AMENDED IN ASSEMBLY APRIL 1, 2013

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CALIFORNIA LEGISLATURE—2013–14 FIRST EXTRAORDINARY SESSION

SENATE BILL No. 2

Introduced by Senator Hernandez
(Principal coauthor: Senator Monning)

January 28, 2013

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 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 inoperative if, and 12 months after, 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.

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

(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 waivered
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 waivered 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 waivered 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 waivered
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
36 by Section 1501 of PPACA, is repealed or amended to no longer
37 apply to the individual market, as defined in Section 2791 of the
38 Public Health Service Act (42 U.S.C. Sec. 300gg-4), paragraph

1 (1) shall become inoperative 12 months after the date of that repeal
2 or 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 waivered 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.

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

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

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

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

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

(f) "Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan consistent with the periods provided pursuant to Section 1357.503 and who subsequently requests enrollment in a health benefit plan of that small employer, except where the employee or dependent qualifies for a special enrollment period provided pursuant to Section 1357.503. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract consistent with the periods provided pursuant to Section 1357.503 and who subsequently requests enrollment in the plan, except where that member or person qualifies for a special enrollment period provided pursuant to Section 1357.503.

(g) "New business" means a health care service plan contract issued to a small employer that is not the plan's in force business.

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

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

(i) "Creditable coverage" means:

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

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

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

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

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

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

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

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

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

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

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

(k) (1) "Small employer" means any of the following:

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

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

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

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

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

(m) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

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

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

(p) "Nongrandfathered small employer health care service plan contract" means a small employer health care service plan contract that is not a grandfathered health plan.

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

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

(s) "Small employer health care service plan contract" means a health care service plan contract issued to a small employer.

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

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

(v) "Family" means the subscriber and his or her dependent or dependents.

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

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

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

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

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

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

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

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

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

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

(3) The small employer agrees to inform the small employer's employees of the availability of coverage and the provision that those not electing coverage must wait until the next open enrollment or a special enrollment period to obtain coverage

through the group if they later decide they would like to have coverage.

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

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

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

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

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

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

(h) (1) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued 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 required by
26 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 (2).
36 (2) Subdivision (b) shall remain operative with respect to health
37 care service plan contracts offered through the Exchange.
38 SEC. 5. Section 1357.504 of the Health and Safety Code is
39 amended to read:

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

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

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

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

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

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

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

the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) If Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added by Section 1201 of PPACA, is repealed, this section shall become inoperative 12 months after the repeal date, in which case rates for health care service plan contracts subject to this section shall instead be subject to Section

1357.12, to the extent permitted by federal law, and all references to this section shall be deemed to be references to Section 1357.12.

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

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

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

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

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

(3) The full premium cost of the plan.

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

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

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

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

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health

care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

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

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

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

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

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

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

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

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

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

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on

1 the patient's choice of acute care hospital care, subacute or
2 transitional inpatient care, or skilled nursing facility.
3 (13) General authorization requirements for referral by a primary
4 care physician to a specialty care physician or a nonphysician
5 health care practitioner.
6 (14) Conditions and procedures for disenrollment.
7 (15) A description as to how an enrollee may request continuity
8 of care as required by Section 1373.96 and request a second opinion
9 pursuant to Section 1383.15.
10 (16) Information concerning the right of an enrollee to request
11 an independent review in accordance with Article 5.55
12 (commencing with Section 1374.30).
13 (17) A notice as required by Section 1364.5.
14 (b) (1) As of July 1, 1999, the director shall require each plan
15 offering a contract to an individual or small group to provide with
16 the disclosure form for individual and small group plan contracts
17 a uniform health plan benefits and coverage matrix containing the
18 plan's major provisions in order to facilitate comparisons between
19 plan contracts. The uniform matrix shall include the following
20 category descriptions together with the corresponding copayments
21 and limitations in the following sequence:
22 (A) Deductibles.
23 (B) Lifetime maximums.
24 (C) Professional services.
25 (D) Outpatient services.
26 (E) Hospitalization services.
27 (F) Emergency health coverage.
28 (G) Ambulance services.
29 (H) Prescription drug coverage.
30 (I) Durable medical equipment.
31 (J) Mental health services.
32 (K) Chemical dependency services.
33 (L) Home health services.
34 (M) Other.
35 (2) The following statement shall be placed at the top of the
36 matrix in all capital letters in at least 10-point boldface type:
37
38 THIS MATRIX IS INTENDED TO BE USED TO HELP YOU
39 COMPARE COVERAGE BENEFITS AND IS A SUMMARY
40 ONLY. THE EVIDENCE OF COVERAGE AND PLAN

CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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

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

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

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

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

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

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

(f) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber

1 under the group contract at the time those persons are offered the
2 plan. If the individual group members are offered a choice of plans,
3 separate disclosure forms shall be supplied for each plan available.
4 Each group contractholder shall also disseminate or cause to be
5 disseminated copies of the evidence of coverage to all applicants,
6 upon request, prior to enrollment and to all subscribers enrolled
7 under the group contract.
8 (g) In the case of conflicts between the group contract and the
9 evidence of coverage, the provisions of the evidence of coverage
10 shall be binding upon the plan notwithstanding any provisions in
11 the group contract that may be less favorable to subscribers or
12 enrollees.
13 (h) In addition to the other disclosures required by this section,
14 every health care service plan and any agent or employee of the
15 plan shall, when presenting a plan for examination or sale to any
16 individual purchaser or the representative of a group consisting of
17 25 or fewer individuals, disclose in writing the ratio of premium
18 costs to health services paid for plan contracts with individuals
19 and with groups of the same or similar size for the plan's preceding
20 fiscal year. A plan may report that information by geographic area,
21 provided the plan identifies the geographic area and reports
22 information applicable to that geographic area.
23 (i) Subdivision (b) shall not apply to any coverage provided by
24 a plan for the Medi-Cal program or the Medicare program pursuant
25 to Title XVIII and Title XIX of the Social Security Act.
26 SEC. 9. Section 1389.4 of the Health and Safety Code is
27 amended to read:
28 1389.4. (a) A full service health care service plan that issues,
29 renews, or amends individual health plan contracts shall be subject
30 to this section.
31 (b) A health care service plan subject to this section shall have
32 written policies, procedures, or underwriting guidelines establishing
33 the criteria and process whereby the plan makes its decision to
34 provide or to deny coverage to individuals applying for coverage
35 and sets the rate for that coverage. These guidelines, policies, or
36 procedures shall ensure that the plan rating and underwriting
37 criteria comply with Sections 1365.5 and 1389.1 and all other
38 applicable provisions of state and federal law.
39 (c) On or before June 1, 2006, and annually thereafter, every
40 health care service plan shall file with the department a general

1 description of the criteria, policies, procedures, or guidelines the
2 plan uses for rating and underwriting decisions related to individual
3 health plan contracts, which means automatic declinable health
4 conditions, health conditions that may lead to a coverage decline,
5 height and weight standards, health history, health care utilization,
6 lifestyle, or behavior that might result in a decline for coverage or
7 severely limit the plan products for which they would be eligible.
8 A plan may comply with this section by submitting to the
9 department underwriting materials or resource guides provided to
10 plan solicitors or solicitor firms, provided that those materials
11 include the information required to be submitted by this section.
12 (d) Commencing January 1, 2011, the director shall post on the
13 department's Internet Web site, in a manner accessible and
14 understandable to consumers, general, noncompany specific
15 information about rating and underwriting criteria and practices
16 in the individual market and information about the California Major
17 Risk Medical Insurance Program (Part 6.5 (commencing with
18 Section 12700) of Division 2 of the Insurance Code) and the federal
19 temporary high risk pool established pursuant to Part 6.6
20 (commencing with Section 12739.5) of Division 2 of the Insurance
21 Code. The director shall develop the information for the Internet
22 Web site in consultation with the Department of Insurance to
23 enhance the consistency of information provided to consumers.
24 Information about individual health coverage shall also include
25 the following notification:
26 "Please examine your options carefully before declining group
27 coverage or continuation coverage, such as COBRA, that may be
28 available to you. You should be aware that companies selling
29 individual health insurance typically require a review of your
30 medical history that could result in a higher premium or you could
31 be denied coverage entirely."
32 (e) Nothing in this section shall authorize public disclosure of
33 company specific rating and underwriting criteria and practices
34 submitted to the director.
35 (f) This section shall not apply to a closed block of business, as
36 defined in Section 1367.15.
37 (g) (1) This section shall become inoperative on November 1,
38 2013, or the 91st calendar day following the adjournment of the
39 2013–14 First Extraordinary Session, whichever date is later.

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

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

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

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

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

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

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

1 (1) "PPACA" means the federal Patient Protection and
2 Affordable Care Act (Public Law 111-148), as amended by the
3 federal Health Care and Education Reconciliation Act of 2010
4 (Public Law 111-152), and any rules, regulations, or guidance
5 issued pursuant to that law.
6 (2) "Grandfathered health plan" has the same meaning as that
7 term is defined in Section 1251 of PPACA.
8 (f) (1) This section shall become operative on November 1,
9 2013, or the 91st calendar day following the adjournment of the
10 2013–14 First Extraordinary Session, whichever date is later.
11 (2) If Section 5000A of the Internal Revenue Code, as added
12 by Section 1501 of PPACA, is repealed or amended to no longer
13 apply to the individual market, as defined in Section 2791 of the
14 federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this
15 section shall become inoperative 12 months after the date of that
16 repeal or amendment.
17 SEC. 11. Section 1389.5 of the Health and Safety Code is
18 amended to read:
19 1389.5. (a) This section shall apply to a health care service
20 plan that provides coverage under an individual plan contract that
21 is issued, amended, delivered, or renewed on or after January 1,
22 2007.
23 (b) At least once each year, the health care service plan shall
24 permit an individual who has been covered for at least 18 months
25 under an individual plan contract to transfer, without medical
26 underwriting, to any other individual plan contract offered by that
27 same health care service plan that provides equal or lesser benefits,
28 as determined by the plan.
29 "Without medical underwriting" means that the health care
30 service plan shall not decline to offer coverage to, or deny
31 enrollment of, the individual or impose any preexisting condition
32 exclusion on the individual who transfers to another individual
33 plan contract pursuant to this section.
34 (c) The plan shall establish, for the purposes of subdivision (b),
35 a ranking of the individual plan contracts it offers to individual
36 purchasers and post the ranking on its Internet Web site or make
37 the ranking available upon request. The plan shall update the
38 ranking whenever a new benefit design for individual purchasers
39 is approved.

1 (d) The plan shall notify in writing all enrollees of the right to
2 transfer to another individual plan contract pursuant to this section,
3 at a minimum, when the plan changes the enrollee's premium rate.
4 Posting this information on the plan's Internet Web site shall not
5 constitute notice for purposes of this subdivision. The notice shall
6 adequately inform enrollees of the transfer rights provided under
7 this section, including information on the process to obtain details
8 about the individual plan contracts available to that enrollee and
9 advising that the enrollee may be unable to return to his or her
10 current individual plan contract if the enrollee transfers to another
11 individual plan contract.
12 (e) The requirements of this section shall not apply to the
13 following:
14 (1) A federally eligible defined individual, as defined in
15 subdivision (c) of Section 1399.801, who is enrolled in an
16 individual health benefit plan contract offered pursuant to Section
17 1366.35.
18 (2) An individual offered conversion coverage pursuant to
19 Section 1373.6.
20 (3) Individual coverage under a specialized health care service
21 plan contract.
22 (4) An individual enrolled in the Medi-Cal program pursuant
23 to Chapter 7 (commencing with Section 14000) of Division 9 of
24 Part 3 of the Welfare and Institutions Code.
25 (5) An individual enrolled in the Access for Infants and Mothers
26 Program pursuant to Part 6.3 (commencing with Section 12695)
27 of Division 2 of the Insurance Code.
28 (6) An individual enrolled in the Healthy Families Program
29 pursuant to Part 6.2 (commencing with Section 12693) of Division
30 2 of the Insurance Code.
31 (f) It is the intent of the Legislature that individuals shall have
32 more choice in their health coverage when health care service plans
33 guarantee the right of an individual to transfer to another product
34 based on the plan's own ranking system. The Legislature does not
35 intend for the department to review or verify the plan's ranking
36 for actuarial or other purposes.
37 (g) (1) This section shall become inoperative January 1, 2014,
38 or the 91st calendar day following the adjournment of the 2013–14
39 First Extraordinary Session, whichever date is later.

1 (2) If Section 5000A of the Internal Revenue Code, as added
2 by Section 1501 of PPACA, is repealed or amended to no longer
3 apply to the individual market, as defined in Section 2791 of the
4 federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this
5 section shall become operative 12 months after the date of that
6 repeal or amendment.
7 SEC. 12. Section 1389.7 of the Health and Safety Code is
8 amended to read:
9 1389.7. (a) Every health care service plan that offers, issues,
10 or renews individual plan contracts shall offer to any individual,
11 who was covered under an individual plan contract that was
12 rescinded, a new individual plan contract, without medical
13 underwriting, that provides equal benefits. A health care service
14 plan may also permit an individual, who was covered under an
15 individual plan contract that was rescinded, to remain covered
16 under that individual plan contract, with a revised premium rate
17 that reflects the number of persons remaining on the plan contract.
18 (b) "Without medical underwriting" means that the health care
19 service plan shall not decline to offer coverage to, or deny
20 enrollment of, the individual or impose any preexisting condition
21 exclusion on the individual who is issued a new individual plan
22 contract or remains covered under an individual plan contract
23 pursuant to this section.
24 (c) If a new individual plan contract is issued, the plan may
25 revise the premium rate to reflect only the number of persons
26 covered on the new individual plan contract.
27 (d) Notwithstanding subdivisions (a) and (b), if an individual
28 was subject to a preexisting condition provision or a waiting or an
29 affiliation period under the individual plan contract that was
30 rescinded, the health care service plan may apply the same
31 preexisting condition provision or waiting or affiliation period in
32 the new individual plan contract. The time period in the new
33 individual plan contract for the preexisting condition provision or
34 waiting or affiliation period shall not be longer than the one in the
35 individual plan contract that was rescinded and the health care
36 service plan shall credit any time that the individual was covered
37 under the rescinded individual plan contract.
38 (e) The plan shall notify in writing all enrollees of the right to
39 coverage under an individual plan contract pursuant to this section,
40 at a minimum, when the plan rescinds the individual plan contract.

1 The notice shall adequately inform enrollees of the right to
2 coverage provided under this section.
3 (f) The plan shall provide 60 days for enrollees to accept the
4 offered new individual plan contract and this contract shall be
5 effective as of the effective date of the original plan contract and
6 there shall be no lapse in coverage.
7 (g) This section shall not apply to any individual whose
8 information in the application for coverage and related
9 communications led to the rescission.
10 (h) (1) This section shall become inoperative on January 1,
11 2014, or the 91st calendar day following the adjournment of the
12 2013–14 First Extraordinary Session, whichever date is later.
13 (2) 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 Service Act (42 U.S.C. Sec. 300gg-4), this
17 section shall become operative 12 months after the date of that
18 repeal or amendment.
19 SEC. 13. Section 1389.7 is added to the Health and Safety
20 Code, to read:
21 1389.7. (a) Every health care service plan that offers, issues,
22 or renews individual plan contracts shall offer to any individual,
23 who was covered by the plan under an individual plan contract
24 that was rescinded, a new individual plan contract that provides
25 the most equivalent benefits.
26 (b) A health care service plan that offers, issues, or renews
27 individual plan contracts inside or outside the California Health
28 Benefit Exchange may also permit an individual, who was covered
29 by the plan under an individual plan contract that was rescinded,
30 to remain covered under that individual plan contract, with a
31 revised premium rate that reflects the number of persons remaining
32 on the individual plan contract consistent with Section 1399.855.
33 (c) The plan shall notify in writing all enrollees of the right to
34 coverage under an individual plan contract pursuant to this section,
35 at a minimum, when the plan rescinds the individual plan contract.
36 The notice shall adequately inform enrollees of the right to
37 coverage provided under this section.
38 (d) The plan shall provide 60 days for enrollees to accept the
39 offered new individual plan contract under subdivision (a), and

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

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

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

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

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

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

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

Article 11.7. Child Access to Health Care Coverage

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

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

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

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

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage

who is not a late enrollee and who failed to maintain coverage with any health care service plan or health insurer for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

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

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

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

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

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

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

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

(g) (1) On and after the operative date of the act adding this subdivision, and until January 1, 2014, a health care service plan shall provide the model notice, as provided in paragraph (3), to all applicants for coverage under this article and to all enrollees, or

1 the responsible party for an enrollee, renewing coverage under this
2 article that contains the following information:
3 (A) Information about the open enrollment period provided
4 under Section 1399.849.
5 (B) An explanation that obtaining coverage during the open
6 enrollment period described in Section 1399.849 will not affect
7 the effective dates of coverage for coverage purchased pursuant
8 to this article unless the applicant cancels that coverage.
9 (C) An explanation that coverage purchased pursuant to this
10 article shall be effective as required under subdivision (d) of
11 Section 1399.826 and that such coverage shall not prevent an
12 applicant from obtaining new coverage during the open enrollment
13 period described in Section 1399.849.
14 (D) Information about the Medi-Cal program, information about
15 the Healthy Families Program if the Healthy Families Program is
16 accepting enrollment, and information about subsidies available
17 through the California Health Benefit Exchange.
18 (2) The notice described in paragraph (1) shall be in plain
19 language and 14-point type.
20 (3) The department shall adopt a uniform model notice to be
21 used by health care service plans in order to comply with this
22 subdivision, and shall consult with the Department of Insurance
23 in adopting that uniform model notice. Use of the model notice
24 shall not require prior approval of the department. The model
25 notice adopted by the department for purposes of this section shall
26 not be subject to the Administrative Procedure Act (Chapter 3.5
27 (commencing with Section 11340) of Part 1 of Division 3 of Title
28 2 of the Government Code).
29 SEC. 17. Section 1399.836 is added to the Health and Safety
30 Code, to read:
31 1399.836. (a) This article shall become inoperative on January
32 1, 2014, or the 91st calendar day following the adjournment of the
33 2013–14 First Extraordinary Session, whichever date is later.
34 (b) If Section 5000A of the Internal Revenue Code, as added
35 by Section 1501 of PPACA, is repealed or amended to no longer
36 apply to the individual market, as defined in Section 2791 of the
37 federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this
38 article shall become operative 12 months after the date of that
39 repeal or amendment.

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

Article 11.8. Individual Access to Health Care Coverage

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

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

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

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

(d) "Family" means the subscriber and his or her dependent or dependents.

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

(f) "Health benefit plan" means any individual or group health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include a specialized health care service plan contract, a health care service plan contract provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, or Medicare supplement coverage, to the extent consistent with PPACA.

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

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

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

(j) "Rating period" means the calendar year for which premium rates are in effect pursuant to subdivision (d) of Section 1399.855.

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

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

1399.849. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively 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. A plan shall limit enrollment in individual health benefit plans to open enrollment periods and special enrollment periods as provided in subdivisions (c) and (d).

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

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

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

(2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a plan shall provide a limited

open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

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

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

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

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

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

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

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

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

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

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

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

(H) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to

the individual because he or she was misinformed that he or she was covered under minimum essential coverage.

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

~~(I)~~

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

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

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

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

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

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that

1 payment is delivered or postmarked, whichever occurs earlier, by
2 December 15, 2013, coverage under the individual health benefit
3 plan shall become effective no later than January 1, 2014. When
4 that payment is delivered or postmarked within the first 15 days
5 of any subsequent month, coverage shall become effective no later
6 than the first day of the following month. When that payment is
7 delivered or postmarked between December 16, 2013, and
8 December 31, 2013, inclusive, or after the 15th day of any
9 subsequent month, coverage shall become effective no later than
10 the first day of the second month following delivery or postmark
11 of the payment.
12 (3) With respect to an individual health benefit plan for which
13 an individual applies during the annual open enrollment period
14 described in subdivision (c), when the individual submits a
15 premium payment, based on the quoted premium charges, and that
16 payment is delivered or postmarked, whichever occurs later, by
17 December 15, coverage shall become effective as of the following
18 January 1. When that payment is delivered or postmarked within
19 the first 15 days of any subsequent month, coverage shall become
20 effective no later than the first day of the following month. When
21 that payment is delivered or postmarked between December 16
22 and December 31, inclusive, or after the 15th day of any subsequent
23 month, coverage shall become effective no later than the first day
24 of the second month following delivery or postmark of the
25 payment.
26 (4) With respect to an individual health benefit plan for which
27 an individual applies during a special enrollment period described
28 in subdivision (d), the following provisions shall apply:
29 (A) When the individual submits a premium payment, based
30 on the quoted premium charges, and that payment is delivered or
31 postmarked, whichever occurs earlier, within the first 15 days of
32 the month, coverage under the plan shall become effective no later
33 than the first day of the following month. When the premium
34 payment is neither delivered nor postmarked until after the 15th
35 day of the month, coverage shall become effective no later than
36 the first day of the second month following delivery or postmark
37 of the payment.
38 (B) Notwithstanding subparagraph (A), in the case of a birth,
39 adoption, or placement for adoption, the coverage shall be effective
40 on the date of birth, adoption, or placement for adoption.

1 (C) Notwithstanding subparagraph (A), in the case of marriage
2 or becoming a registered domestic partner or in the case where a
3 qualified individual loses minimum essential coverage, the
4 coverage effective date shall be the first day of the month following
5 the date the plan receives the request for special enrollment.
6 (g) (1) A health care service plan shall not establish rules for
7 eligibility, including continued eligibility, of any individual to
8 enroll under the terms of an individual health benefit plan based
9 on any of the following factors:
10 (A) Health status.
11 (B) Medical condition, including physical and mental illnesses.
12 (C) Claims experience.
13 (D) Receipt of health care.
14 (E) Medical history.
15 (F) Genetic information.
16 (G) Evidence of insurability, including conditions arising out
17 of acts of domestic violence.
18 (H) Disability.
19 (I) Any other health status-related factor as determined by any
20 federal regulations, rules, or guidance issued pursuant to Section
21 2705 of the federal Public Health Service Act.
22 (2) Notwithstanding Section 1389.1, a health care service plan
23 shall not require an individual applicant or his or her dependent
24 to fill out a health assessment or medical questionnaire prior to
25 enrollment under an individual health benefit plan. A health care
26 service plan shall not acquire or request information that relates
27 to a health status-related factor from the applicant or his or her
28 dependent or any other source prior to enrollment of the individual.
29 (h) (1) A health care service plan shall consider as a single risk
30 pool for rating purposes in the individual market the claims
31 experience of all insureds and enrollees in all nongrandfathered
32 individual health benefit plans offered by that health care service
33 plan in this state, whether offered as health care service plan
34 contracts or individual health insurance policies, including those
35 insureds and enrollees who enroll in individual coverage through
36 the Exchange and insureds and enrollees who enroll in individual
37 coverage outside of the Exchange. Student health insurance
38 coverage, as that coverage is defined in Section 147.145(a) of Title
39 45 of the Code of Federal Regulations, shall not be included in a
40 health care service plan's single risk pool for individual coverage.

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

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

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

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

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (vii) Region 7 shall consist of the County of Santa Clara.
2 (viii) Region 8 shall consist of the County of San Mateo.
3 (ix) Region 9 shall consist of the Counties of Monterey, San
4 Benito, and Santa Cruz.
5 (x) Region 10 shall consist of the Counties of Mariposa, Merced,
6 San Joaquin, Stanislaus, and Tulare.
7 (xi) Region 11 shall consist of the Counties of Fresno, Kings,
8 and Madera.
9 (xii) Region 12 shall consist of the Counties of San Luis Obispo,
10 Santa Barbara, and Ventura.
11 (xiii) Region 13 shall consist of the Counties of Imperial, Inyo,
12 and Mono.
13 (xiv) Region 14 shall consist of the County of Kern.
14 (xv) Region 15 shall consist of the ZIP Codes in the County of
15 Los Angeles starting with 906 to 912, inclusive, 915, 917, 918,
16 and 935.
17 (xvi) Region 16 shall consist of the ZIP Codes in the County of
18 Los Angeles other than those identified in clause (xv).
19 (xvii) Region 17 shall consist of the Counties of Riverside and
20 San Bernardino.
21 (xviii) Region 18 shall consist of the County of Orange.
22 (xix) Region 19 shall consist of the County of San Diego.
23 (B) No later than June 1, 2017, the department, in collaboration
24 with the Exchange and the Department of Insurance, shall review
25 the geographic rating regions specified in this paragraph and the
26 impacts of those regions on the health care coverage market in
27 California, and make a report to the appropriate policy committees
28 of the Legislature.
29 (3) Whether the plan covers an individual or family, as described
30 in PPACA.
31 (b) The rate for a health benefit plan subject to this section shall
32 not vary by any factor not described in this section.
33 (c) With respect to family coverage under an individual health
34 benefit plan, the rating variation permitted under paragraph (1) of
35 subdivision (a) shall be applied based on the portion of the
36 premium attributable to each family member covered under the
37 plan. The total premium for family coverage shall be determined
38 by summing the premiums for each individual family member. In
39 determining the total premium for family members, premiums for

no more than the three oldest family members who are under 21 years of age shall be taken into account.

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

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

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

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

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

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

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

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

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

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

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

1 (ii) The date the plan notifies the director that it has the ability
2 to deliver services to individuals, and certifies to the director that
3 from the date of the notice it will enroll all individuals requesting
4 coverage in that area from the plan.
5 (C) Subparagraph (B) shall not limit the plan's ability to renew
6 coverage already in force or relieve the plan of the responsibility
7 to renew that coverage as described in Section 1365.
8 (D) Coverage offered within a service area after the period
9 specified in subparagraph (B) shall be subject to this section.
10 (b) (1) A health care service plan may decline to offer an
11 individual health benefit plan to an individual if the plan
12 demonstrates to the satisfaction of the director both of the
13 following:
14 (A) It does not have the financial reserves necessary to
15 underwrite additional coverage. In determining whether this
16 subparagraph has been satisfied, the director shall consider, but
17 not be limited to, the plan's compliance with the requirements of
18 Section 1367, Article 6 (commencing with Section 1375), and the
19 rules adopted thereunder.
20 (B) It is applying this subdivision uniformly to all individuals
21 without regard to the claims experience of those individuals or any
22 health status-related factor relating to those individuals.
23 (2) A plan that denies coverage to an individual under paragraph
24 (1) shall not offer coverage before the later of the following dates:
25 (A) The 181st day after the date that coverage is denied pursuant
26 to this subdivision.
27 (B) The date the plan demonstrates to the satisfaction of the
28 director that the plan has sufficient financial reserves necessary to
29 underwrite additional coverage.
30 (3) Paragraph (2) shall not limit the plan's ability to renew
31 coverage already in force or relieve the plan of the responsibility
32 to renew that coverage as described in Section 1365.
33 (4) Coverage offered within a service area after the period
34 specified in paragraph (2) shall be subject to this section.
35 (c) Nothing in this article shall be construed to limit the
36 director's authority to develop and implement a plan of
37 rehabilitation for a health care service plan whose financial viability
38 or organizational and administrative capacity has become impaired,
39 to the extent permitted by PPACA.

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

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

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

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

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

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

New improved health insurance options are available in California. You currently have health insurance that is not required to follow many of the new laws. For example, your plan may not provide preventive health services without you having to pay any

cost sharing (copayments or coinsurance). Also, your current plan may be allowed to increase your rates based on your health status while new plans and policies cannot. You have the option to remain in your current plan or switch to a new plan. Under the new rules, a health plan cannot deny your application based on any health conditions you may have. For more information about your options, please contact ~~the California Health Benefit Exchange,~~ *Covered California at ____,* the Office of Patient ~~Advocate,~~ *Advocate at ____,* your plan ~~representative,~~ *representative* or ~~an~~ insurance ~~broker.~~ *agent, or an entity paid by Covered California to assist with health coverage enrollment such as a navigator or an assister.*

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

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

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

1399.863. (a) The department may adopt emergency regulations implementing this article no later than December 31, 2014. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(b) The initial adoption of emergency regulations implementing this article and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. Initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be exempt from review by the Office of

1 Administrative Law. The initial emergency regulations and the
2 one readoption of emergency regulations authorized by this section
3 shall be submitted to the Office of Administrative Law for filing
4 with the Secretary of State and each shall remain in effect for no
5 more than one year, by which time final regulations may be
6 adopted. The department shall consult with the Insurance
7 Commissioner prior to adopting any regulations pursuant to this
8 section for the specific purpose of ensuring, to the extent practical,
9 that there is consistency of regulations applicable to entities
10 regulated by the department and those regulated by the Insurance
11 Commissioner.
12 SEC. 19. This act shall become operative only if Assembly
13 Bill 2 of the 2013–14 First Extraordinary Session is enacted and
14 becomes effective.
15 SEC. 20. No reimbursement is required by this act pursuant
16 to Section 6 of Article XIII B of the California Constitution because
17 the only costs that may be incurred by a local agency or school
18 district will be incurred because this act creates a new crime or
19 infraction, eliminates a crime or infraction, or changes the penalty
20 for a crime or infraction, within the meaning of Section 17556 of
21 the Government Code, or changes the definition of a crime within
22 the meaning of Section 6 of Article XIII B of the California
23 Constitution.

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