AMENDED IN SENATE MAY 20, 2010

AMENDED IN SENATE APRIL 27, 2010

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AMENDED IN SENATE APRIL 6, 2010

SENATE BILL No. 890

Introduced by Senators Alquist and Steinberg
(Coauthors: Assembly Members De La Torre*, Feuer,* and Jones)

January 21, 2010

An act to amend Sections 1363 and 1389.25 of, to add Sections 1367.001 and 1378.1 to, and to add Article 4.1 (commencing with Section 1366.10) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 10113.9, 10603, and 10604 of, to add Sections 10112.56, 10112.7, and 10604.2 to, and to add Chapter 9.6 (commencing with Section 10960) to Part 2 of Division 2 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 890, as amended, Alquist. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, on and after January 1, 2014, requires a health insurance issuer offering health insurance coverage in the individual or small group market to accept every employer and individual in the state that applies for that coverage, as specified, and requires those issuers to ensure that the coverage includes a specified essential benefits package. Among other things, the act allows premiums for that coverage to vary only by rating area, age, tobacco use, and whether the coverage is for an individual or family, 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 provides for the regulation of health insurers by the Department of Insurance.

Existing law imposes various requirements with respect to individual contracts and policies issued by health care service plans and health insurers. Existing law requires a health care service plan to permit, at least once each year, an individual who has been covered for at least 18 months under an individual plan contract issued by the health care service plan to transfer, without medical underwriting, as defined, to another individual plan contract offered by the health care service plan having equal or lesser benefits, as specified. Existing law imposes a parallel requirement with respect to individual policies issued by health insurers.

This bill would require plans and insurers issuing individual coverage to make certain standard benefit plan designs available to individuals, would require that these designs be offered in five different coverage choice categories, as specified, and would require a plan or insurer to offer and market one standard benefit plan design in each category. The bill would require plans to, on and after July 1, 2011, discontinue offering and selling benefit plan designs other than the standard benefit plan designs, but would require plans and insurers to renew benefit plan designs issued prior to that date until July 1, 2012. The bill would allow a subscriber or policyholder of an individual contract or policy, on the annual renewal date of that contract or policy, to transfer on a guarantee issue basis to another benefit plan design issued by his or her plan or insurer or a benefit plan design issued by another plan or insurer, provided that the new plan design is in the same or a lower coverage choice category or has an equal or lower actuarial value, as specified. The bill would require plans and insurers to provide notice of these transfer rights in their evidence of coverage and in notices regarding changes to premiums or coverage.

The bill would create the Individual Insurance Market Reform Commission, which would consist of 9 voting members, appointed by the Legislature and the Governor, as specified, and 3 *specified* nonvoting members. The bill would require the commission to review and suggest changes to the standard benefit plan designs described above and would require the Department of Managed Health Care and the Department of Insurance to jointly adopt regulations based on those suggestions.

The bill would require the commission to develop a standardized enrollment questionnaire to be used by all plans and insurers when offering and selling individual coverage, but would prohibit plans and insurers from requesting or obtaining health information from applicants eligible for guaranteed issuance of coverage on and after January 1, 2014. The bill would also require the commission to establish a methodology for the graduation of risk into three specified categories and would require plans and insurers in the individual market to set rates consistent with this methodology. The bill would place limits on the annualized premium rate increase for a contract and the variation between the highest standard premium rate and the lowest standard premium rate and would enact other related provisions.

Existing law prohibits a health care service plan from expending for administrative costs, as defined, an excessive amount of the payments ~~it~~ *the plan* receives for providing health care services to its subscribers and enrollees. The Insurance Commissioner is required to withdraw approval of an individual or mass-marketed policy of disability insurance if the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged, as specified.

This bill would require full service health care service plans and health insurers to expend no less than a certain percentage of the aggregate fees, premiums, and other periodic payments they receive on health care benefits, as specified, and would require plans and insurers to provide for rebates to enrollees and insureds if they fail to meet that percentage, as specified. The bill would authorize plans and insurers to assess compliance with this requirement by averaging their total costs across all plan contracts or insurance policies issued, amended, or renewed by them and their affiliated plans and insurers in California, as specified. The bill would require the departments to jointly adopt and amend regulations to implement these provisions, as specified.

Existing law requires health care service plans and health insurers to use disclosure forms containing certain information in order to provide a full and fair disclosure of the provisions of a contract or policy, as specified.

This bill would require that this disclosure be made available on the plan's or insurer's Internet Web site. With respect to individual plan contracts or policies, the bill would require the form to include provisions relating to an individual's right to apply for any benefit plan design issued by the plan or insurer at the time of application for a new contract or policy and at the time of renewal of a contract or policy and

information concerning the availability of a listing of all the contracts or policies and benefit designs offered to individuals by the plan or insurer, as specified.

Existing law requires each health care service plan offering a contract to an individual or small group to provide a uniform health plan benefits and coverage matrix containing the plan's major provisions, as specified.

This bill would also impose that requirement on health insurers offering policies to individual or small groups and would, with respect to both plans and insurers, require that the matrix be made available on the plan's or insurer's Internet Web site.

Existing law requires health care service plan contracts and health insurance policies to provide coverage for certain benefits. Under existing law, health care service plan contracts are required, subject to certain exemptions, to provide basic health care services, as defined, among other benefits.

This bill would require health insurance policies issued, amended, or renewed on or after January 1, 2011, to provide coverage for medically necessary basic health care services, as defined. The bill would also prohibit health insurance policies and health care service plan contracts issued, amended, or renewed on or after January 1, 2011, from imposing annual or lifetime limits on basic health care services.

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the 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.

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

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

SECTION 1. 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, except that the disclosure form shall also be made available on the plan's Internet Web site.

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, including the location of that information on the plan's Internet Web site.

(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 the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

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

(14) Conditions and procedures for disenrollment.

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

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

(17) A notice as required by Section 1364.5.

(18) For individual contracts, both of the following:

(A) Provisions relating to an individual's right to apply for any benefit plan design 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.

(B) Information concerning the availability of a listing of all the plan's contracts and benefit plan designs offered to individuals, including the rates for each contract.

(b) (1) The director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall be made available on the plan's Internet Web site and shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.

(K) Chemical dependency services.

(L) Home health services.

(M) Other.

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

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(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 under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

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

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

provided the plan identifies the geographic area and reports information applicable to that geographic area.

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

SEC. 2. Article 4.1 (commencing with Section 1366.10) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 4.1. California Individual Market Simplification

1366.10. (a) It is the intent of the Legislature to require health care service plans and health insurers issuing coverage in the individual market to compete on the basis of price, quality, and service, and not on risk selection.

(b) The purpose of this article is to provide for individual coverage with standardized benefit plan designs and to facilitate comparison shopping and price competition.

1366.11. For purposes of this article, the following definitions shall apply:

(a) "Benefit plan design" means a specific individual health care coverage product issued by a health care service plan.

(b) "Commission" means the Individual Insurance Market Reform Commission established pursuant to Section 1366.14.

(c) "Coverage choice category" refers to the levels of coverage identified in subdivision (c) of Section 1366.13.

1366.13. (a) A health care service plan offering individual plan contracts shall fairly and affirmatively offer and market all of the standard benefit plan designs provided for in this section and any additional standard benefit plan designs authorized through regulations adopted pursuant to subdivision (c) of Section 1366.14 to all individual purchasers in each service area in which the plan provides or arranges for the provision of health care services.

(b) Except as provided in subdivision (a) of Section 1366.15, no benefit plan designs other than the standard benefit plan designs described in this article shall be offered for sale to individuals in this state.

(c) Standard benefit plan designs shall be offered in platinum, gold, silver, bronze, and catastrophic coverage choice categories and shall meet the requirements described in the following table,

except as modified by regulations adopted pursuant to subdivision (c) of Section 1366.14:

HMO					
	1	2	3	4	5
Plan Name	Platinum	Gold	Silver	Bronze	Catastrophic
Benefit Designs					
Deductible	$0	$0	$1,500	$2,000	$2,500
Out-of-pocket Maximum	$1,000	$2,000	$4,000	$5,000	$5,950
Maternity	Yes	Yes	Yes	Yes	Yes
Office Visit	$10	$40	$30	$40	$45
In-Patient stay /day	$100	$200	$350	$500	20%
GP-Surgery	$50	$100	$200	$250	20%
Lab/Rad	$10	$15	$20	$25	20%
MRI, CT, and PET	$25	$50	$100	$100	20%
Emergency Room	$100	$100	$150	$250	20%
Preventive Health Services	$0	$0	$0	$0	$0
In-Patient stay /day	-	-	-	-	-
Outpatient Surgery	-	-	-	-	-

PPO											
	1		2		3		4		5		
Plan Name	Platinum		Gold		Silver		Bronze		Catastrophic		
Benefits Designs											
	In-Network	Out-of-Network	IN	OON	IN	OON	IN	OON	IN	OON	
Deductible		$100		$500		$1,500		$2,000		$2,500	
Out-of-pocket Maximum		$1,000		$2,000		$4,000		$5,000		$5,950	
Maternity		Yes		Yes		Yes		Yes		Yes	
Office Visit	$5	30%	$20	40%	$30	50%	$40	50%	$45	50%	
In-Patient stay /day	10%	30%	20%	40%	30%	50%	35%	50%	40%	50%	
GP-Surgery											
Lab/Rad											
MRI, CT, and PET											
Emergency Room											
Preventive Health Services	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%	
In-Patient stay /day	-	$800	-	$800	-	$800	-	$800	-	$800	
Outpatient Surgery	-	$500	-	$500	-	$500	-	$500	-	$500	

		HMO					PPO					
		1	2	3	4	5	1	2	3	4	5	
Plan Name		Platinum	Gold	Silver	Bronze	Catastrophic	Platinum	Gold	Silver	Bronze	Catastrophic	
Benefit Designs							Benefits Designs					
							In-Network	Out-of-Network	IN	OON	IN	OON	IN	OON	IN	OON	IN	OON
	Deductible	$0	$0	$1,500	$2,000	$2,500	$100		$500		$1,500		$2,000		$2,500	
	Out-Of-Pocket Maximum	$1,000	$2,000	$4,000	$5,000	$5,950	$1,000		$2,000		$4,000		$5,000		$5,950	
	Maternity	Yes	Yes	Yes	Yes	Yes	Yes		Yes		Yes		Yes		Yes	
Copays / Co-insurance (after meeting deductible where applicable)	Office Visit	$10	$40	$30	$40	$45	$5	30%	$20	40%	$30	50%	$40	50%	$45	50%
	In Patient stay /day	$100	$200	$350	$500	20%										
	OP Surgery	$50	$100	$200	$250	20%										
	Lab/Rad	$10	$15	$20	$25	20%	10%	30%	20%	40%	30%	50%	35%	50%	40%	50%
	MRI, CT, and PET	$25	$50	$100	$100	20%										
	Emergency Room	$100	$100	$150	$250	20%										
	Preventive Health Services	$0	$0	$0	$0	$0	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%
Maximum payment for Out-of-Network	In Patient stay /day	-	-	-	-	-	-	$800	-	$800	-	$800	-	$800	-	$800
	Outpatient Surgery	-	-	-	-	-	-	$500	-	$500	-	$500	-	$500	-	$500

(d) For families enrolled in the same plan contract, the deductible and out-of-pocket maximum thresholds shall be twice the individual thresholds. In calculating these thresholds for the catastrophic benefit plan design, a plan shall follow the requirements for health savings accounts under Section 223 of the Internal Revenue Code.

(e) A health care service plan shall offer and market one standard benefit plan design in each coverage choice category. A health care service plan may, but shall not be required, to offer a preferred provider type of benefit plan design.

(f) A plan design in the catastrophic coverage choice category shall have cost-sharing and an out-of-pocket maximum that enables it to be offered with a health savings account that has preferred federal income tax status under Section 223 of the Internal Revenue Code.

(g) For the plan designs offered in the catastrophic coverage choice category, all services, except preventive health services, as defined in Section 2713 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), shall be subject to the deductible. For all other standard benefit plan designs, all services, except office visits and preventive health services, as defined in Section 2713 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), shall be subject to the deductible.

(h) Compliance with the requirements of this article and Chapter 9.6 (commencing with Section 10960) of Part 2 of Division 2 of the Insurance Code, and any regulations adopted pursuant to subdivision (c) of Section 1366.14, shall be enforced consistently between health care service plans and health insurers regardless of licensure.

(i) Nothing in this section shall require guarantee issue of coverage.

1366.14. (a) The Individual Insurance Market Reform Commission is hereby established to do both of the following:

(1) Develop, as required by Section 1366.16 of this code and Section 10960.4 of the Insurance Code, a standardized enrollment questionnaire to be used by all health care service plans and health insurers that offer and sell individual coverage.

(2) Review and, if necessary, suggest changes to the standard benefit plan designs required to be offered by health care service plans in the individual market under this article, and the standard

benefit plan designs required to be offered by health insurers in the individual market under Chapter 9.6 (commencing with Section 10960) of Part 2 of Division 2 of the Insurance Code.

(b) (1) The commission shall consist of nine members, each of whom shall have demonstrated knowledge and experience in health care and issues relevant to the commission's responsibilities. The appointments shall be made as follows:

(A) The Governor shall appoint five members as follows:

(i) One actuary with experience in health care coverage pricing in the individual market.

(ii) One representative of a health insurer, which insurer has a certificate of authority from the Department of Insurance, provides preferred provider organization coverage, and has a significant number of insureds in the individual market.

(iii) One representative of a health care service plan, which plan is licensed by the department, provides health maintenance organization coverage, and has a significant number of enrollees in the individual market.

(iv) One representative of consumers who has a demonstrated record of advocating health care issues on behalf of consumers before a state regulatory agency.

~~(v) One representative of ____.~~

(v) One health care economist with knowledge of the individual market.

(B) The Senate Committee on Rules shall appoint two members as follows:

(i) One representative of health care providers who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code or under an initiative act referred to in that division.

(ii) One representative of consumers who has a demonstrated record advocating health care issues on behalf of consumers before a state regulatory agency.

(C) The Speaker of the Assembly shall appoint two members as follows:

(i) One representative of consumers who has a demonstrated record of advocating health care issues on behalf of consumers before a state regulatory agency.

~~(ii) One representative of ____.~~

(ii) One representative of self-employed individuals who purchase individual health insurance.

(2) In addition, the Secretary of California Health and Human Services or his or her designee, the director or his or her designee, and the Insurance Commissioner or his or her designee shall serve as nonvoting members of the commission.

(c) (1) The commission shall conduct the review required by paragraph (2) of subdivision (a) within six months following the effective date of federal regulations adopted pursuant to Section 1302 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), and at least every two years thereafter.

(2) If the commission suggests changes to the standard benefit plan designs established under Section 1366.13 of this code and Section 10960.4 of the Insurance Code or suggests standard benefit plan designs that are in addition to those established under those sections, the director and the Insurance Commissioner shall jointly adopt regulations, pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), that shall contain standardized benefits and cost sharing and shall be substantially based on the standard benefit plan designs suggested by the commission.

1366.15. (a) On and after July 1, 2011, health care service plans participating in the individual market shall discontinue offering and selling health benefit plan designs other than those that meet the requirements of the standard benefit plan designs described in this article. However, health care service plans shall renew health benefit plan designs issued to individuals and their dependents prior to July 1, 2011, until July 1, 2012.

(b) (1) Notwithstanding Section 1389.5, an individual enrolled in a benefit plan design may, on a guarantee issue basis, change to a different benefit plan design issued by the same plan or to a benefit plan design issued by a health insurer or a different health care service plan only as set forth in this subdivision. For individuals enrolled as a family, only the subscriber may change plan designs or switch to a health insurer or a different health care service plan for himself or herself and for his or her enrolled spouse, registered domestic partner, and dependents.

(2) On the annual renewal date of an individual plan contract, an individual shall have the right to select, on a guarantee issue

basis, a different benefit plan design issued by the same plan, or a benefit plan design issued by a health insurer or a different health care service plan, provided that the new plan design is within the same or a lower coverage choice category. A subscriber enrolled in a benefit plan design issued prior to July 1, 2011, may switch to a standard benefit plan design pursuant to this paragraph that is of equal or lesser actuarial value.

(3) Notice of the right to change benefit plan designs and to switch to a health insurer or a different health care service plan established by paragraph (2) shall be included in the plan's evidence of coverage and in the notice required pursuant to paragraph (2) of subdivision (b) of Section 1389.25.

(c) Nothing in this section shall prohibit a subscriber or enrollee from changing benefit plan designs, health care service plans, or health insurers at any time if the individual passes medical underwriting, or as required by federal law.

1366.16. (a) (1) The commission shall develop a standardized enrollment questionnaire to be used by all health care service plans and health insurers that offer and sell individual coverage. The questionnaire shall be written in clear and easy to understand language. The questionnaire, which shall be completed by a prospective subscriber applying for individual coverage from a plan or insurer, shall provide for an objective evaluation of the potential subscriber's health status, and that of his or her dependents applying for coverage, by assigning a discrete measure, such as a system of point scoring, to each potential subscriber.

(2) No later than six months following the date the commission develops the standardized enrollment questionnaire, all health care service plans shall do both of the following:

(A) Exclusively use that questionnaire and not use other questionnaires or forms in order to conduct underwriting, except as provided in paragraph (3).

(B) Utilize the objective evaluation developed by the commission under paragraph (1) in determining whether to provide coverage.

(3) On and after January 1, 2014, a health care service plan shall not require, request, or obtain health information as part of the application process for an applicant who is eligible for guaranteed issuance of coverage. The application form shall include a clear

and conspicuous statement that the applicant is not required to provide health information.

(b) The commission shall establish a methodology for the graduation of accepted risk into three risk categories based on responses to the questionnaire: "higher risk," "standard risk," and "preferred risk."

(c) On and after January 1, 2011, rates between the highest risk category and the lowest risk category shall not vary by more than a ratio of 2 to 1 within each standard benefit plan design offered by a health care service plan within each coverage choice category. ~~On and after ____, rates between the highest risk category and the lowest risk category shall not vary by more than ____ within each standard benefit plan design offered by a health care service plan within each coverage choice category.~~

1366.17. (a) Except as provided in subdivision (b), a health care service plan shall rate its entire portfolio of health benefit plan designs in the individual market utilizing the methodology established under subdivision (b) of Section 1366.16.

(b) The annualized premium rate increase for a health care service plan contract issued by a health care service plan to an individual shall not vary by more than 10 percent above or below the weighted average premium rate increase when calculated across all of the health care service plan's health benefit plan designs. This limitation shall exclude any change in the annual premium rate due to a change in the individual's age. In addition, the highest standard premium rate for a standard benefit plan design offered in the individual market by a health care service plan (at any age, geographic area, family size, contract type, network, and effective date) shall not exceed the lowest standard premium rate for a standard benefit plan design offered in the individual market by the health care service plan (at the same age, geographic area, family size, contract type, network, and effective date) by more than 50 percent, after taking into consideration the actuarial difference of the standard benefit plan designs offered.

(c) In rating individuals, only the following characteristics of an individual shall be used: age, geographic region, and family composition, plus the health benefit plan design selected by the individual, except that health status may also be used until January 1, 2014. In using age as a rating factor, benefit plan designs in the individual market shall use single-use year age categories for

individuals above 18 years of age and under 65 years of age. In using geographic region as a rating factor, a health care service plan shall use the same geographic rating requirements required under paragraph (3) of subdivision (k) of Section 1357. Health care service plans shall base rates for individuals using no more than the following family size categories:

(1) Single.

(2) More than one child 18 years of age or under and no adults.

(3) Married couple or registered domestic partners.

(4) One adult and child.

(5) One adult and children.

(6) Married couple and child or children, or registered domestic partners and child or children.

1366.18. This article shall not apply to individual health care service plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medi-Cal contracts with the State Department of Health Care Services, Healthy Families Program contracts with the Managed Risk Medical Insurance Board, contracts with the Managed Risk Medical Insurance Board under the Major Risk Medical Insurance Program, Medicare supplement contracts, long-term care contracts, or specialized health care service plan contracts.

SEC. 3. Section 1367.001 is added to the Health and Safety Code, to read:

1367.001. A full service health care service plan contract issued, amended, or renewed on or after January 1, 2011, shall have no annual or lifetime limits on basic health care services.

~~SEC. 3.~~

SEC. 4. Section 1378.1 is added to the Health and Safety Code, to read:

1378.1. (a) For purposes of this section, the following definitions apply:

(1) (A) "Health care benefits" means health care services that are either provided by or reimbursed by the plan or its contracted providers as plan benefits. "Health care benefits" shall also include all of the following:

(i) The costs of programs or activities, including training and the provision of informational materials that are determined as part of the regulations under subdivision (e) to improve the

provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.

(ii) Disease management expenses using cost-effective evidence-based guidelines.

(iii) Plan medical advice by telephone.

(iv) Payments to providers as risk pool payments of pay-for-performance initiatives.

(B) "Health care benefits" shall not include administrative costs listed in Section 1300.78 of Title 28 of the California Code of Regulations in effect on January 1, 2010.

(2) "Large group coverage," "large group health care service plan contract," or "large group health insurance policy" means group coverage other than coverage issued to a small employer, as defined in Section 1357.

(3) "Small group coverage," "small group health care service plan contract," or "small group health insurance policy" means group coverage issued to a small employer, as defined in Section 1357.

(b) Except as provided in subdivision (g), on and after January 1, 2011, a full-service health care service plan shall expend in the form of health care benefits no less than the following percentage of the aggregate dues, fees, premiums, or other periodic payments received by the plan:

(1) Eighty-five percent, with respect to large group coverage.

(2) Eighty percent, with respect to individual and small group coverage.

(c) For purposes of this section, the plan may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the plan the amount of income taxes or other taxes that the plan expensed.

(d) (1) To assess compliance with paragraph (1) of subdivision (b), a plan licensed to operate in California may average its total costs across all large group health care service plan contracts issued, amended, or renewed by the plan in California and all large group health insurance policies issued, amended, or renewed in California by its affiliated health insurers with valid California certificates of authority, except for those policies listed in subdivision (g) of Section 10112.7 of the Insurance Code.

(2) To assess compliance with paragraph (2) of subdivision (b), a plan licensed to operate in California may average its total costs

across all individual and small group health care service plan contracts issued, amended, or renewed by the plan in California and all individual and small group health insurance policies issued, amended, or renewed in California by its affiliated health insurers with valid California certificates of authority, except for those policies listed in subdivision (g) of Section 10112.7 of the Insurance Code.

(e) The department and the Department of Insurance shall jointly adopt and amend regulations to implement this section and Section 10112.7 of the Insurance Code to establish uniform reporting by plans and insurers of the information necessary to determine compliance with this section. These regulations may include additional elements in the definition of health care benefits not identified in paragraph (1) of subdivision (a) in order to consistently implement the requirements of this section among health plans and health insurers, but such regulatory additions shall be consistent with the legislative intent that health plans expend at least 80 or 85 percent of aggregate payments on health care benefits as provided in subdivision (b).

(f) A health care service plan shall, in a manner specified by the department and the Department of Insurance in regulations adopted pursuant to subdivision (e), provide for rebates to enrollees reflecting the amount by which the plan's medical loss ratio is less than the level required by this section.

(g) This section shall not apply to Medicare supplement plans or to coverage offered by specialized health care service plans, including, but not limited to, ambulance, dental, vision, behavioral health, chiropractic, and naturopathic.

~~SEC. 4. Section 1367.001 is added to the Health and Safety Code, to read:~~

~~1367.001. A full service health care service plan contract issued, amended, or renewed on or after January 1, 2011, shall have no annual or lifetime limits on basic health care services.~~

SEC. 5. Section 1389.25 of the Health and Safety Code is amended to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000)

of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) A health care service plan that declines to offer coverage or denies enrollment for an individual or his or her dependents applying for individual coverage or that offers individual coverage at a rate that is higher than the standard rate, shall provide the individual applicant with the specific reason or reasons for the decision in writing at the time of the denial or offer of coverage.

(2) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has delivered a written notice of the change at least 30 days prior to the effective date of the contract renewal or the date on which the rate or coverage changes. A notice of an increase in the premium rate shall include the reasons for the rate increase.

(3) The written notice required pursuant to paragraph (2) shall be delivered to the individual contractholder at his or her last address known to the plan, at least 30 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium rate increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change to the plan design or benefits. The notice shall also describe the individual contractholder's right

to change benefit plan designs and to switch to a health insurer or a different health care service plan, as set forth in Section 1366.15.

(4) If a plan rejects an applicant or the dependents of an applicant for coverage or offers individual coverage at a rate that is higher than the standard rate, the plan shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code). The information provided to the applicant by the plan shall specifically include the program's toll-free telephone number and its Internet Web site address. The requirement to notify applicants of the availability of the California Major Risk Medical Insurance Program shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

(c) A notice provided pursuant to this section is a private and confidential communication and at the time of application, the plan shall give the individual applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

SEC. 6. Section 10112.56 is added to the Insurance Code, to read:

10112.56. (a) For purposes of this section, "basic health care services" has the same meaning as set forth in Section 1345 of the Health and Safety Code and in Section 1300.67 of Title 28 of the California Code of Regulations.

(b) A health insurance policy issued, amended, or renewed on or after January 1, 2011, shall provide coverage for medically necessary basic health care services.

(c) A health insurance policy issued, amended, or renewed on or after January 1, 2011, shall have no annual or lifetime limits on basic health care services.

(d) Nothing in this section shall prohibit a health insurer from charging policyholders or insureds a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the commissioner and set forth to the policyholder or insured pursuant to the disclosure provisions of Section 10604.

(e) This section shall not apply to specialized health insurance policies, Medicare supplement policies, CHAMPUS-supplement insurance policies, TRICARE supplement insurance policies, accident-only insurance policies, or insurance policies excluded from the definition of "health insurance" under subdivision (b) of Section 106.

SEC. 7. Section 10112.7 is added to the Insurance Code, to read:

10112.7. (a) For purposes of this section, the following definitions apply:

(1) (A) "Health care benefits" means health care services that are either provided or reimbursed by the insurer or its contracted providers as covered benefits. "Health care benefits" shall also include all of the following:

(i) The costs of programs or activities, including training and the provision of informational materials that are determined as part of the regulations under subdivision (e) to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.

(ii) Disease management expenses using cost-effective evidence-based guidelines.

(iii) Plan medical advice by telephone.

(iv) Payments to providers as risk pool payments of pay-for-performance initiatives.

(B) "Health care benefits" shall not include administrative costs listed in Section 1300.78 of Title 28 of the California Code of Regulations in effect on January 1, 2010.

(2) "Large group coverage," "large group health care service plan contract," or "large group health insurance policy" means group coverage other than coverage issued to a small employer, as defined in Section 10700.

(3) "Small group coverage," "small group health care service plan contract," or "small group health insurance policy" means group coverage issued to a small employer, as defined in Section 10700.

(b) Except as provided in subdivision (g), on and after January 1, 2011, a health insurer shall expend in the form of health care benefits no less than the following percentage of the aggregate dues, fees, premiums, or other periodic payments received by the insurer:

(1) Eighty-five percent, with respect to large group coverage.

(2) Eighty percent, with respect to individual and small group coverage.

(c) For purposes of this section, the insurer may deduct from the aggregate dues, fees, premiums, or other periodic payments received by the insurer the amount of income taxes or other taxes that the insurer expensed.

(d) (1) To assess compliance with paragraph (1) of subdivision (b), a health insurer with a valid certificate of authority may average its total costs across all large group health insurance policies issued, amended, or renewed by the insurer in California and all large group health care service plan contracts issued, amended, or renewed in California by its affiliated health care service plans licensed to operate in California, except for those contracts listed in subdivision (g) of Section 1378.1 of the Health and Safety Code.

(2) To assess compliance with paragraph (2) of subdivision (b), a health insurer with a valid certificate of authority may average its total costs across all individual and small group health insurance policies issued, amended, or renewed by the insurer in California and all individual and small group health care service plan contracts issued, amended, or renewed in California by its affiliated health care service plans licensed to operate in California, except for those contracts listed in subdivision (g) of Section 1378.1 of the Health and Safety Code.

(e) The department and the Department of Managed Health Care shall jointly adopt and amend regulations to implement this section and Section 1378.1 of the Health and Safety Code to establish uniform reporting by plans and insurers of the information necessary to determine compliance with this section. These regulations may include additional elements in the definition of health care benefits not identified in paragraph (1) of subdivision (a) in order to consistently implement the requirements of this section among health plans and health insurers, but such regulatory additions shall be consistent with the legislative intent that health plans and health insurers expend at least 80 or 85 percent of aggregate payments on health care benefits as provided in subdivision (b).

(f) A health insurer shall, in a manner specified by the department and the Department of Managed Health Care in

regulations adopted pursuant to subdivision (e), provide for rebates to insureds reflecting the amount by which the insurer's medical loss ratio is less than the level required by this section.

(g) This section shall not apply to Medicare supplement policies, administrative services-only policies, or other similar administrative arrangements, short-term limited duration health insurance policies, vision-only, dental-only, behavioral health-only, or pharmacy-only policies, CHAMPUS-supplement or TRICARE-supplement insurance policies, or to hospital indemnity, hospital only, accident only, or specified disease insurance policies that do not pay benefits on a fixed benefit, cash payment only basis.

SEC. 8. Section 10113.9 of the Insurance Code is amended to read:

10113.9. (a) This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, or CHAMPUS-supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) No change in the premium rate or coverage for an individual health insurance policy shall become effective unless the insurer has delivered a written notice of the change at least 30 days prior to the effective date of the contract renewal or the date on which the rate or coverage changes. A notice of an increase in the premium rate shall include the reasons for the rate increase.

(c) The written notice required pursuant to subdivision (b) shall be delivered to the individual policyholder at his or her last address known to the insurer, at least 30 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits. The notice shall also describe the individual policyholder's right to change benefit plan designs and to switch to a health care service plan or a different health insurer, as set forth in Section 10960.3.

(d) If an insurer rejects an applicant or the dependents of an applicant for coverage or offers individual coverage at a rate that is higher than the standard rate, the insurer shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)). The information provided to the applicant by the insurer shall specifically include the program's toll-free telephone number and its Internet Web site address. The requirement to notify applicants of the availability of the California Major Risk Medical Insurance Program shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

SEC. 9. Section 10603 of the Insurance Code is amended to read:

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

(b) Nothing in this section shall preclude the disclosure form from being included with the evidence of coverage or certificate of coverage or policy, except that, with respect to health insurance policies, the disclosure form shall also be made available on the insurer's Internet Web site.

SEC. 10. Section 10604 of the Insurance Code is amended to read:

10604. The disclosure form described in Section 10603 shall include the following information, in concise and specific terms, relative to the disability insurance policy:

(a) The applicable category or categories of coverage provided by the policy, from among the following:

(1) Basic hospital expense coverage.

(2) Basic medical-surgical expense coverage.

(3) Hospital confinement indemnity coverage.

(4) Major medical expense coverage.

(5) Disability income protection coverage.

(6) Accident only coverage.

(7) Specified disease or specified accident coverage.

(8) Such other categories as the commissioner may prescribe.

(b) The principal benefits and coverage of the disability insurance policy.

(c) The exceptions, reductions, and limitations that apply to such policy.

(d) A summary, including a citation of the relevant contractual provisions, of the process used to authorize or deny payments for services under the coverage provided by the policy including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. This subdivision shall only apply to policies of disability insurance that cover hospital, medical, or surgical expenses.

(e) The full premium cost of such policy.

(f) Any copayment, coinsurance, or deductible requirements that may be incurred by the insured or his or her family in obtaining coverage under the policy.

(g) The terms under which the policy may be renewed by the insured, including any reservation by the insurer of any right to change premiums.

(h) A statement that the disclosure form is a summary only, and that the policy itself should be consulted to determine governing contractual provisions.

(i) For individual health insurance policies and health benefit plans, as defined in Section 10700, identification of the location of the health plan benefits and coverage matrix required by Section 10604.2, including the location of this information on the insurer's Internet Web site.

(j) For individual health insurance policies, both of the following:

(A) Provisions relating to an individual's right to apply for any benefit plan design written, issued, or administered by the health insurer at the time of application for a new health insurance policy, or at the time of renewal of a health insurance policy.

(B) Information concerning the availability of a listing of all the health insurer's policies and benefit plan designs offered to individuals, including the rates for each policy.

SEC. 11. Section 10604.2 is added to the Insurance Code, to read:

10604.2. (a) The commissioner shall require each health insurer offering a policy of health insurance to an individual or small employer, as defined in Section 10700, to provide with the disclosure form described in Section 10603 for individual policies and health benefit plans, as defined in Section 10700, a uniform health plan benefits and coverage matrix containing the policy's major provisions in order to facilitate comparisons between policies. The uniform matrix shall be available on the insurer's Internet Web site, and shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(1) Deductibles.
(2) Lifetime maximums.
(3) Professional services.
(4) Outpatient services.
(5) Hospitalization services.
(6) Emergency health coverage.
(7) Ambulance services.
(8) Prescription drug coverage.
(9) Durable medical equipment.
(10) Mental health services.
(11) Chemical dependency services.
(12) Home health services.
(13) Other.

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

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

SEC. 12. Chapter 9.6 (commencing with Section 10960) is added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 9.6. California Individual Market Simplification

10960. (a) It is the intent of the Legislature to require health care service plans and health insurers issuing coverage in the

individual market to compete on the basis of price, quality, and service, and not on risk selection.

(b) The purpose of this chapter is to provide for individual coverage with standardized benefit plan designs, and to facilitate comparison shopping and price competition.

10960.1. For purposes of this chapter, the following definitions shall apply:

(a) "Benefit plan design" means a specific individual health care coverage product issued by a health insurer.

(b) "Commission" means the Individual Insurance Market Reform Commission established pursuant to Section 1366.14 of the Health and Safety Code.

(c) "Coverage choice category" refers to the levels of coverage identified in subdivision (c) of Section 10960.2.

10960.2. (a) An insurer offering individual health insurance policies shall fairly and affirmatively offer and market all of the standard benefit plan designs provided for in this section and any additional standard benefit plan designs authorized through regulations adopted pursuant to subdivision (c) of Section 1366.14 of the Health and Safety Code to all individual purchasers in each service area in which the insurer makes coverage available or provides benefits.

(b) Except as provided in subdivision (a) of Section 10960.3, no benefit plan designs other than the standard benefit plan designs described in this chapter shall be offered for sale to individuals in this state.

(c) Standard benefit plan designs shall be offered in platinum, gold, silver, bronze, and catastrophic coverage choice categories and shall meet the requirements described in the following table, except as modified by regulations adopted pursuant to subdivision (c) of Section 1366.14 of the Health and Safety Code:

		PPO									
		1		2		3		4		5	
	Plan Name	Platinum		Gold		Silver		Bronze		Catastrophic	
		Benefits Designs									
		In-Network	Out-of-Network	IN	OON	IN	OON	IN	OON	IN	OON
	Deductible	$100		$500		$1,500		$2,000		$2,500	
	Out-of-pocket Maximum	$1,000		$2,000		$4,000		$5,000		$5,950	
	Maternity	Yes		Yes		Yes		Yes		Yes	
Copays / Co-insurance (after meeting deductible where applicable)	Office Visit	$5	30%	$20	40%	$30	50%	$40	50%	$45	50%
	In Patient stay /day	10%	30%	20%	40%	30%	50%	35%	50%	40%	50%
	OP Surgery										
	Lab/Rad										
	MRI, CT, and PET										
	Emergency Room										
	Preventive Health Services	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%
Maximum payment for Out	In Patient stay /day	-	$800	-	$800	-	$800	-	$800	-	$800
	Outpatient Surgery	-	$500	-	$500	-	$500	-	$500	-	$500

PPO										
	1		2		3		4		5	
Plan Name	Platinum		Gold		Silver		Bronze		Catastrophic	
Benefit Designs										
	In-Network	**Out-of-Network**	**IN**	**OON**	**IN**	**OON**	**IN**	**OON**	**IN**	**OON**
Deductible	$100		$500		$1,500		$2,000		$2,500	
Out-Of-Pocket Maximum	$1,000		$2,000		$4,000		$5,000		$5,950	
Maternity	Yes		Yes		Yes		Yes		Yes	
Copays / Co-insurance (after meeting deductible where applicable)	Office Visit	$5	30%	$20	40%	$30	50%	$40	50%	$45	50%
	In Patient stay /day	10%	30%	20%	40%	30%	50%	35%	50%	40%	50%
	OP Surgery										
	Lab/Rad										
	MRI, CT, and PET										
	Emergency Room										
	Preventive Health Services	$0	0%	$0	0%	$0	0%	$0	0%	$0	0%
Maximum payment for Out-of-Network	In Patient stay /day	-	$800	-	$800	-	$800	-	$800	-	$800
	Outpatient Surgery	-	$500	-	$500	-	$500	-	$500	-	$500

(d) For families enrolled in the same policy, the deductible and maximum out-of-pocket thresholds shall be twice the individual thresholds. In calculating these thresholds for the catastrophic benefit plan design, an insurer shall follow the requirements for health savings accounts under Section 223 of the Internal Revenue Code.

(e) A health insurer shall offer and market one standard benefit plan design in each coverage choice category. A health insurer shall not be required to offer a health maintenance organization benefit plan design.

(f) A plan design in the catastrophic coverage choice category shall have cost-sharing and an out-of-pocket maximum that enables it to be offered with a health savings account that has preferred federal income tax status under Section 223 of the Internal Revenue Code.

(g) For the plan designs offered in the catastrophic coverage choice category, all services, except preventive health services, as defined in Section 2713 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), shall be subject to the deductible. For all other standard benefit plan designs, all services, except office visits and preventive health services, as defined in Section 2713 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), shall be subject to the deductible.

(h) Compliance with the requirements of this chapter and Article 4.1 (commencing with Section 1366.10) of Chapter 2.2 of Division 2 of the Health and Safety Code, and any regulations adopted pursuant to subdivision (c) of Section 1366.14 of the Health and Safety Code, shall be enforced consistently between health insurers and health care service plans regardless of licensure.

(i) Nothing in this section shall require guarantee issue of coverage.

10960.3. (a) On and after July 1, 2011, health insurers participating in the individual market shall discontinue offering and selling health benefit plan designs other than those that meet the requirements of the standard health benefit plan designs described in this chapter. However, health insurers shall renew health benefit plan designs issued to individuals and their dependents prior to July 1, 2011, until July 1, 2012.

(b) (1) Notwithstanding Section 10119.1, an individual enrolled in a benefit plan design may change to a different benefit plan

design issued by the same insurer or to a benefit plan design issued by a health care service plan or a different health insurer on a guarantee issue basis only as set forth in this subdivision. For individuals enrolled as a family, only the policyholder may change plan designs or switch to a health care service plan or a different health insurer for himself or herself and for his or her enrolled spouse, registered domestic partner, and dependents.

(2) On the annual renewal date of an individual health insurance policy, an individual shall have the right to select, on a guarantee issue basis, a different benefit plan design issued by the same insurer, or a benefit plan design issued by a health care service plan or a different health insurer, provided that the new plan design is within the same or a lower coverage choice category. A policyholder enrolled in a benefit plan design issued prior to July 1, 2011, may switch to a standard benefit plan design pursuant to this paragraph that is of equal or lesser actuarial value.

(3) Notice of the right to change benefit plan designs and to switch to a health care service plan or a different health insurer established by paragraph (2) shall be included in the insurer's evidence of coverage and in the notice required pursuant to subdivision (c) of Section 10113.9.

(c) Nothing in this section shall prohibit a policyholder or insured from changing benefit plan designs, health care service plans, or health insurers at any time if the individual passes medical underwriting, or as required by federal law.

10960.4. (a) (1) The commission shall develop a standardized enrollment questionnaire to be used by all health care service plans and health insurers that offer and sell individual coverage. The questionnaire shall be written in clear and easy to understand language. The questionnaire, which shall be completed by a prospective policyholder applying for individual coverage from an insurer, shall provide for an objective evaluation of the potential policyholder's health status, and that of his or her dependents applying for coverage, by assigning a discrete measure, such as a system of point scoring, to each potential policyholder.

(2) No later than six months following the date the commission develops the standardized enrollment questionnaire, all health insurers shall do both of the following:

(A) Exclusively use that questionnaire and not use other questionnaires or forms in order to conduct underwriting, except as provided in paragraph (3).

(B) Utilize the objective evaluation developed by the commission under paragraph (1) in determining whether to provide coverage.

(3) On and after January 1, 2014, a health insurer shall not require, request, or obtain health information as part of the application process for an applicant who is eligible for guaranteed issuance of coverage. The application form shall include a clear and conspicuous statement that the applicant is not required to provide health information.

(b) The commission shall establish a methodology for the graduation of accepted risk into three risk categories based on responses to the questionnaire: "higher risk," "standard risk," and "preferred risk."

(c) On and after January 1, 2011, rates between the highest risk category and the lowest risk category shall not vary by more than a ratio of 2 to 1 within each standard benefit plan design offered by a health insurer within each coverage choice category. ~~On and after _____, rates between the highest risk category and the lowest risk category shall not vary by more than _____ within each standard benefit plan design offered by a health insurer within each coverage choice category.~~

~~10690.5.~~

10960.5. (a) Except as provided in subdivision (b), a health insurer shall rate its entire portfolio of health benefit plan designs in the individual market utilizing the methodology established under subdivision (b) of Section ~~10690.4~~ *10960.4*.

(b) The annualized premium rate increase for a health insurance policy issued by a health insurer to an individual shall not vary by more than 10 percent above or below the weighted average premium rate increase when calculated across all of the health insurer's health benefit plan designs. This limitation shall exclude any change in the annual premium rate due to a change in the individual's age. In addition, the highest standard premium rate for a standard benefit plan design offered in the individual market by a health insurer (at any age, geographic area, family size, contract type, network, and effective date) shall not exceed the lowest standard premium rate for a standard benefit plan design

offered in the individual market by the health insurer (at the same age, geographic area, family size, contract type, network, and effective date) by more than 50 percent, after taking into consideration the actuarial difference of the standard benefit plan designs offered.

(c) In rating individuals, only the following characteristics of an individual shall be used: age, geographic region, and family composition, plus the health benefit plan design selected by the individual, except that health status may also be used until January 1, 2014. In using age as a rating factor, benefit plan designs in the individual market shall use single-year age categories for individuals above 18 years of age and under 65 years of age. In using geographic region as a rating factor, a health insurer shall use the same geographic rating requirements required under paragraph (3) of subdivision (v) of Section 10700. Health insurers shall base rates for individuals using no more than the following family size categories:

(1) Single.

(2) More than one child 18 years of age or under and no adults.

(3) Married couple or registered domestic partners.

(4) One adult and child.

(5) One adult and children.

(6) Married couple and child or children, or registered domestic partners and child or children.

10962. This chapter shall not apply to individual health insurance policies for coverage of Medicare services pursuant to contracts with the United States Government, Medi-Cal contracts with the State Department of Health Care Services, Healthy Families Program contracts with the Managed Risk Medical Insurance Board, contracts with the Managed Risk Medical Insurance Board under the Major Risk Medical Insurance Program, Medicare supplement policies, long-term care policies, or specialized health insurance policies.

SEC. 13. 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.

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