AMENDED IN ASSEMBLY APRIL 5, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2244

Introduced by Assembly Member Feuer

February 18, 2010

~~An act to amend Section 13291 of the Government Code, relating to state government.~~ *An act to add Article 11.7 (commencing with Section 1399.825) to Chapter 2.2 of Division 2 of the Health and Safety Code, and to add Chapter 9.7 (commencing with Section 10950) to Part 2 of Division 2 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2244, as amended, Feuer. ~~State finance.~~ *Health care coverage.*

Existing law provides for the licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health care service plan or health insurer to exclude an applicant from coverage for a specified time for preexisting conditions. A willful violation of provisions governing health care service plans is a crime.

This bill would require all health care service plans and insurance carriers that offer health care coverage to children or individuals to offer that coverage, by specified dates, to any child or individual seeking coverage. The bill would also prohibit, by specified dates, the exclusion or limitation of coverage due to any preexisting condition. The bill would further establish and require the implementation of standard risk rates with respect to plan contracts or health benefit plans that provide coverage to children, as specified. The bill would authorize the

Department of Managed Health Care and the Department of Insurance to adopt emergency regulations for purposes of implementation.

By imposing new requirements on health care service plans, the willful violation of which would be a crime, this bill would impose a state-mandated local program.

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.

~~Existing law authorizes the Department of Finance to require certain state agencies to produce financial and statistical reports on forms provided by the department.~~

~~This bill would make a technical, nonsubstantive change to this provision.~~

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

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

SECTION 1. Article 11.7 (commencing with Section 1399.825) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.7. Individual Access to Health Care

1399.825. As used in this article:

(a) (1) "Child" means any individual under 19 years of age.

(2) "Responsible party for a child" means an adult having custody of a child with the right to make medical decisions for, and with the responsibility for the financial needs of, the child.

(b) "Individual" means any individual over 19 years of age.

(c) "In force business" means an existing health benefit plan contract issued by the plan to an individual.

(e) "New business" means a health care service plan contract issued to an individual that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the individual'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.

(g) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than 12 months.

(h) "Risk adjusted individual risk rate" means the rate determined for an eligible individual or child in a particular risk category after applying the risk adjustment factor.

(i) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard risk rate for a particular child, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until January 1, 2012. Effective January 1, 2012, this factor may not be more than 110 percent or less than 90 percent. Effective January 1, 2014, the standard risk rate shall apply to all policies sold to individuals or for children.

(j) "Risk category" means the following characteristics of an eligible child: age, geographic region, and family composition of the individual, plus the health benefit plan selected by the individual.

(1) Until January 1, 2014, no more than the following age categories may be used in determining premium rates:

(A) Under age 5.

(B) Age 5-15.

(C) Age 15-19.

(2) The rate shall not vary by more than 2 to 1 for children.

(3) Individual health care service plans shall base rates for individuals and children using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(4) In determining rates for individuals and children, a plan that operates statewide shall use the geographic regions specified in Section 1357.

(k) Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

1399.826. (a) (1) Effective January 1, 2011, every health care service plan offering plan contracts for children shall offer coverage to the responsible party for any child that seeks coverage.

(2) Effective January 1, 2014, every health care service plan offering plan contracts to individuals shall offer coverage to any individual who seeks coverage.

(b) (1) Effective January 1, 2011, notwithstanding any other provision of state law or regulation, every health care service plan offering contracts for children shall not exclude or limit coverage due to any preexisting condition.

(2) Effective January 1, 2014, notwithstanding any other provision of state law or regulation, every health care service plan offering contracts for children shall not exclude or limit coverage due to any preexisting condition.

(c) This article shall not apply to coverage to which an employer makes any contribution.

(d) Every health care service plan offering plan contracts to individuals shall in addition to complying with the provisions of this chapter and the rules adopted thereunder comply with the provisions of this article.

1399.827. This article shall not apply to health plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Services, Healthy Families, long-term care coverage, or specialized health plan contracts.

1399.828. (a) Upon the effective date of this article, a health care service plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are offered and sold to the responsible party for a child. Effective January 1, 2014, a health care service plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to individuals.

(b) Effective January 1, 2011, a health care service plan shall not reject an application from the responsible party for a child for a health care service plan contract. Effective January 1, 2014, a health care service plan shall not reject an application from an individual for a health care service plan contract.

(c) No health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

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

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

(d) 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 a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual or child. 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 or child.

(e) Effective January 1, 2011, a health care service plan contract that covers a child shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(1) Health status.

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

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

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

(8) Disability.

(9) Any other health status-related factor determined appropriate by department.

(f) A health care service plan shall comply with the requirements of Section 1374.3.

(g) Effective January 1, 2014, this section shall apply to all individuals and children obtaining coverage with no contribution from an employer.

1399.829. (a) After an individual or the responsible party for a child submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the individual or responsible party for a child of actual premium charges for that plan contract established in accordance with Section 1399.836. The individual or responsible party for a child shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(b) When an individual or the responsible party for a child 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) During the first 60 days after the effective date of the plan contract, the individual or responsible party for a child shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If an individual or the responsible party for a child 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 an individual or the responsible party for a child 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.

1399.830. (a) Effective January 1, 2011, a health care service plan may not exclude any child who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that child. No health care service plan contract may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.

(b) Effective January 1, 2014, a health care service plan may not exclude any individual who would otherwise be entitled to health care services on the basis of an actual or expected health

condition of that individual. No health care service plan contract may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.

1399.831. All health care service plan contracts offered to an individual or child shall provide to subscribers and enrollees at least all of the basic health care services in this act.

1399.832. No health care service plan shall 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:

(a) To an individual or child, if the individual or child who is to be covered by the plan contract does not work or reside within the plan's approved service areas.

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

(2) A health care service plan that cannot offer a health care service plan contract to individuals or children because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the plan is not offering coverage to individuals to new employer groups until the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan unless the plan has met the requirements of subdivision (d).

(3) 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.

(c) Offer coverage to an individual or child that, within 12 months of application for coverage, disenrolled from a plan contract offered by the plan.

(d) (1) The director approves the plan's certification that the number of eligible employees and dependents enrolled under

contracts issued during the current calendar year equals or exceeds either of the following:

(A) In the case of a plan that administers any self-funded health coverage arrangements in California, 10 percent of the total enrollment of the plan in California as of December 31 of the preceding year.

(B) In the case of a plan that does not administer any self-funded health coverage arrangements in California, 8 percent of the total enrollment of the plan in California as of December 31 of the preceding year. If that certification is approved, the plan shall not offer any health benefit plan to any small employers during the remainder of the current year.

(2) If a health care service plan treats an affiliate or subsidiary as a separate carrier for the purpose of this article because one health care service plan is qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and does not offer coverage to small employers, while the affiliate or subsidiary offers a plan contract that is not qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and offers plan contracts to small employers, the health care service plan offering coverage to small employers shall enroll new eligible employees and dependents, equal to the applicable percentage of the total enrollment of both the health care service plan qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.

(3) (A) The certified statement filed pursuant to this subdivision shall state the following:

(i) Whether the plan administers any self-funded health coverage arrangements in California.

(ii) The plan's total enrollment as of December 31 of the preceding year.

(iii) The number of eligible employees and dependents enrolled under contracts issued to small employer groups during the current calendar year.

(B) The director shall, within 45 days, approve or disapprove the certified statement. If the certified statement is disapproved, the plan shall continue to issue coverage as required by Section 1357.03 and be subject to disciplinary action as set forth in Article 7 (commencing with Section 1386).

1399.833. The director may require a health care service plan to discontinue the offering of contracts or acceptance of applications from any individual or child 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 1375.1), and the rules adopted under those provisions.

1399.834. All health care service plan contracts offered to a child or individual shall be renewable at the option of the enrollee or responsible party for a child except:

(a) For nonpayment of the required premiums by the enrollee or responsible party for a child.

(b) For fraud or misrepresentation by the individuals or their representatives.

(c) When the health care service plan ceases to provide or arrange for the provision of health care services for new individual health care service plan contracts in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefits plans in this state is provided to the director and to the contractholder at least 360 days prior to the discontinuation of the coverage.

(2) Individual health care service plan contracts subject to this article shall not be canceled for 360 days after the date of the notice required under paragraph (1) and for that business of a plan which remains in force, any plan that ceases to offer for sale new individual health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.

(3) Except as authorized under subdivision (d) of Section 1399.832 or Section 1399.833, a plan that ceases to write new individual business in this state after the effective date of this article shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of five years from the date of notice to the director.

(d) When the health care service plan withdraws a health care service plan contract from the individual market; provided, the

plan notifies all affected contractholders and the director at least 180 days prior to the discontinuation of those contracts, and the plan makes available to the individual all plan contracts that it makes available to new individual business; and provided, that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1399.836.

1399.836. Effective January 1, 2011, premiums for contracts offered or delivered by health care service plans on or after the effective date of this article for children shall be subject to the following requirements:

(a) The premium for new business shall be determined for an eligible child in a particular risk category after applying a risk adjustment factor to the plan's standard risk rates. The risk adjusted risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard risk rate until January 1, 2012. Effective January 1, 2012, this factor may not be more than 110 percent or less than 90 percent. The standard risk rates applied to a child for new business shall be in effect for no less than 12 months.

(b) (1) The premium for in force business shall be determined for an eligible child in a particular risk category after applying a risk adjustment factor to the plan's standard individual risk rates. The risk adjusted individual risk rates may not be more than 120 percent or less than 80 percent of the plan's applicable standard risk rate until January 1, 2011. Effective January 1, 2012, this factor may not be more than 110 percent or less than 90 percent. The factor effective January 1, 2011, shall apply to in force business at the earlier of either the time of renewal or January 1, 2012. The risk adjustment factor applied to a child may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a child may not be modified more frequently than once every 12 months.

(2) The standard risk rates shall be in effect for no less than 12 months.

(3) For a contract that a plan has discontinued offering, the risk adjustment factor applied to the standard risk rates for the first rating period of the new contract that the responsible party for the child elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the

discontinued contract. However, the risk adjusted individual risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard risk rate until January 1, 2012. Effective January 1, 2012, this factor may not be more than 110 percent or less than 90 percent. The factor effective January 1, 2012, shall apply to in force business at the earlier of either the time of renewal or January 1, 2012. The risk adjustment factor for a child may not be modified more frequently than once every 12 months.

1399.837. Health care service plans shall apply standard risk rates consistently with respect to all children.

1399.838. In connection with the offering for sale of any plan contract for children, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The extent to which premium rates for a specific child are established or adjusted in part based upon the actual or expected variation in service costs or actual or expected variation in health condition of the child.

(b) The provisions concerning the plan's right to change premium rates and the factors, other than provision of services experience, that affect changes in premium rates.

(c) Provisions relating to the guaranteed issue and renewal of contracts.

(d) Provisions relating to the child's right to apply for any contract written, issued, or administered by the plan at the time of application for a new health care service plan contract, or at the time of renewal of a health care service plan contract.

(e) The availability, upon request, of a listing of all the plan's contracts and benefit plan designs offered for children, including the rates for each contract.

(f) At the time it offers a contract to the responsible party for a child, each plan shall provide the responsible party with a statement of all of its plan contracts offered to children, including the rates for each plan contract, in the service area in which the individuals who are to be covered by the plan contract reside. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(g) Each health care service plan shall do all of the following:

(1) Prepare a brochure that summarizes all of its plan contracts offered to children and to make this summary available to any responsible party for a child and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard risk rates, and a phone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to responsible parties, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide to responsible parties and solicitors, upon request, for any given child the standard risk rates. When requesting this information, responsible parties, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the individual's risk adjusted risk rate.

(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from responsible parties for children.

For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(h) Every solicitor or solicitor firm contracting with one or more plans to solicit enrollments or subscriptions from responsible parties for children shall do all of the following:

(1) When providing information on contracts to a responsible party for a child or children but making no specific recommendations on particular plan contracts:

(A) Advise the responsible party of the plan's obligation to sell to any responsible party any plan contract it offers for children and provide them, upon request, with the actual rates that would be charged for that child for a given contract.

(B) Notify the responsible party that the solicitor or solicitor firm will procure rate and benefit information for the responsible party for the child on any plan contract offered by a plan whose contract the solicitor sells.

(C) Notify the responsible party that upon request the solicitor or solicitor firm will provide the responsible party with the summary brochure required under this paragraph for any plan contract offered by a plan with whom the solicitor or solicitor firm has contracted to solicit enrollments or subscriptions.

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

(3) Prior to filing an application for a responsible party for a child for a particular contract:

(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the responsible party with the benefit summary required in paragraph (1) and the standard risk rates for that particular child.

(B) Notify the responsible party that, upon request, the solicitor or solicitor firm will provide the responsible party with an evidence of coverage brochure for each contract the plan offers.

(C) Notify the responsible party for a child that, from January 1, 2011, to January 1, 2012, actual rates may be 20 percent higher or lower than the standard risk rates, and from January 1, 2012, until December 31, 2014, actual rates may be 10 percent higher or lower than the standard risk rates, depending on how the plan assesses the risk of the child.

(D) Notify the responsible party that, upon request, the solicitor or solicitor firm will submit information to the plan to ascertain the child's risk adjusted risk rate for any contract the plan offers.

(E) Obtain a signed statement from the responsible party acknowledging that the responsible party has received the disclosures required by this section.

1399.839. (a) At least 30 business days prior to renewing or amending a plan contract subject to this article that will be in force on the operative date of this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification

shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1399.825 and Section 1399.836. The certified statement shall set forth the standard risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract is not in compliance with the requirements of this chapter.

(b) At least 30 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1399.825 and Section 1399.836. The certified statement shall set forth the standard risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Plans that will be offering to a responsible party for a child contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract is not in compliance with the requirements of this chapter.

(c) Prior to making any changes in the risk categories, risk adjustment factors, or standard risk rates filed with the director pursuant to subdivision (a) or (b), the plan shall file, as an amendment, a statement setting forth the changes and certifying that the plan is in compliance with subdivision (j) of Section 1399.825 and Section 1399.836. A plan may commence offering plan contracts utilizing the changed risk categories set forth in the certified statement on the 45th day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the reasons therefor. If only the standard risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence offering plan contracts utilizing the changed standard

risk rate upon the 31st day after filing the certified statement unless the director disapproves the amendment by written notice.

(d) Periodic changes to the standard risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).

(e) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.

(f) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular child.

(g) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.

1399.840. The director may issue regulations that are necessary to carry out the purposes of this article. Prior to the public comment period required by regulations under the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the director shall provide the Insurance Commissioner with a copy of the proposed regulations. The Insurance Commissioner shall have 30 days to notify the director in writing of any comments on the regulations. The Insurance Commissioner's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with the Administrative Procedure Act. Until December 31, 2015, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Any regulations adopted prior to December 31, 2015, in order to remain in effect after December 31, 2016, shall be readopted as nonemergency regulations in accordance with the Administrative Procedures Act prior to December 31, 2016.

SEC. 2. Chapter 9.7 (commencing with Section 10950) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.7. INDIVIDUAL ACCESS TO HEALTH INSURANCE

10950. As used in this article:

(a) (1) "Child" means any individual under 19 years of age.

(2) "Responsible party for a child" means an adult having custody of a child with the right to make medical decisions for, and with the responsibility for the financial needs of, the child.

(b) "Individual" means any individual over 19 years of age.

(c) "In force business" means an existing health benefit plan issued by a carrier to an individual.

(e) "New business" means a health benefit plan issued to an individual that is not the carrier's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the individual'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.

(g) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than 12 months.

(h) "Risk adjusted individual risk rate" means the rate determined for an eligible individual or child in a particular risk category after applying the risk adjustment factor.

(i) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard risk rate for a particular child, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until January 1, 2012. Effective January 1, 2012, this factor may not be more than 110 percent or less than 90 percent. Effective January 1, 2014, the standard risk rate shall apply to all policies sold to individuals or for children.

(j) "Risk category" means the following characteristics of an eligible child: age, geographic region, and family composition of the individual, plus the health benefit plan selected by the individual.

(1) Until January 1, 2014, no more than the following age categories may be used in determining premium rates:

(A) Under age 5.

(B) Age 5-15.

(C) Age 15-19.

(2) The rate shall not vary by more than 2 to 1 for children.

(3) Carriers shall base rates for individuals and children using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(4) In determining rates for individuals and children, a carrier that operates statewide shall the geographic regions specified in Section 10700.

(k) Nothing in this section shall be construed to require a carrier to establish a new service area or to offer health coverage on a statewide basis, outside of the carrier's existing service area.

10951. (a) (1) Effective January 1, 2011, every carrier offering health benefit plans for children shall offer coverage to the responsible party for any child that seeks coverage.

(2) Effective January 1, 2014, every carrier offering health benefit plans to individuals shall offer coverage to any individual who seeks coverage.

(b) (1) Effective January 1, 2011, notwithstanding any other provision of state law or regulation, every carrier offering contracts for children shall not exclude or limit coverage due to any preexisting condition.

(2) Effective January 1, 2014, notwithstanding any other provision of state law or regulation, every carrier offering contracts for children shall not exclude or limit coverage due to any preexisting condition.

(c) This article shall not apply to coverage to which an employer makes any contribution.

(d) Every carrier offering health benefit plans to individuals shall in addition to complying with the provisions of this chapter and the rules adopted thereunder comply with the provisions of this article.

10952. This article shall not apply to health benefit plans for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Services, Healthy Families, long-term care coverage, or specialized health benefit plans.

10953. (a) Upon the effective date of this article, a carrier shall fairly and affirmatively offer, market, and sell all of the

carrier's contracts that are offered and sold to the responsible party for a child. Effective January 1, 2014, a carrier shall fairly and affirmatively offer, market, and sell all of the carrier's contracts that are sold to individuals.

(b) Effective January 1, 2011, a carrier shall not reject an application from the responsible party for a child for a health benefit plan. Effective January 1, 2014, a carrier shall not reject an application from an individual for a health benefit plan.

(c) No carrier or solicitor shall, directly or indirectly, engage in the following activities:

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

(2) Encourage or direct individuals or children to seek coverage from another carrier because of the health status, claims experience, industry, occupation of the individual or child, or geographic location, provided that it is within the carrier's approved service area.

(d) A carrier 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 benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual or child. 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 or child.

(e) Effective January 1, 2011, a health care service health benefit plan that covers a child shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the carrier based on any of the following health status-related factors:

(1) Health status.

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

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

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

(8) Disability.

(9) Any other health status-related factor determined appropriate by department.

(f) A carrier shall comply with the requirements of subdivision (c) of Section 10119.

(g) Effective January 1, 2014, this section shall apply to all individuals and children obtaining coverage with no contribution from an employer.

10954. (a) After an individual or the responsible party for a child submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual or responsible party for a child of actual premium charges for that health benefit plan established in accordance with Section 10960. The individual or responsible party for a child shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(b) When an individual or the responsible party for a child 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 health benefit plan 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) During the first 60 days after the effective date of the health benefit plan, the individual or responsible party for a child shall have the option of changing coverage to a different health benefit plan offered by the same carrier. If an individual or the responsible party for a child notifies the carrier of the change within the first 15 days of a month, coverage under the new health benefit plan shall become effective no later than the first day of the following month. If an individual or the responsible party for a child notifies the carrier of the change after the 15th day of a month, coverage under the new health benefit plan shall become effective no later than the first day of the second month following notification.

10955. (a) Effective January 1, 2011, a carrier may not exclude any child who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that child. No health care service health benefit plan may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.

(b) Effective January 1, 2014, a carrier may not exclude any individual who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that individual. No health care service health benefit plan may limit or exclude coverage for a child by type of illness, treatment, medical condition, or accident.

10956. All health benefit plans offered to an individual or child shall provide to contractholders and insureds at least all of the basic health care services in this act.

10957. No carrier shall be required to offer a health benefit plan or accept applications for the contract pursuant to this article in the case of any of the following:

(a) To an individual or child, if the individual or child who is to be covered by the health benefit plan does not work or reside within the carrier's approved service areas.

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

(2) A carrier that cannot offer a health benefit plan to individuals or children because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the carrier is not offering coverage to individuals to new employer groups until the carrier notifies the commissioner that it has the ability to deliver services to individuals, and certifies to the commissioner that from the date of the notice it will enroll all individuals requesting coverage in that area from the carrier unless the carrier has met the requirements of subdivision (d).

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

rehabilitation for a carrier whose financial viability or organizational and administrative capacity has become impaired.

(c) Offer coverage to an individual or child that, within 12 months of application for coverage, disenrolled from a health benefit plan offered by the carrier.

(d) (1) The commissioner approves the carrier's certification that the number of eligible employees and dependents enrolled under contracts issued during the current calendar year equals or exceeds either of the following:

(A) In the case of a carrier that administers any self-funded health coverage arrangements in California, 10 percent of the total enrollment of the carrier in California as of December 31 of the preceding year.

(B) In the case of a carrier that does not administer any self-funded health coverage arrangements in California, 8 percent of the total enrollment of the carrier in California as of December 31 of the preceding year. If that certification is approved, the carrier shall not offer any health benefit plan to any small employers during the remainder of the current year.

(2) If a carrier treats an affiliate or subsidiary as a separate carrier for the purpose of this article because one carrier is qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and does not offer coverage to small employers, while the affiliate or subsidiary offers a plan contract that is not qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and offers health benefit plans to small employers, the carrier offering coverage to small employers shall enroll new eligible employees and dependents, equal to the applicable percentage of the total enrollment of both the carrier qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.

(3) (A) The certified statement filed pursuant to this subdivision shall state the following:

(i) Whether the carrier administers any self-funded health coverage arrangements in California.

(ii) The carrier's total enrollment as of December 31 of the preceding year.

(iii) The number of eligible employees and dependents enrolled under health benefit plans issued to small employer groups during the current calendar year.

(B) The commissioner shall, within 45 days, approve or disapprove the certified statement. If the certified statement is disapproved, the carrier shall continue to issue coverage and be subject to disciplinary action.

10958. The commissioner may require a carrier to discontinue the offering of contracts or acceptance of applications from any individual or child upon a determination by the commissioner that the carrier does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its insureds. In determining whether the conditions of this section have been met, the commissioner shall consider, but not be limited to, the carrier's compliance with the requirements of this part and the rules adopted under those provisions.

10959. All health benefit plans offered to a child or individual shall be renewable at the option of the insured or responsible party for a child except:

(a) For nonpayment of the required premiums by the insured or responsible party for a child.

(b) For fraud or misrepresentation by the individuals or their representatives.

(c) When the carrier ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefits plans in this state is provided to the commissioner and to the contractholder at least 360 days prior to the discontinuation of the coverage.

(2) Individual health benefit plans subject to this article shall not be canceled for 360 days after the date of the notice required under paragraph (1) and for that business of a carrier which remains in force, any carrier that ceases to offer for sale new individual health benefit plans shall continue to be governed by this article with respect to business conducted under this article.

(3) Except as authorized under subdivision (d) of Section 10957 or Section 10959, a carrier that ceases to write new individual

business in this state after the effective date of this article shall be prohibited from offering for sale new individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.

(d) When the carrier withdraws a health benefit plan from the individual market; provided, the carrier notifies all affected contractholders and the commissioner at least 180 days prior to the discontinuation of those contracts, and the carrier makes available to the individual all health benefit plans that it makes available to new individual business; and provided, that the premium for the new health benefit plan complies with the renewal increase requirements set forth in Section 10960.

10960. Effective January 1, 2011, premiums for contracts offered or delivered by carriers on or after the effective date of this article for children shall be subject to the following requirements:

(a) The premium for new business shall be determined for an eligible child in a particular risk category after applying a risk adjustment factor to the carrier's standard risk rates. The risk adjusted risk rate may not be more than 120 percent or less than 80 percent of the carrier's applicable standard risk rate until January 1, 2012. Effective January 1, 2012, this factor may not be more than 110 percent or less than 90 percent. The standard risk rates applied to a child for new business shall be in effect for no less than 12 months.

(b) (1) The premium for in force business shall be determined for an eligible child in a particular risk category after applying a risk adjustment factor to the carrier's standard individual risk rates. The risk adjusted individual risk rates may not be more than 120 percent or less than 80 percent of the carrier's applicable standard risk rate until January 1, 2011. Effective January 1, 2012, this factor may not be more than 110 percent or less than 90 percent. The factor effective January 1, 2011, shall apply to in force business at the earlier of either the time of renewal or January 1, 2012. The risk adjustment factor applied to a child may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a child may not be modified more frequently than once every 12 months.

(2) The standard risk rates shall be in effect for no less than 12 months.

(3) For a contract that a carrier has discontinued offering, the risk adjustment factor applied to the standard risk rates for the first rating period of the new contract that the responsible party for the child elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, the risk adjusted individual risk rate may not be more than 120 percent or less than 80 percent of the carrier's applicable standard risk rate until January 1, 2012. Effective January 1, 2012, this factor may not be more than 110 percent or less than 90 percent. The factor effective January 1, 2012, shall apply to in force business at the earlier of either the time of renewal or January 1, 2012. The risk adjustment factor for a child may not be modified more frequently than once every 12 months.

10961. Carriers shall apply standard risk rates consistently with respect to all children.

10962. In connection with the offering for sale of any health benefit plan for children, each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The extent to which premium rates for a specific child are established or adjusted in part based upon the actual or expected variation in service costs or actual or expected variation in health condition of the child.

(b) The provisions concerning the carrier's right to change premium rates and the factors, other than provision of services experience, that affect changes in premium rates.

(c) Provisions relating to the guaranteed issue and renewal of contracts.

(d) Provisions relating to the child's right to apply for any contract written, issued, or administered by the carrier at the time of application for a new health benefit plan, or at the time of renewal of a health benefit plan.

(e) The availability, upon request, of a listing of all the plan's contracts and benefit plan designs offered for children, including the rates for each contract.

(f) At the time it offers a contract to the responsible party for a child, each carrier shall provide the responsible party with a

statement of all of its health benefit plans offered to children, including the rates for each health benefit plan, in the service area in which the individuals who are to be covered by the health benefit plan reside. For purposes of this subdivision, carriers that are affiliated carriers or that are eligible to file a consolidated income tax return shall be treated as one carrier.

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

(1) Prepare a brochure that summarizes all of its health benefit plans offered to children and to make this summary available to any responsible party for a child and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard risk rates, and a phone number that can be called for more detailed benefit information. carriers are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the health benefit plans to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to responsible parties, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide to responsible parties and solicitors, upon request, for any given child the standard risk rates. When requesting this information, responsible parties, solicitors, and solicitor firms shall provide the carrier with the information the carrier needs to determine the individual's risk adjusted risk rate.

(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the carrier to solicit enrollments or subscriptions from responsible parties for children.

For purposes of this subdivision, carriers that are affiliated carriers or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(h) Every solicitor or solicitor firm contracting with one or more carriers to solicit enrollments or subscriptions from responsible parties for children shall do all of the following:

(1) When providing information on contracts to a responsible party for a child or children but making no specific recommendations on particular health benefit plans:

(A) Advise the responsible party of the carrier's obligation to sell to any responsible party any health benefit plan it offers for children and provide them, upon request, with the actual rates that would be charged for that child for a given contract.

(B) Notify the responsible party that the solicitor or solicitor firm will procure rate and benefit information for the responsible party for the child on any health benefit plan offered by a carrier whose contract the solicitor sells.

(C) Notify the responsible party that upon request the solicitor or solicitor firm will provide the responsible party with the summary brochure required under this paragraph for any health benefit plan offered by a carrier with whom the solicitor or solicitor firm has contracted to solicit enrollments or subscriptions.

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

(3) Prior to filing an application for a responsible party for a child for a particular contract:

(A) For each of the health benefit plans offered by the carrier whose contract the solicitor or solicitor firm is offering, provide the responsible party with the benefit summary required in paragraph (1) and the standard risk rates for that particular child.

(B) Notify the responsible party that, upon request, the solicitor or solicitor firm will provide the responsible party with an evidence of coverage brochure for each contract the carrier offers.

(C) Notify the responsible party for a child that, from January 1, 2011, to January 1, 2012, actual rates may be 20 percent higher or lower than the standard risk rates, and from January 1, 2012, until December 31, 2014, actual rates may be 10 percent higher or lower than the standard risk rates, depending on how the carrier assesses the risk of the child.

(D) Notify the responsible party that, upon request, the solicitor or solicitor firm will submit information to the carrier to ascertain the child's the risk adjusted risk rate for any contract the carrier offers.

(E) Obtain a signed statement from the responsible party acknowledging that the responsible party has received the disclosures required by this section.

10963. (a) At least 30 business days prior to renewing or amending a health benefit plan subject to this article that will be in force on the operative date of this article, a carrier shall file a notice of material modification with the commissioner. The notice of material modification shall include a statement certifying that the carrier is in compliance with subdivision (j) of Section 10950 and Section 10960. The certified statement shall set forth the standard risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the commissioner to disapprove, suspend or postpone the carrier's use of a health benefit plan shall be in writing, specifying the reasons that the health benefit plan is not in compliance with the requirements of this chapter.

(b) At least 30 business days prior to offering a health benefit plan subject to this article, all carriers shall file a notice of material modification with the commissioner. The notice of material modification shall include a statement certifying that the carrier is in compliance with subdivision (j) of Section 10950 and Section 10960. The certified statement shall set forth the standard risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Carriers that will be offering to a responsible party for a child contracts approved by the commissioner prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the commissioner to disapprove, suspend, or postpone the carrier's use of a health benefit plan shall be in writing, specifying the reasons that the health benefit plan is not in compliance with the requirements of this chapter.

(c) Prior to making any changes in the risk categories, risk adjustment factors or standard risk rates filed with the commissioner pursuant to subdivision (a) or (b), the carrier shall file, as an amendment, a statement setting forth the changes and certifying that the carrier is in compliance with subdivision (j) of Section 10950 and Section 10960. A carrier may commence offering health benefit plans utilizing the changed risk categories

set forth in the certified statement on the 45th day from the date of the filing, or at an earlier time determined by the commissioner, unless the commissioner disapproves the amendment by written notice, stating the reasons therefor. If only the standard risk rate is being changed, and not the risk categories or risk adjustment factors, a carrier may commence offering health benefit plans utilizing the changed standard risk rate upon the 31st day after filing the certified statement unless the commissioner disapproves the amendment by written notice.

(d) Periodic changes to the standard risk rate that a carrier proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).

(e) Each carrier shall maintain at its principal place of business all of the information required to be filed with the commissioner pursuant to this section.

(f) Each carrier shall make available to the commissioner, on request, the risk adjustment factor used in determining the rate for any particular child.

(g) Nothing in this section shall be construed to limit the commissioner's authority to enforce the rating practices set forth in this article.

10964. The commissioner may issue regulations that are necessary to carry out the purposes of this article. Prior to the public comment period required by regulations under the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the commissioner shall provide the Director of Managed Health Care with a copy of the proposed regulations. The director shall have 30 days to notify the commissioner in writing of any comments on the regulations. The director's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with the Administrative Procedure Act. Until December 31, 2015, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Any regulations adopted prior to December 31, 2015, in order to remain in effect after December 31, 2016, shall

be readopted as nonemergency regulations in accordance with the Administrative Procedures Act prior to December 31, 2016.

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

~~SECTION 1. Section 13291 of the Government Code is amended to read:~~

~~13291. The department may require financial and statistical reports, duly verified and covering the period of each fiscal year, from all agencies of the state included within the provisions of Section 13300.~~

~~Reports shall be made upon blank forms prescribed and furnished by the department, and mailed to each such agency not less than 60 days before the time the reports are required to be filed with the department.~~

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