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AMENDED IN ASSEMBLY APRIL 9, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1461

Introduced by Assembly Member Monning
(Principal coauthor: Senator Hernandez)

January 9, 2012

An act to amend Sections ~~1357.51~~ *1363* and 1399.829 of, to amend the heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of, *to amend, renumber, and add Section 1389.1 of, to amend and repeal Sections 1389.5 and 1399.816 of, to amend, repeal, and add Sections 1389.25, 1389.4, 1389.7, 1399.805, and 1399.811 of,* to add Section 1399.836 to, to add Article 11.8 (commencing with Section 1399.845) to Chapter 2.2 of Division 2 of, and to repeal Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections ~~10198.7~~ *10291.5* and 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, *to amend and repeal Sections 10119.1 and 10902.4 of, to amend, repeal, and add Sections 10113.9, 10113.95, 10119.2, 10901.3, and 10901.9 of,* to add ~~Section 10961~~ *Section 10960.5* to, to add Chapter ~~9.8~~ *9.9* (commencing with Section 10965) to Part 2 of Division 2 of, and to repeal Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1461, as amended, Monning. ~~Individual health~~ *Health* care coverage.

~~Existing~~

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA) enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate charge by a health insurance issuer offering small group or individual coverage to vary only by family composition, rating area, age, and tobacco use, as specified, and prohibits discrimination against individuals based on health status.

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 also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires plans and insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements.

This bill would ~~prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, from imposing any preexisting condition provision upon any individual, except as specified. The bill would~~ require a plan or insurer, on and after ~~January 1, 2014~~ *October 1, 2013*, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals *and dependents* in each service area in which the plan provides or arranges for the provision of health care services, *with coverage effective on or after January 1, 2014, as specified*, but would require plans and insurers to limit enrollment *in individual health benefit plans* to specified open enrollment and special enrollment periods. *The bill would prohibit these health benefit plans from imposing any preexisting condition upon any individual.* Commencing January 1, 2014, the bill would prohibit a plan or insurer from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified, and would authorize plans and insurers to use only age, geographic region, and ~~family size~~ *whether the plan covers an individual or family* for purposes of establishing rates for

individual health benefit plans*, as specified. The bill would require a health care service plan or health insurer to issue a specified notice at least 60 days prior to the renewal date of an individual grandfathered health plan to all subscribers and policyholders of the plan*. The bill would enact other related provisions and make related conforming changes.

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.

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

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

This bill would authorize the Department of Managed Health Care, until January 1, 2015, to waive or modify those requirements for purposes of compliance with PPACA, as specified.

(3) Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual insurance policies to fairly and affirmatively offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. Existing law prohibits the premium for those policies and contracts from exceeding the premium paid by a subscriber of the California Major Risk Medical Insurance Program who is of the same age and resides in the same geographic region as the federally eligible defined individual, as specified.

This bill would prohibit the premium for those policies and contracts from exceeding the premium for a specified plan offered in the individual market through the California Health Benefit Exchange in the rating area in which the individual resides.

~~The~~

(4) 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 1357.51 of the Health and Safety Code is amended to read:~~

~~1357.51. (a) No plan contract that covers three or more enrollees shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.~~

~~(b) No plan contract that covers one or two individuals shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall the plan limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.~~

~~(c) (1) Notwithstanding subdivision (a), a plan contract for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age. A plan contract for group coverage issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.~~

~~(2) Notwithstanding subdivision (b), a plan contract for individual coverage that is not a grandfathered health plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (P.L. 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age. A plan contract for individual coverage that is issued, amended, or renewed on or after January 1, 2014, and that is not a grandfathered health plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any individual.~~

~~(d) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.~~

~~(e) A plan that does not utilize a preexisting condition provision in plan contracts that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No plan may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.~~

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

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

~~(g) No plan shall exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.~~

~~(h) A health care service plan issuing group coverage may not impose a preexisting condition exclusion upon a condition relating to benefits for pregnancy or maternity care.~~

~~(i) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(e)).~~

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.

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

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

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

(3) The full premium cost of the plan.

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

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

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

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

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

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

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

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

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

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of

nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

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

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

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

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

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

(b) (1) As of July 1, 1999, 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 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.

(j) The department may waive or modify the requirements of this section for the purpose of resolving duplication or conflict with federal requirements for uniform benefit disclosure in effect pursuant to Section 2715 of the federal Public Health Service Act and the regulations adopted thereunder. The department shall implement this subdivision in a manner that preserves disclosure requirements of this section that exceed or are not in direct conflict with federal requirements. The department shall consult and coordinate with the Department of Insurance in implementing any regulations pursuant to this subdivision in order to provide consumers with comparable product information and uniform benefit summaries for all health care coverage in this state, consistent with the intent of federal law and this section. The department shall implement this section through issuance of all-plan letters until January 1, 2015.

SEC. 2. Section 1389.1 of the Health and Safety Code is amended and renumbered to read:

~~1389.1.~~

1389.11. (a) The director shall not approve any plan contract unless the director finds that the application conforms to ~~both of~~ the following requirements, *as applicable*:

(1) All applications for coverage, *except that which is guaranteed issue,* which include health-related questions shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions related to an applicant's health *in applications described in paragraph (1)* shall be based on medical information that is reasonable and necessary for medical underwriting purposes. The application shall include a prominently displayed notice that shall read:

"California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage."

(3) All applications for coverage subject to Article 11.8 (commencing with Section 1399.845) shall comply with paragraph (2) of subdivision (g) of Section 1399.849.

(b) Nothing in this section shall authorize the director to establish or require a single or standard application form for application questions.

SEC. 3. Section 1389.1 is added to the Health and Safety Code, to read:

1389.1. (a) For purposes of this article, the following definitions shall apply:

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

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

(b) This section shall become operative on November 1, 2013.

SEC. 4. 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, at the time of the denial or offer of coverage, provide the individual applicant with the specific reason or reasons for the decision in writing in clear, easily understandable language.

(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 60 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 60 days prior to the effective date of the change. The notice shall state in italics and in 12-point type the actual dollar amount of the premium rate increase and 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.

(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 (MRMIP) (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code. The information provided to the applicant by the plan shall be in accordance with standards developed by the department, in consultation with the Managed Risk Medical Insurance Board, and shall specifically include the toll-free telephone number and Internet Web site address for MRMIP and the federal temporary high risk pool. The requirement to notify applicants of the availability of MRMIP and the federal temporary high risk pool 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.

(d) This section shall become inoperative on November 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 5. Section 1389.25 is added to the Health and Safety Code, to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan contract in the individual market in California and shall not apply to a specialized health care service plan contract, 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 the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), a health care service plan contract offered under Part 6.4 (commencing with Section 12699.50) 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) No change in the premium rate or coverage for an individual health care service plan contract shall become effective unless the plan has delivered a written notice of the change at least 60 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.

(2) The written notice required pursuant to paragraph (1) shall be delivered to the individual contractholder at his or her last address known to the plan, at least 60 days prior to the effective date of the change. The notice shall state in italics and in 12-point type the actual dollar amount of the premium rate increase and 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. For individual grandfathered health plans, the notice shall also inform the individual contractholder about the availability of new coverage options and the potential for subsidized coverage in the California Health Benefit Exchange. The notice shall direct persons seeking more information to the California Health Benefit Exchange, the Office of Patient Advocate, plan or policy representatives, and insurance brokers or health navigators.

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

(2) If a plan rejects the dependents of an applicant for an individual grandfathered health plan or offers an individual grandfathered health plan at a rate that is higher than the standard rate, the plan shall inform the applicant about the new coverage options and the potential for subsidized coverage in the California Health Benefit Exchange. The plan shall direct persons seeking more information to the California Health Benefit Exchange, the Office of Patient Advocate, plan or policy representatives, and insurance brokers or health navigators.

(d) 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.

(e) This section shall become operative on November 1, 2013.

SEC. 6. Section 1389.4 of the Health and Safety Code is amended to read:

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

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 1365.5 and ~~1389.1~~ *1389.11* and all other applicable provisions of state and federal law.

(c) On or before June 1, 2006, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual

health plan contracts, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

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

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

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

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

(g) This section shall become inoperative on November 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 7. Section 1389.4 is added to the Health and Safety Code, to read:

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

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to individuals applying for an individual grandfathered health plan and sets the rate for that coverage. These guidelines, policies, or procedures shall ensure that the plan rating and underwriting criteria comply with Sections 1365.5 and 1389.11 and all other applicable provisions of state and federal law.

(c) On or before November 1, 2013, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual grandfathered health plans, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

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

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

(f) This section shall become operative on November 1, 2013.

SEC. 8. Section 1389.5 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 9. Section 1389.7 of the Health and Safety Code is amended to read:

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

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

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

(d) Notwithstanding subdivision (a) and (b), if an individual was subject to a preexisting condition provision or a waiting or an

affiliation period under the individual plan contract that was rescinded, the health care service plan may apply the same preexisting condition provision or waiting or affiliation period in the new individual plan contract. The time period in the new individual plan contract for the preexisting condition provision or waiting or affiliation period shall not be longer than the one in the individual plan contract that was rescinded and the health care service plan shall credit any time that the individual was covered under the rescinded individual plan contract.

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

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

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

(h) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 10. Section 1389.7 is added to the Health and Safety Code, to read:

1389.7. (a) Every health care service plan that offers, issues, or renews individual plan contracts shall offer to any individual, who was covered under an individual plan contract that was rescinded, a new individual plan contract that provides equal benefits. A health care service plan may also permit an individual, who was covered under an individual plan contract that was rescinded, to remain covered under that individual plan contract, with a revised premium rate that reflects the number of persons remaining on the plan contract consistent with Section 1399.855.

(b) If a new individual plan contract is issued, the plan may revise the premium rate to reflect only the number of persons covered on the new individual plan contract consistent with Section 1399.855.

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

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

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

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

(g) This section shall become operative on January 1, 2014.

SEC. 11. Section 1399.805 of the Health and Safety Code is amended to read:

1399.805. (a) (1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the following amounts:

(A) For health care service plan contracts that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible

defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A plan may adjust the premium based on family size, not to exceed the following amounts:

(A) For health care service plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.

(B) For health care service plans identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or 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 30 days after the effective date of the plan contract, the individual shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If the individual notified 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 enrolled individual notified 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.

(d) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 12. Section 1399.805 is added to the Health and Safety Code, to read:

1399.805. (a) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the premium for the second lowest cost silver plan of the individual market in the rating area in which the individual resides which is offered through the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code, as described in Section 36B(b)(3)(B) of Title 26 of the United States Code.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin 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 30 days after the effective date of the plan contract, the individual shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If the individual notified 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 enrolled individual notified 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.

(d) This section shall become operative on January 1, 2014.

SEC. 13. Section 1399.811 of the Health and Safety Code is amended to read:

1399.811. Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2001, shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age

and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(3) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

(4) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 14. Section 1399.811 is added to the Health and Safety Code, to read:

1399.811. (a) Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2014, shall be subject to the following requirements:

(1) The premium for in force or new business for a federally eligible defined individual shall not exceed the premium for the second lowest cost silver plan of the individual market in the rating area in which the individual resides which is offered through the

California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code, as described in Section 36B(b)(3)(B) of Title 26 of the United States Code.

(2) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

(b) This section shall become operative on January 1, 2014.

SEC. 15. Section 1399.816 of the Health and Safety Code is amended to read:

1399.816. *(a)* Carriers and health care service plans that offer contracts to individuals may elect to establish a mechanism or method to share in the financing of high-risk individuals. This mechanism or method shall be established through a committee of all carriers and health care service plans offering coverage to individuals by July 1, 2002, and shall be implemented by January 1, 2003. If carriers and health care service plans wish to establish a risk-sharing mechanism but cannot agree on the terms and conditions of such an agreement, the Managed Risk Medical Insurance Board shall develop a risk-sharing mechanism or method by January 1, 2003, and it shall be implemented by July 1, 2003.

(b) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

~~SEC. 2.~~

SEC. 16. The heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of the Health and Safety Code is amended to read:

Article 11.7. Child Access to Health Care Coverage

~~SEC. 3.~~

SEC. 17. Section 1399.829 of the Health and Safety Code is amended to read:

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

composition, plus the health care service plan contract selected by the child or the responsible party for the child.

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

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

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

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

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

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

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

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

(e) Health care service plans may require documentation from applicants relating to their coverage history.

(f) (1) On and after January 1, 2013, a health care service plan shall provide a notice to all applicants for coverage under this article and to all enrollees, or the responsible party for an enrollee, renewing coverage under this article that contains the following information:

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

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

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

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

(3) The department may adopt a model notice to be used by health care service plans in order to comply with this subdivision. Use of the model notice shall not require prior approval of the department. Any model notice designated by the department for purposes of this section shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

~~SEC. 4.~~

SEC. 18. Section 1399.836 is added to the Health and Safety Code, to read:

1399.836. This article shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

~~SEC. 5.~~

SEC. 19. Article 11.8 (commencing with Section 1399.845) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.8. Individual Access to Health Care Coverage

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

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

~~(a)~~

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

~~(b)~~

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

~~(c)~~

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

~~(d)~~

(e) "Health benefit plan" means any individual or group ~~health insurance~~ policy *of health insurance as defined in Section 106 of the Insurance Code* or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include ~~accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.~~ *a specialized health insurance policy, as defined in Section 106 of the Insurance Code, a specialized health care service plan contract, a health care service plan conversion contract offered pursuant to Section 1373.6, a health insurance conversion policy offered pursuant to Section 12682.1 of the Insurance Code, a health insurance policy or health care service plan contract provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of*

Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, a health care service plan contract or health insurance policy offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) of this code or Chapter 9.5 (commencing with Section 10900) of Part 2 of Division 2 of the Insurance Code, or Medicare supplement coverage, to the extent consistent with PPACA.

~~(e)~~

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

~~(f)~~

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

~~(g)~~

(h) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of PPACA.

~~(h)~~

(i) "Rating period" means the period for which premium rates established by a plan are in effect.

1399.847. Every health care service plan offering individual health benefit plans shall, in addition to complying with the provisions of this chapter and rules adopted thereunder, comply with the provisions of this article.

1399.849. (a) (1) On and after ~~January 1, 2014~~ *October 1, 2013*, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals *and dependents* in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment *in individual health*

benefit plans to open enrollment periods and special enrollment periods as provided in subdivisions (c) and (d).

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

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

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

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

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

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

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

(B) "Loss of minimum essential coverage" includes loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations. "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to Section 1389.21.

(2) He or she gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.

(3) He or she becomes a resident of California.

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

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

(6) His or her health benefit plan substantially violated a material provision of the contract.

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

(8) He or she was receiving services from a contracting provider under another health benefit plan for one of the conditions described in subdivision (c) of Section 1373.96 and that provider is terminated.

~~(5)~~

(9) With respect to individual health benefit plans offered through the Exchange, *in addition to the triggering events listed in this subdivision,* the individual meets any of the requirements listed in Section ~~155.420(d)(3)~~ *155.420(d)* of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 63 days from the date of a triggering event identified in subdivision (d) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 63 days from the date of a triggering event *identified in subdivision (d)*to select a plan offered through the Exchange.

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

(2) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the initial open enrollment period described in subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014~~, except that coverage for an individual under~~

~~19 years of age shall, at the option of the subscriber, become effective as required under Section 1399.826~~. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

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

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month.

(B) When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

(D) Notwithstanding subparagraph (A) or (B), in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the following month.

(5) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage selected pursuant to this section shall be the same as the applicable date specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(g) *(1)* On or after January 1, 2014, a health care service plan shall not ~~condition the issuance or offering of an individual health benefit plan~~ *establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based* on any of the following factors:

~~(1)~~

(A) Health status.

~~(2)~~

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

~~(3)~~

(C) Claims experience.

~~(4)~~

(D) Receipt of health care.

~~(5)~~

(E) Medical history.

~~(6)~~

(F) Genetic information.

~~(7)~~

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

~~(8)~~

(H) Disability.

~~(9)~~

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

(2) A health care service plan shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan.

(h) A health care service plan offering coverage in the individual market shall not reject the request of a subscriber during an open enrollment period to include a dependent of the subscriber as a dependent on an existing individual health benefit plan ~~that provides dependent coverage~~.

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

1399.851. (a) Commencing January 1, 2014, no health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

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

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

(b) Commencing January 1, 2014, a health care service plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

~~(c) This section shall not apply to a grandfathered health plan.~~

1399.853. (a) All individual health benefit plans shall conform to the requirements of Sections 1365, 1366.3, 1367.001, and 1373.6, *and any other requirements imposed by this chapter,* and shall be renewable at the option of the enrollee except as permitted to be canceled, rescinded, or not renewed pursuant to Section 1365.

(b) Any plan that ceases to offer for sale new individual health benefit plans pursuant to Section 1365 shall continue to be

governed by this article with respect to business conducted under this article.

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

(1) Age, as described in regulations adopted by the department in conjunction with the Department of Insurance that do not prevent the application of PPACA. Rates based on age shall be determined based on the individual's ~~birthday and shall not vary by more than three to one for adults.~~ *birthday. A plan shall not use any age bands for rating purposes that are inconsistent with the age bands established by the United States Secretary of Health and Human Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg (a)(3)).*

~~(2) Geographic region. With respect to the 2014 plan year, the geographic regions for purposes of rating shall be the same as those used by a health benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code). For subsequent plan years, the geographic regions for purposes of rating shall be determined by the Exchange in consultation with the department, the Department of Insurance, and other private and public purchasers of health care coverage.~~

~~(3) Family size, as described in PPACA.~~

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

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

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

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

(D) Region 4 shall consist of the Counties of San Francisco, Contra Costa, Alameda, Santa Clara, and San Mateo.

(E) Region 5 shall consist of the Counties of Santa Cruz, Monterey, and San Benito.

(F) Region 6 shall consist of the Counties of San Joaquin, Stanislaus, Merced, Mariposa, Madera, Fresno, Kings, and Tulare.

(G) Region 7 shall consist of the Counties of San Luis Obispo, Santa Barbara, and Ventura.

(H) Region 8 shall consist of the Counties of Mono, Inyo, Kern, and Imperial.

(I) Region 9 shall consist of the ZIP Codes in Los Angeles County starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(J) Region 10 shall consist of the ZIP Codes in Los Angeles County other than those identified in subparagraph (I).

(K) Region 11 shall consist of the Counties of San Bernardino and Riverside.

(L) Region 12 shall consist of the County of Orange.

(M) Region 13 shall consist of the County of San Diego.

(3) Whether the health benefit plan covers an individual or family.

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

(c) The rating period for rates subject to this section shall be ~~no less than 12 months~~ *from January 1 to December 31, inclusive*.

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

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

(a) To an individual who 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 because of its obligations to existing enrollees.

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

a service area may not offer a health benefit plan 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.

(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.

1399.859. The director may require a health care service plan to discontinue the offering of individual health benefit plans or acceptance of applications from any individual upon a determination by the director that the plan does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375.1), and the rules adopted under those provisions.

1399.860. (a) On or before October 1, 2013, and annually thereafter, a health care service plan shall issue the following notice to all subscribers enrolled in an individual health benefit plan that is a grandfathered health plan:

Beginning on and after January 1, 2014, new improved health insurance options are available in California. You currently have health insurance that is exempt from many of the new requirements. You have the option to remain in your current plan or switch to a new plan. Under the new rules, a health insurance company cannot deny your application based on any health conditions you may have. For more information about your options, please contact the California Health Benefit Exchange, the Office of Patient Advocate, your plan or policy representative, an insurance broker, or a health care navigator.

(b) A health care service plan shall include the notice described in subdivision (a) in any marketing material of the individual grandfathered health plan.

~~SEC. 6. Section 10198.7 of the Insurance Code is amended to read:~~

~~10198.7. (a) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.~~

~~(b) No health benefit plan that covers one or two individuals and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.~~

~~(c) (1) Notwithstanding subdivision (a), a health benefit plan for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age. A health benefit plan for group coverage issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.~~

~~(2) Notwithstanding subdivision (b), a health benefit plan for individual coverage that is not a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and~~

~~Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age. A health benefit plan for individual coverage that is issued, amended, or renewed on or after January 1, 2014, and that is not a grandfathered health plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any individual.~~

~~(d) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.~~

~~(e) A carrier that does not utilize a preexisting condition provision in health plans that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No carrier may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.~~

~~(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any person, all health benefit plans shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A health benefit plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any affiliation or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated or, an employer's contribution toward health coverage has terminated, a carrier shall~~

~~credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period.~~

~~(g) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.~~

~~(h) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act, 42 U.S.C. Sec. 300gg(e).~~

~~(i) A group health benefit plan may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.~~

~~(j) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.~~

SEC. 20. 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) (1) A health insurer that declines to offer coverage to 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, at the time of the denial or offer of coverage, provide the applicant with the

specific reason or reasons for the decision in writing, in clear, easily understandable language.

(2) 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 60 days prior to the effective date of the policy 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 policyholder at his or her last address known to the insurer, at least 60 days prior to the effective date of the change. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase and 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.

(4) 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 (MRMIP) (Part 6.5 (commencing with Section 12700)), and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5). The information provided to the applicant by the insurer shall be in accordance with standards developed by the department, in consultation with the Managed Risk Medical Insurance Board, and shall specifically include the toll-free telephone number and Internet Web site address for MRMIP and the federal temporary high risk pool. The requirement to notify applicants of the availability of MRMIP and the federal temporary high risk pool 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 insurer shall give the 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.

(d) This section shall become inoperative on November 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 21. Section 10113.9 is added to the Insurance Code, 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) (1) 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 60 days prior to the effective date of the plan 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.

(2) The written notice required pursuant to paragraph (1) shall be delivered to the individual policyholder at his or her last address known to the insurer, at least 60 days prior to the effective date of the change. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase and 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. For individual grandfathered health plans, the notice shall also inform the individual contractholder about the availability of coverage through the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code and shall include the toll-free telephone number and Internet Web site for the California Health Benefit Exchange.

(c) (1) A health insurer that declines to offer coverage to or denies enrollment for an individual or his or her dependents

applying for an individual grandfathered health plan or that offers an individual grandfathered health plan at a rate that is higher than the standard rate shall, at the time of the denial or offer of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(2) If a health insurer rejects an applicant or the dependents of an applicant for an individual grandfathered health plan or offers an individual grandfathered health plan at a rate that is higher than the standard rate, the insurer shall inform the applicant about the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code. The information provided to the applicant by the insurer shall include the toll-free telephone number and Internet Web site for the California Health Benefit Exchange.

(d) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the insurer shall give the 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.

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

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

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

(f) This section shall become operative on November 1, 2013.

SEC. 22. Section 10113.95 of the Insurance Code is amended to read:

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

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

with Sections 10140 and 10291.5 and all other applicable provisions.

(c) On or before June 1, 2006, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which individuals applying for coverage would be eligible. An insurer may comply with this section by submitting to the department underwriting materials or resource guides provided to agents and brokers, provided that those materials include the information required to be submitted by this section.

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

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

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

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

(g) This section shall become inoperative on November 1, 2013, and, as of January 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 23. Section 10113.95 is added to the Insurance Code, to read:

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

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

(c) On or before November 1, 2013, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual grandfathered health plans, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which individuals applying for coverage would be eligible. An insurer may comply with this section by submitting to the department underwriting materials or resource guides provided to agents and brokers, provided that those materials include the information required to be submitted by this section.

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

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

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

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

federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

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

(g) This section shall become operative on November 1, 2013.

SEC. 24. Section 10119.1 of the Insurance Code is amended to read:

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

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

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

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

(d) The insurer shall notify in writing all insureds of the right to transfer to another individual health benefit plan pursuant to this section, at a minimum, when the insurer changes the insured's premium rate. Posting this information on the insurer's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform insureds of the transfer rights provided under this section including information on the process to obtain details about the individual health benefit plans available to that insured and advising that the insured may be unable to

return to his or her current individual health benefit plan if the insured transfers to another individual health benefit plan.

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

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

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

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

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

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

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

(g) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 25. Section 10119.2 of the Insurance Code is amended to read:

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

(b) "Without medical underwriting" means that the health insurer shall not decline to offer coverage to, or deny enrollment of, the

individual or impose any preexisting condition exclusion on the individual who is issued a new individual health benefit plan or remains covered under an individual health benefit plan pursuant to this section.

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

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

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

(f) The insurer shall provide 60 days for insureds to accept the offered new individual health benefit plan and this plan shall be effective as of the effective date of the original individual health benefit plan and there shall be no lapse in coverage.

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

(h) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 26. Section 10119.2 is added to the Insurance Code, to read:

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

may also permit an individual, who was covered under an individual health benefit plan that was rescinded, to remain covered under that individual health benefit plan, with a revised premium rate that reflects the number of persons remaining on the health benefit plan consistent with Section 10965.9.

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

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

(d) The insurer shall provide 60 days for insureds to accept the offered new individual health benefit plan and this plan shall be effective as of the effective date of the original individual health benefit plan and there shall be no lapse in coverage.

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

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

(g) This section shall become operative on January 1, 2014.

SEC. 27. Section 10291.5 of the Insurance Code is amended to read:

10291.5. (a) The purpose of this section is to achieve both of the following:

(1) Prevent, in respect to disability insurance, fraud, unfair trade practices, and insurance economically unsound to the insured.

(2) Assure that the language of all insurance policies can be readily understood and interpreted.

(b) The commissioner shall not approve any disability policy for insurance or delivery in this state in any of the following circumstances:

(1) If the commissioner finds that it contains any provision, or has any label, description of its contents, title, heading, backing, or other indication of its provisions which is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(2) If it contains any provision for payment at a rate, or in an amount (other than the product of rate times the periods for which payments are promised) for loss caused by particular event or events (as distinguished from character of physical injury or illness of the insured) more than triple the lowest rate, or amount, promised in the policy for the same loss caused by any other event or events (loss caused by sickness, loss caused by accident, and different degrees of disability each being considered, for the purpose of this paragraph, a different loss); or if it contains any provision for payment for any confining loss of time at a rate more than six times the least rate payable for any partial loss of time or more than twice the least rate payable for any nonconfining total loss of time; or if it contains any provision for payment for any nonconfining total loss of time at a rate more than three times the least rate payable for any partial loss of time.

(3) If it contains any provision for payment for disability caused by particular event or events (as distinguished from character of physical injury or illness of the insured) payable for a term more than twice the least term of payment provided by the policy for the same degree of disability caused by any other event or events; or if it contains any benefit for total nonconfining disability payable for lifetime or for more than 12 months and any benefit for partial disability, unless the benefit for partial disability is payable for at least three months; or if it contains any benefit for total confining disability payable for lifetime or for more than 12 months, unless it also contains benefit for total nonconfining disability caused by the same event or events payable for at least three months, and, if it also contains any benefit for partial disability, unless the benefit for partial disability is payable for at least three months. The provisions of this paragraph shall apply separately to accident benefits and to sickness benefits.

(4) If it contains provision or provisions which would have the effect, upon any termination of the policy, of reducing or ending the liability as the insurer would have, but for the termination, for loss of time resulting from accident occurring while the policy is in force or for loss of time commencing while the policy is in force and resulting from sickness contracted while the policy is in force or for other losses resulting from accident occurring or sickness contracted while the policy is in force, and also contains provision or provisions reserving to the insurer the right to cancel or refuse

to renew the policy, unless it also contains other provision or provisions the effect of which is that termination of the policy as the result of the exercise by the insurer of any such right shall not reduce or end the liability in respect to the hereinafter specified losses as the insurer would have had under the policy, including its other limitations, conditions, reductions, and restrictions, had the policy not been so terminated.

The specified losses referred to in the preceding paragraph are:

(i) Loss of time which commences while the policy is in force and results from sickness contracted while the policy is in force.

(ii) Loss of time which commences within 20 days following and results from accident occurring while the policy is in force.

(iii) Losses which result from accident occurring or sickness contracted while the policy is in force and arise out of the care or treatment of illness or injury and which occur within 90 days from the termination of the policy or during a period of continuous compensable loss or losses which period commences prior to the end of such 90 days.

(iv) Losses other than those specified in clause (i), (ii), or (iii) of this paragraph which result from accident occurring or sickness contracted while the policy is in force and which losses occur within 90 days following the accident or the contraction of the sickness.

(5) If by any caption, label, title, or description of contents the policy states, implies, or infers without reasonable qualification that it provides loss of time indemnity for lifetime, or for any period of more than two years, if the loss of time indemnity is made payable only when house confined or only under special contingencies not applicable to other total loss of time indemnity.

(6) If it contains any benefit for total confining disability payable only upon condition that the confinement be of an abnormally restricted nature unless the caption of the part containing any such benefit is accurately descriptive of the nature of the confinement required and unless, if the policy has a description of contents, label, or title, at least one of them contain reference to the nature of the confinement required.

(7) (A) If, irrespective of the premium charged therefor, any benefit of the policy is, or the benefits of the policy as a whole are, not sufficient to be of real economic value to the insured.

(B) In determining whether benefits are of real economic value to the insured, the commissioner shall not differentiate between insureds of the same or similar economic or occupational classes and shall give due consideration to all of the following:

(i) The right of insurers to exercise sound underwriting judgment in the selection and amounts of risks.

(ii) Amount of benefit, length of time of benefit, nature or extent of benefit, or any combination of those factors.

(iii) The relative value in purchasing power of the benefit or benefits.

(iv) Differences in insurance issued on an industrial or other special basis.

(C) To be of real economic value, it shall not be necessary that any benefit or benefits cover the full amount of any loss which might be suffered by reason of the occurrence of any hazard or event insured against.

(8) If it substitutes a specified indemnity upon the occurrence of accidental death for any benefit of the policy, other than a specified indemnity for dismemberment, which would accrue prior to the time of that death or if it contains any provision which has the effect, other than at the election of the insured exercisable within not less than 20 days in the case of benefits specifically limited to the loss by removal of one or more fingers or one or more toes or within not less than 90 days in all other cases, of doing any of the following:

(A) Of substituting, upon the occurrence of the loss of both hands, both feet, one hand and one foot, the sight of both eyes or the sight of one eye and the loss of one hand or one foot, some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or greater than the total of the benefit or benefits for which such specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of such dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(B) Of substituting, upon the occurrence of any other dismemberment some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or

greater than one-fourth of the total of the benefit or benefits for which the specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of the dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(C) Of substituting a specified indemnity upon the occurrence of any dismemberment for any benefit of the policy which would accrue prior to the time of dismemberment.

As used in this section, loss of a hand shall be severance at or above the wrist joint, loss of a foot shall be severance at or above the ankle joint, loss of an eye shall be the irrecoverable loss of the entire sight thereof, loss of a finger shall mean at least one entire phalanx thereof and loss of a toe the entire toe.

(9) If it contains provision, other than as provided in Section 10369.3, reducing any original benefit more than 50 percent on account of age of the insured.

(10) If the insuring clause or clauses contain no reference to the exceptions, limitations, and reductions (if any) or no specific reference to, or brief statement of, each abnormally restrictive exception, limitation, or reduction.

(11) If it contains benefit or benefits for loss or losses from specified diseases only unless:

(A) All of the diseases so specified in each provision granting the benefits fall within some general classification based upon the following:

(i) The part or system of the human body principally subject to all such diseases.

(ii) The similarity in nature or cause of such diseases.

(iii) In case of diseases of an unusually serious nature and protracted course of treatment, the common characteristics of all such diseases with respect to severity of affliction and cost of treatment.

(B) The policy is entitled and each provision granting the benefits is separately captioned in clearly understandable words so as to accurately describe the classification of diseases covered and expressly point out, when that is the case, that not all diseases of the classification are covered.

(12) If it does not contain provision for a grace period of at least the number of days specified below for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force provided, that the grace period to be included in the policy shall be not less than seven days for policies providing for weekly payment of premium, not less than 10 days for policies providing for monthly payment of premium and not less than 31 days for all other policies.

(13) If it fails to conform in any respect with any law of this state.

(c) The commissioner shall not approve any disability policy covering hospital, medical, or surgical expenses unless the commissioner finds that the application conforms to ~~both of~~ the following requirements, *as applicable*:

(1) All applications for disability insurance covering hospital, medical, or surgical expenses, except that which is guaranteed issue, which include questions relating to medical conditions, shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions designed to ascertain the health condition or history of the applicant *in applications subject to paragraph (1)* shall be based on medical information that is reasonable and necessary for medical underwriting purposes. The application shall include a prominently displayed notice that states:

"California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."

(3) All applications for coverage subject to Chapter 9.9 (commencing with Section 10965) shall comply with paragraph (2) of subdivision (g) of Section 10965.3.

(d) Nothing in this section authorizes the commissioner to establish or require a single or standard application form for application questions.

(e) The commissioner may, from time to time as conditions warrant, after notice and hearing, promulgate such reasonable rules and regulations, and amendments and additions thereto, as are necessary or convenient, to establish, in advance of the submission of policies, the standard or standards conforming to subdivision (b), by which he or she shall disapprove or withdraw approval of any disability policy.

In promulgating any such rule or regulation the commissioner shall give consideration to the criteria herein established and to the desirability of approving for use in policies in this state uniform provisions, nationwide or otherwise, and is hereby granted the authority to consult with insurance authorities of any other state and their representatives individually or by way of convention or committee, to seek agreement upon those provisions.

Any such rule or regulation shall be promulgated in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) The commissioner may withdraw approval of filing of any policy or other document or matter required to be approved by the commissioner, or filed with him or her, by this chapter when the commissioner would be authorized to disapprove or refuse filing of the same if originally submitted at the time of the action of withdrawal.

Any such withdrawal shall be in writing and shall specify reasons. An insurer adversely affected by any such withdrawal may, within a period of 30 days following mailing or delivery of the writing containing the withdrawal, by written request secure a hearing to determine whether the withdrawal should be annulled, modified, or confirmed. Unless, at any time, it is mutually agreed to the contrary, a hearing shall be granted and commenced within 30 days following filing of the request and shall proceed with reasonable dispatch to determination. Unless the commissioner in writing in the withdrawal, or subsequent thereto, grants an extension, any such withdrawal shall, in the absence of any such request, be effective, prospectively and not retroactively, on the 91st day following the mailing or delivery of the withdrawal, and, if request for the hearing is filed, on the 91st day following mailing or delivery of written notice of the commissioner's determination.

(g) No proceeding under this section is subject to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Except as provided in subdivision (k), any action taken by the commissioner under this section is subject to review by the courts of this state and proceedings on review shall be in accordance with the Code of Civil Procedure.

Notwithstanding any other provision of law to the contrary, petition for any such review may be filed at any time before the effective date of the action taken by the commissioner. No action of the commissioner shall become effective before the expiration of 20 days after written notice and a copy thereof are mailed or delivered to the person adversely affected, and any action so submitted for review shall not become effective for a further period of 15 days after the filing of the petition in court. The court may stay the effectiveness thereof for a longer period.

(i) This section shall be liberally construed to effectuate the purpose and intentions herein stated; but shall not be construed to grant the commissioner power to fix or regulate rates for disability insurance or prescribe a standard form of disability policy, except that the commissioner shall prescribe a standard supplementary disclosure form for presentation with all disability insurance policies, pursuant to Section 10603.

(j) This section shall be effective on and after July 1, 1950, as to all policies thereafter submitted and on and after January 1, 1951, the commissioner may withdraw approval pursuant to subdivision (d) of any policy thereafter issued or delivered in this state irrespective of when its form may have been submitted or approved, and prior to those dates the provisions of law in effect on January 1, 1949, shall apply to those policies.

(k) Any such policy issued by an insurer to an insured on a form approved by the commissioner, and in accordance with the conditions, if any, contained in the approval, at a time when that approval is outstanding shall, as between the insurer and the insured, or any person claiming under the policy, be conclusively presumed to comply with, and conform to, this section.

SEC. 28. Section 10901.3 of the Insurance Code is amended to read:

10901.3. (a) (1) After the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average premium paid by a

subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A carrier may adjust the premium based on family size, not to exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or 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 30 days after the effective date of the health benefit plan, the individual shall have the option of changing coverage to a different health benefit plan design offered by the same carrier. If the individual notified the plan 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 enrolled individual notified the carrier of the change after the 15th day of a month, coverage under the health benefit plan shall become effective no later than the first day of the second month following notification.

(d) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 29. Section 10901.3 is added to the Insurance Code, to read:

10901.3. (a) After the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the premium for the second lowest cost silver plan of the individual market in the rating area in which the individual resides which is offered through the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code, as described in Section 36B(b)(3)(B) of Title 26 of the United States Code.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or 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 30 days after the effective date of the health benefit plan, the individual shall have the option of changing coverage to a different health benefit plan design offered by the same carrier. If the individual notified the plan 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 enrolled individual notified the carrier of the change after the 15th day of a month, coverage under the health benefit plan shall become effective no later than the first day of the second month following notification.

(d) This section shall become operative on January 1, 2014.

SEC. 30. Section 10901.9 of the Insurance Code is amended to read:

10901.9. Commencing January 1, 2001, premiums for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age

and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

~~(2)~~

(3) For a contract that a carrier has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

(d) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 31. Section 10901.9 is added to the Insurance Code, to read:

10901.9. (a) Commencing January 1, 2014, premiums for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

(1) The premium for in force or new business for a federally eligible defined individual shall not exceed the premium for the second lowest cost silver plan of the individual market in the rating area in which the individual resides which is offered through the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code, as described in Section 36B(b)(3)(B) of Title 26 of the United States Code.

(2) For a contract that a carrier has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

(b) This section shall become operative on January 1, 2014.

SEC. 32. Section 10902.4 of the Insurance Code is amended to read:

10902.4. *(a)* Carriers and health care service plans that offer contracts to individuals may elect to establish a mechanism or method to share in the financing of high-risk individuals. This mechanism or method shall be established through a committee of all carriers and health care service plans offering coverage to individuals by July 1, 2002, and shall be implemented by January 1, 2003. If carriers and health care service plans wish to establish a risk-sharing mechanism but cannot agree on the terms and conditions of such an agreement, the Managed Risk Medical Insurance Board shall develop a risk-sharing mechanism or method by January 1, 2003, and it shall be implemented by July 1, 2003.

(b) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

~~SEC. 7.~~

SEC. 33. The heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of the Insurance Code is amended to read:

CHAPTER 9.7. CHILD ACCESS TO HEALTH INSURANCE

~~SEC. 8.~~

SEC. 34. Section 10954 of the Insurance Code is amended to read:

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

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

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

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

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

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

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

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

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

(e) Carriers may require documentation from applicants relating to their coverage history.

(f) (1) On and after January 1, 2013, a carrier shall provide a notice to all applicants for coverage under this chapter and to all insureds, or the responsible party for an insured, renewing coverage under this chapter that contains the following information:

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

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

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

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

(3) The department may adopt a model notice to be used by carriers in order to comply with this subdivision. Use of the model notice shall not require prior approval of the department. Any model notice designated by the department for purposes of this section shall not be subject to the Administrative Procedure Act

(Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

~~SEC. 9.~~

SEC. 35. Section 10961 is added to the Insurance Code, to read:

10961. This chapter shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

~~SEC. 10.~~

SEC. 36. Chapter ~~9.8~~ *9.9* (commencing with Section 10965) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER ~~9.8.~~*9.9.* INDIVIDUAL ACCESS TO HEALTH INSURANCE

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

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

~~(a)~~

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

~~(b)~~

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

~~(c)~~

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

~~(d)~~

(e) "Health benefit plan" means any individual or group ~~health insurance~~ policy *of health insurance, as defined in Section 106,* or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include ~~accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable~~

~~with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.~~ *a health insurance policy consisting solely of coverage of excepted benefits, as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91), subject to Section 10965.01, a specialized health care service plan contract, as defined in Section 1345 of the Health and Safety Code, a health care service plan conversion contract offered pursuant to Section 1373.6 of the Health and Safety Code, a health insurance conversion policy offered pursuant to Section 12682.1, a health insurance policy or health care service plan contract provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2, a health care service plan contract or health insurance policy offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) of Chapter 2.2 of Division 2 of the Health and Safety Code or Chapter 9.5 (commencing with Section 10900), or Medicare supplement coverage, to the extent consistent with PPACA.*

~~(e)~~

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

~~(f)~~

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

~~(g)~~

(h) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of PPACA.

~~(h)~~

(i) "Rating period" means the period for which premium rates established by an insurer are in effect.

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

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

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

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

"This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in PPACA. Commencing January 1, 2014, you may be subject to a federal tax if you do not obtain minimum essential coverage."

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

(3) In the case of a policy or certificate that is described in this section and that is offered for the first time in this state on or after January 1, 2013, the carrier files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

(b) As used in this section, "policies or certificates of specified disease" and "policies or certificates of hospital confinement indemnity" mean policies or certificates of insurance sold to an

insured to supplement other health insurance coverage as specified in this section.

10965.1. Every health insurer offering individual health benefit plans shall, in addition to complying with the provisions of this part and rules adopted thereunder, comply with the provisions of this chapter.

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

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

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

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

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

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

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

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

(B) "Loss of minimum essential coverage" includes loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations. "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to Section 10384.17.

(2) He or she gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.

(3) He or she becomes a California resident.

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

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

(6) His or her health benefit plan substantially violated a material provision of the policy

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

(8) He or she was receiving services from a contracting provider under another health benefit plan for one of the conditions described in subdivision (a) of Section 10133.56 and that provider is terminated.

~~(5)~~

(9) With respect to individual health benefit plans offered through the Exchange, *in addition to the triggering events listed in this subdivision,* the individual meets any of the requirements listed in Section ~~155.420(d)(3)~~ *155.420(d)* of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 63 days from the date of a triggering event identified in subdivision (d) to apply for coverage from a health benefit plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 63 days from the date of a triggering event *identified in subdivision (d)* to select a plan offered through the Exchange.

(f) (1) With respect to individual health benefit plans offered outside the Exchange, after an individual submits a completed

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

(2) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the initial open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014~~, except that coverage for an individual under 19 years of age shall, at the option of the policyholder, become effective as required under Section 10951.~~ When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

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

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month.

(B) When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

(D) Notwithstanding subparagraph (A) or (B), in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the following month.

(5) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage selected pursuant to this section shall be the same as the applicable date specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(g) *(1)* On or after January 1, 2014, a health insurer shall not ~~condition the issuance or offering of an individual health benefit plan~~ *establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based* on any of the following factors:

~~(1)~~

(A) Health status.

~~(2)~~

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

~~(3)~~

(C) Claims experience.

~~(4)~~

(D) Receipt of health care.

~~(5)~~

(E) Medical history.

~~(6)~~

(F) Genetic information.

~~(7)~~

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

~~(8)~~

(H) Disability.

~~(9)~~

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

(2) A health insurer shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan.

(h) A health insurer offering coverage in the individual market shall not reject the request of a policyholder during an open enrollment period to include a dependent of the policyholder as a dependent on an existing individual health benefit plan ~~that provides dependent coverage~~.

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

10965.5. (a) Commencing January 1, 2014, no health insurer or agent or broker shall, directly or indirectly, engage in the following activities:

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

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

(b) Commencing January 1, 2014, a health insurer shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a broker or agent that provides for or results in the compensation paid to a broker or agent for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision does not apply to a

compensation arrangement that provides compensation to a broker or agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

~~(c) This section shall not apply to a grandfathered health plan.~~

10965.7. (a) All individual health benefit plans shall conform to the requirements of Sections 10112.1, 10127.18, 10273.4, and 12682.1, *and any other requirements imposed by this code,* and shall be renewable at the option of the insured except as permitted to be canceled, rescinded, or not renewed pursuant to Section 10273.4.

(b) Any insurer that ceases to offer for sale new individual health benefit plans pursuant to Section 10273.4 shall continue to be governed by this chapter with respect to business conducted under this chapter.

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

(1) Age, as described in regulations adopted by the department in conjunction with the Department of Managed Health Care that do not prevent the application of PPACA. Rates based on age shall be determined based on the individual's ~~birthday and shall not vary by more than three to one for adults.~~ *birthday. A plan shall not use any age bands for rating purposes that are inconsistent with the age bands established by the United States Secretary of Health and Human Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).*

~~(2) Geographic region. With respect to the 2014 plan year, the geographic regions for purposes of rating shall be the same as those used by a health benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code). For subsequent plan years, the geographic regions for purposes of rating shall be determined~~

~~by the Exchange in consultation with the department, the Department of Managed Health Care, and other private and public purchasers of health care coverage.~~

~~(3) Family size, as described in PPACA.~~

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

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

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

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

(D) Region 4 shall consist of the Counties of San Francisco, Contra Costa, Alameda, Santa Clara, and San Mateo.

(E) Region 5 shall consist of the Counties of Santa Cruz, Monterey, and San Benito.

(F) Region 6 shall consist of the Counties of San Joaquin, Stanislaus, Merced, Mariposa, Madera, Fresno, Kings, and Tulare.

(G) Region 7 shall consist of the Counties of San Luis Obispo, Santa Barbara, and Ventura.

(H) Region 8 shall consist of the Counties of Mono, Inyo, Kern, and Imperial.

(I) Region 9 shall consist of the ZIP Codes in Los Angeles County starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(J) Region 10 shall consist of the ZIP Codes in Los Angeles County other than those identified in subparagraph (I).

(K) Region 11 shall consist of the Counties of San Bernardino and Riverside.

(L) Region 12 shall consist of the County of Orange.

(M) Region 13 shall consist of the County of San Diego.

(3) Whether the health benefit plan covers an individual or family.

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

(c) The rating period for rates subject to this section shall be ~~no less than 12 months~~ *from January 1 to December 31, inclusive*.

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

10965.11. A health insurer shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to this chapter in the case of any of the following:

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

(b) (1) Within a specific service area or portion of a service area, if the insurer 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 because of its obligations to existing insureds.

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

(3) Nothing in this chapter shall be construed to limit the commissioner's authority to develop and implement a plan of rehabilitation for a health insurer whose financial viability or organizational and administrative capacity has become impaired.

10965.13. The commissioner may require a health insurer to discontinue the offering of individual health benefit plans or acceptance of applications from any individual upon a determination by the commissioner that the insurer 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 insurer's compliance with the requirements of this part and the rules adopted under those provisions.

10965.14. (a) On or before October 1, 2013, and annually thereafter, a health insurer shall issue the following notice to all policyholders enrolled in an individual health benefit plan that is a grandfathered health plan:

Beginning on and after January 1, 2014, new improved health insurance options are available in California. You currently have health insurance that is exempt from many of the new requirements. You have the option to remain in your current plan or switch to a new plan. Under the new rules, a health insurance company cannot deny your application based on any health conditions you may have. For more information about your options, please contact the California Health Benefit Exchange, the Office of Patient Advocate, your plan or policy representative, an insurance broker, or a health care navigator.

(b) A health insurer shall include the notice described in subdivision (a) in any marketing material of the individual grandfathered health plan.

SEC. 37. This act shall be implemented to the extent consistent with or more stringent than the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

~~SEC. 11.~~

SEC. 38. 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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