of the California Constitution because  
29 the only costs that may be incurred by a local agency or school  
30 district will be incurred because this act creates a new crime or  
31 infraction, eliminates a crime or infraction, or changes the penalty  
32 for a crime or infraction, within the meaning of Section 17556 of  
33 the Government Code, or changes the definition of a crime within  
34 the meaning of Section 6 of Article XIII B of the California  
35 Constitution.

O