

AMENDED IN ASSEMBLY AUGUST 20, 2012

AMENDED IN SENATE APRIL 9, 2012

**SENATE BILL**

**No. 961**

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

January 10, 2012

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~~An act to amend Sections 1357.51 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 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 and 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, to add Section 10961 to, to add Chapter 9.8 (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. An act to amend Sections 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 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 10960.5 to, to add Chapter 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

SB 961, as amended, Hernandez. ~~Individual health care coverage.~~  
Health care coverage.

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA) enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate 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 require a plan or insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market 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 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.

(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.*

Existing 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, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals in each service area in which the plan provides or arranges for the provision of health care services, but would require plans and insurers to limit enrollment to specified open enrollment and special enrollment periods. 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 for purposes of establishing rates for individual health benefit plans. 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.~~

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

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

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1     SECTION 1. Section 1363 of the Health and Safety Code is  
2     amended to read:

3     1363. (a) The director shall require the use by each plan of  
4     disclosure forms or materials containing information regarding  
5     the benefits, services, and terms of the plan contract as the director  
6     may require, so as to afford the public, subscribers, and enrollees  
7     with a full and fair disclosure of the provisions of the plan in  
8     readily understood language and in a clearly organized manner.  
9     The director may require that the materials be presented in a  
10    reasonably uniform manner so as to facilitate comparisons between  
11    plan contracts of the same or other types of plans. Nothing  
12    contained in this chapter shall preclude the director from permitting  
13    the disclosure form to be included with the evidence of coverage  
14    or plan contract.

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

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

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

- 1 (3) The full premium cost of the plan.
- 2 (4) Any copayment, coinsurance, or deductible requirements
- 3 that may be incurred by the member or the member's family in
- 4 obtaining coverage under the plan.
- 5 (5) The terms under which the plan may be renewed by the plan
- 6 member, including any reservation by the plan of any right to
- 7 change premiums.
- 8 (6) A statement that the disclosure form is a summary only, and
- 9 that the plan contract itself should be consulted to determine
- 10 governing contractual provisions. The first page of the disclosure
- 11 form shall contain a notice that conforms with all of the following
- 12 conditions:
  - 13 (A) (i) States that the evidence of coverage discloses the terms
  - 14 and conditions of coverage.
  - 15 (ii) States, with respect to individual plan contracts, small group
  - 16 plan contracts, and any other group plan contracts for which health
  - 17 care services are not negotiated, that the applicant has a right to
  - 18 view the evidence of coverage prior to enrollment, and, if the
  - 19 evidence of coverage is not combined with the disclosure form,
  - 20 the notice shall specify where the evidence of coverage can be
  - 21 obtained prior to enrollment.
  - 22 (B) Includes a statement that the disclosure and the evidence of
  - 23 coverage should be read completely and carefully and that
  - 24 individuals with special health care needs should read carefully
  - 25 those sections that apply to them.
  - 26 (C) Includes the plan's telephone number or numbers that may
  - 27 be used by an applicant to receive additional information about
  - 28 the benefits of the plan or a statement where the telephone number
  - 29 or numbers are located in the disclosure form.
  - 30 (D) For individual contracts, and small group plan contracts as
  - 31 defined in Article 3.1 (commencing with Section 1357), the
  - 32 disclosure form shall state where the health plan benefits and
  - 33 coverage matrix is located.
  - 34 (E) Is printed in type no smaller than that used for the remainder
  - 35 of the disclosure form and is displayed prominently on the page.
  - 36 (7) A statement as to when benefits shall cease in the event of
  - 37 nonpayment of the prepaid or periodic charge and the effect of
  - 38 nonpayment upon an enrollee who is hospitalized or undergoing
  - 39 treatment for an ongoing condition.

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

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

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

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

14 (12) A description of any limitations on the patient's choice of  
15 primary care physician, specialty care physician, or nonphysician  
16 health care practitioner, based on service area and limitations on  
17 the patient's choice of acute care hospital care, subacute or  
18 transitional inpatient care, or skilled nursing facility.

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

22 (14) Conditions and procedures for disenrollment.

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

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

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

30 (b) (1) As of July 1, 1999, the director shall require each plan  
31 offering a contract to an individual or small group to provide with  
32 the disclosure form for individual and small group plan contracts  
33 a uniform health plan benefits and coverage matrix containing the  
34 plan's major provisions in order to facilitate comparisons between  
35 plan contracts. The uniform matrix shall include the following  
36 category descriptions together with the corresponding copayments  
37 and limitations in the following sequence:

38 (A) Deductibles.

39 (B) Lifetime maximums.

40 (C) Professional services.

- 1 (D) Outpatient services.
- 2 (E) Hospitalization services.
- 3 (F) Emergency health coverage.
- 4 (G) Ambulance services.
- 5 (H) Prescription drug coverage.
- 6 (I) Durable medical equipment.
- 7 (J) Mental health services.
- 8 (K) Chemical dependency services.
- 9 (L) Home health services.
- 10 (M) Other.

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

13  
 14 **THIS MATRIX IS INTENDED TO BE USED TO HELP YOU**  
 15 **COMPARE COVERAGE BENEFITS AND IS A SUMMARY**  
 16 **ONLY. THE EVIDENCE OF COVERAGE AND PLAN**  
 17 **CONTRACT SHOULD BE CONSULTED FOR A DETAILED**  
 18 **DESCRIPTION OF COVERAGE BENEFITS AND**  
 19 **LIMITATIONS.**

20  
 21 (c) Nothing in this section shall prevent a plan from using  
 22 appropriate footnotes or disclaimers to reasonably and fairly  
 23 describe coverage arrangements in order to clarify any part of the  
 24 matrix that may be unclear.

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

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

33 (f) Group contractholders shall disseminate copies of the  
 34 completed disclosure form to all persons eligible to be a subscriber  
 35 under the group contract at the time those persons are offered the  
 36 plan. If the individual group members are offered a choice of plans,  
 37 separate disclosure forms shall be supplied for each plan available.  
 38 Each group contractholder shall also disseminate or cause to be  
 39 disseminated copies of the evidence of coverage to all applicants,



1 upon request, prior to enrollment and to all subscribers enrolled  
2 under the group contract.

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

8 (h) In addition to the other disclosures required by this section,  
9 every health care service plan and any agent or employee of the  
10 plan shall, when presenting a plan for examination or sale to any  
11 individual purchaser or the representative of a group consisting of  
12 25 or fewer individuals, disclose in writing the ratio of premium  
13 costs to health services paid for plan contracts with individuals  
14 and with groups of the same or similar size for the plan's preceding  
15 fiscal year. A plan may report that information by geographic area,  
16 provided the plan identifies the geographic area and reports  
17 information applicable to that geographic area.

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

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

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

1 ~~1389.1.~~

2 *1389.11.* (a) The director shall not approve any plan contract  
3 unless the director finds that the application conforms to ~~both of~~  
4 the following ~~requirements:~~ *requirements, as applicable:*

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

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

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

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

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

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

25 *1389.1. (a) For purposes of this article, the following*  
26 *definitions shall apply:*

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

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

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

35 *SEC. 4. Section 1389.25 of the Health and Safety Code is*  
36 *amended to read:*

37 1389.25. (a) (1) This section shall apply only to a full service  
38 health care service plan offering health coverage in the individual  
39 market in California and shall not apply to a specialized health  
40 care service plan, a health care service plan contract in the

1 Medi-Cal program (Chapter 7 (commencing with Section 14000)  
2 of Part 3 of Division 9 of the Welfare and Institutions Code), a  
3 health care service plan conversion contract offered pursuant to  
4 Section 1373.6, a health care service plan contract in the Healthy  
5 Families Program (Part 6.2 (commencing with Section 12693) of  
6 Division 2 of the Insurance Code), or a health care service plan  
7 contract offered to a federally eligible defined individual under  
8 Article 4.6 (commencing with Section 1366.35).

9 (2) A local initiative, as defined in subdivision (v) of Section  
10 53810 of Title 22 of the California Code of Regulations, that is  
11 awarded a contract by the State Department of Health Care Services  
12 pursuant to subdivision (b) of Section 53800 of Title 22 of the  
13 California Code of Regulations, shall not be subject to this section  
14 unless the plan offers coverage in the individual market to persons  
15 not covered by Medi-Cal or the Healthy Families Program.

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

23 (2) No change in the premium rate or coverage for an individual  
24 plan contract shall become effective unless the plan has delivered  
25 a written notice of the change at least 60 days prior to the effective  
26 date of the contract renewal or the date on which the rate or  
27 coverage changes. A notice of an increase in the premium rate  
28 shall include the reasons for the rate increase.

29 (3) The written notice required pursuant to paragraph (2) shall  
30 be delivered to the individual contractholder at his or her last  
31 address known to the plan, at least 60 days prior to the effective  
32 date of the change. The notice shall state in italics and in 12-point  
33 type the actual dollar amount of the premium rate increase and the  
34 specific percentage by which the current premium will be  
35 increased. The notice shall describe in plain, understandable  
36 English any changes in the plan design or any changes in benefits,  
37 including a reduction in benefits or changes to waivers, exclusions,  
38 or conditions, and highlight this information by printing it in italics.  
39 The notice shall specify in a minimum of 10-point bold typeface,

1 the reason for a premium rate change or a change to the plan design  
2 or benefits.

3 (4) If a plan rejects an applicant or the dependents of an  
4 applicant for coverage or offers individual coverage at a rate that  
5 is higher than the standard rate, the plan shall inform the applicant  
6 about the state's high-risk health insurance pool, the California  
7 Major Risk Medical Insurance Program (MRMIP) (Part 6.5  
8 (commencing with Section 12700) of Division 2 of the Insurance  
9 Code), and the federal temporary high risk pool established  
10 pursuant to Part 6.6 (commencing with Section 12739.5) of  
11 Division 2 of the Insurance Code. The information provided to the  
12 applicant by the plan shall be in accordance with standards  
13 developed by the department, in consultation with the Managed  
14 Risk Medical Insurance Board, and shall specifically include the  
15 toll-free telephone number and Internet Web site address for  
16 MRMIP and the federal temporary high risk pool. The requirement  
17 to notify applicants of the availability of MRMIP and the federal  
18 temporary high risk pool shall not apply when a health plan rejects  
19 an applicant for Medicare supplement coverage.

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

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

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

32 *1389.25. (a) (1) This section shall apply only to a full service*  
33 *health care service plan contract in the individual market in*  
34 *California and shall not apply to a specialized health care service*  
35 *plan contract, a health care service plan contract in the Medi-Cal*  
36 *program (Chapter 7 (commencing with Section 14000) of Part 3*  
37 *of Division 9 of the Welfare and Institutions Code), a health care*  
38 *service plan conversion contract offered pursuant to Section*  
39 *1373.6, a health care service plan contract in the Healthy Families*  
40 *Program (Part 6.2 (commencing with Section 12693) of Division*

1 *2 of the Insurance Code) or the Access for Infants and Mothers*  
2 *Program (Part 6.3 (commencing with Section 12695) of Division*  
3 *2 of the Insurance Code), a health care service plan contract*  
4 *offered under Part 6.4 (commencing with Section 12699.50) of*  
5 *Division 2 of the Insurance Code, or a health care service plan*  
6 *contract offered to a federally eligible defined individual under*  
7 *Article 4.6 (commencing with Section 1366.35).*

8 *(2) A local initiative, as defined in subdivision (v) of Section*  
9 *53810 of Title 22 of the California Code of Regulations, that is*  
10 *awarded a contract by the State Department of Health Care*  
11 *Services pursuant to subdivision (b) of Section 53800 of Title 22*  
12 *of the California Code of Regulations, shall not be subject to this*  
13 *section unless the plan offers coverage in the individual market to*  
14 *persons not covered by Medi-Cal or the Healthy Families Program.*

15 *(b) (1) No change in the premium rate or coverage for an*  
16 *individual health care service plan contract shall become effective*  
17 *unless the plan has delivered a written notice of the change at least*  
18 *60 days prior to the effective date of the contract renewal or the*  
19 *date on which the rate or coverage changes. A notice of an increase*  
20 *in the premium rate shall include the reasons for the rate increase.*

21 *(2) The written notice required pursuant to paragraph (1) shall*  
22 *be delivered to the individual contractholder at his or her last*  
23 *address known to the plan, at least 60 days prior to the effective*  
24 *date of the change. The notice shall state in italics and in 12-point*  
25 *type the actual dollar amount of the premium rate increase and*  
26 *the specific percentage by which the current premium will be*  
27 *increased. The notice shall describe in plain, understandable*  
28 *English any changes in the plan design or any changes in benefits,*  
29 *including a reduction in benefits or changes to waivers, exclusions,*  
30 *or conditions, and highlight this information by printing it in italics.*  
31 *The notice shall specify in a minimum of 10-point bold typeface,*  
32 *the reason for a premium rate change or a change to the plan*  
33 *design or benefits. For individual grandfathered health plans, the*  
34 *notice shall also inform the individual contractholder about the*  
35 *availability of new coverage options and the potential for*  
36 *subsidized coverage in the California Health Benefit Exchange.*  
37 *The notice shall direct persons seeking more information to the*  
38 *California Health Benefit Exchange, the Office of Patient Advocate,*  
39 *plan or policy representatives, and insurance brokers or health*  
40 *navigators.*

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

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

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

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

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

26 1389.4. (a) A full service health care service plan that issues,  
27 renews, or amends individual health plan contracts shall be subject  
28 to this section.

29 (b) A health care service plan subject to this section shall have  
30 written policies, procedures, or underwriting guidelines establishing  
31 the criteria and process whereby the plan makes its decision to  
32 provide or to deny coverage to individuals applying for coverage  
33 and sets the rate for that coverage. These guidelines, policies, or  
34 procedures shall assure that the plan rating and underwriting criteria  
35 comply with Sections 1365.5 and ~~1389.4~~ 1389.11 and all other  
36 applicable provisions of state and federal law.

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

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

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

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

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

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

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

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

3     1389.4. (a) *A full service health care service plan that renews*  
4     *individual grandfathered health plans shall be subject to this*  
5     *section.*

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

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

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

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

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

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

37    1389.5. (a) *This section shall apply to a health care service*  
38    *plan that provides coverage under an individual plan contract that*  
39    *is issued, amended, delivered, or renewed on or after January 1,*  
40    *2007.*



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

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

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

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

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

31 (1) A federally eligible defined individual, as defined in  
32 subdivision (c) of Section 1399.801, who is enrolled in an  
33 individual health benefit plan contract offered pursuant to Section  
34 1366.35.

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

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

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

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

7 (6) An individual enrolled in the Healthy Families Program  
8 pursuant to Part 6.2 (commencing with Section 12693) of Division  
9 2 of the Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

27 *1389.7. (a) Every health care service plan that offers, issues,*  
28 *or renews individual plan contracts shall offer to any individual,*  
29 *who was covered under an individual plan contract that was*  
30 *rescinded, a new individual plan contract that provides equal*  
31 *benefits. A health care service plan may also permit an individual,*  
32 *who was covered under an individual plan contract that was*  
33 *rescinded, to remain covered under that individual plan contract,*  
34 *with a revised premium rate that reflects the number of persons*  
35 *remaining on the plan contract consistent with Section 1399.855.*

36 *(b) If a new individual plan contract is issued, the plan may*  
37 *revise the premium rate to reflect only the number of persons*  
38 *covered on the new individual plan contract consistent with Section*  
39 *1399.855.*

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

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

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

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

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

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

18 1399.805. (a) (1) *After the federally eligible defined individual*  
19 *submits a completed application form for a plan contract, the plan*  
20 *shall, within 30 days, notify the individual of the individual's actual*  
21 *premium charges for that plan contract, unless the plan has*  
22 *provided notice of the premium charge prior to the application*  
23 *being filed. In no case shall the premium charged for any health*  
24 *care service plan contract identified in subdivision (d) of Section*  
25 *1366.35 exceed the following amounts:*

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

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

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

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

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

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

20 (b) When a federally eligible defined individual submits a  
21 premium payment, based on the quoted premium charges, and that  
22 payment is delivered or postmarked, whichever occurs earlier,  
23 within the first 15 days of the month, coverage shall begin no later  
24 than the first day of the following month. When that payment is  
25 neither delivered or postmarked until after the 15th day of a month,  
26 coverage shall become effective no later than the first day of the  
27 second month following delivery or postmark of the payment.

28 (c) During the first 30 days after the effective date of the plan  
29 contract, the individual shall have the option of changing coverage  
30 to a different plan contract offered by the same health care service  
31 plan. If the individual notified the plan of the change within the  
32 first 15 days of a month, coverage under the new plan contract  
33 shall become effective no later than the first day of the following  
34 month. If an enrolled individual notified the plan of the change  
35 after the 15th day of a month, coverage under the new plan contract  
36 shall become effective no later than the first day of the second  
37 month following notification.

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

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

3     1399.805. (a) *After the federally eligible defined individual*  
4     *submits a completed application form for a plan contract, the plan*  
5     *shall, within 30 days, notify the individual of the individual's actual*  
6     *premium charges for that plan contract, unless the plan has*  
7     *provided notice of the premium charge prior to the application*  
8     *being filed. In no case shall the premium charged for any health*  
9     *care service plan contract identified in subdivision (d) of Section*  
10    *1366.35 exceed the premium for the second lowest cost silver plan*  
11    *of the individual market in the rating area in which the individual*  
12    *resides which is offered through the California Health Benefit*  
13    *Exchange established under Title 22 (commencing with Section*  
14    *100500) of the Government Code, as described in Section*  
15    *36B(b)(3)(B) of Title 26 of the United States Code.*

16    (b) *When a federally eligible defined individual submits a*  
17    *premium payment, based on the quoted premium charges, and that*  
18    *payment is delivered or postmarked, whichever occurs earlier,*  
19    *within the first 15 days of the month, coverage shall begin no later*  
20    *than the first day of the following month. When that payment is*  
21    *neither delivered nor postmarked until after the 15th day of a*  
22    *month, coverage shall become effective no later than the first day*  
23    *of the second month following delivery or postmark of the payment.*

24    (c) *During the first 30 days after the effective date of the plan*  
25    *contract, the individual shall have the option of changing coverage*  
26    *to a different plan contract offered by the same health care service*  
27    *plan. If the individual notified the plan of the change within the*  
28    *first 15 days of a month, coverage under the new plan contract*  
29    *shall become effective no later than the first day of the following*  
30    *month. If an enrolled individual notified the plan of the change*  
31    *after the 15th day of a month, coverage under the new plan*  
32    *contract shall become effective no later than the first day of the*  
33    *second month following notification.*

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

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

37    1399.811. *Premiums for contracts offered, delivered, amended,*  
38    *or renewed by plans on or after January 1, 2001, shall be subject*  
39    *to the following requirements:*

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

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

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

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

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

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

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

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

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

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

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

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

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

34 *1399.811. (a) Premiums for contracts offered, delivered,*  
35 *amended, or renewed by plans on or after January 1, 2014, shall*  
36 *be subject to the following requirements:*

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



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

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

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

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

13 1399.816. (a) *Carriers and health care service plans that offer*  
14 *contracts to individuals may elect to establish a mechanism or*  
15 *method to share in the financing of high-risk individuals. This*  
16 *mechanism or method shall be established through a committee*  
17 *of all carriers and health care service plans offering coverage to*  
18 *individuals by July 1, 2002, and shall be implemented by January*  
19 *1, 2003. If carriers and health care service plans wish to establish*  
20 *a risk-sharing mechanism but cannot agree on the terms and*  
21 *conditions of such an agreement, the Managed Risk Medical*  
22 *Insurance Board shall develop a risk-sharing mechanism or method*  
23 *by January 1, 2003, and it shall be implemented by July 1, 2003.*

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

27 *SEC. 16. The heading of Article 11.7 (commencing with Section*  
28 *1399.825) of Chapter 2.2 of Division 2 of the Health and Safety*  
29 *Code is amended to read:*

30  
31 *Article 11.7. ~~Individual~~ Child Access to Health Care Coverage*  
32

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

35 1399.829. (a) *A health care service plan may use the following*  
36 *characteristics of an eligible child for purposes of establishing the*  
37 *rate of the plan contract for that child, where consistent with federal*  
38 *regulations under PPACA: age, geographic region, and family*  
39 *composition, plus the health care service plan contract selected by*  
40 *the child or the responsible party for the child.*

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

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

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

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

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

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

29  
30 “Please consider your options carefully before failing to maintain  
31 or ~~renew~~ *renewing* coverage for a child for whom you are  
32 responsible. If you attempt to obtain new individual coverage for  
33 that child, the premium for the same coverage may be higher than  
34 the premium you pay now.”

35  
36 (d) A child who applied for coverage between September 23,  
37 2010, and the end of the initial open enrollment period shall be  
38 deemed to have maintained coverage during that period.

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

4 ~~(f) Health care service plans may require documentation from~~  
5 ~~applicants relating to their coverage history.~~

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

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

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

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

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

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

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

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

35 *1399.836. This article shall remain in effect only until January*  
36 *1, 2014, and as of that date is repealed, unless a later enacted*  
37 *statute, that is enacted before January 1, 2014, deletes or extends*  
38 *that date.*

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

4

5             *Article 11.8. Individual Access to Health Care Coverage*

6

7     *1399.845. For purposes of this article, the following definitions*  
8     *shall apply:*

9     (i) *“Child” means a child described in Section 22775 of the*  
10     *Government Code and subdivisions (n) to (p), inclusive, of Section*  
11     *599.500 of Title 2 of the California Code of Regulations.*

12     (ii) *“Dependent” means the spouse, domestic partner, or child*  
13     *of an individual, subject to applicable terms of the health benefit*  
14     *plan.*

15     (iii) *“Exchange” means the California Health Benefit Exchange*  
16     *created by Section 100500 of the Government Code.*

17     (iv) *“Grandfathered health plan” has the same meaning as that*  
18     *term is defined in Section 1251 of PPACA.*

19     (v) *“Health benefit plan” means any individual or group policy*  
20     *of health insurance as defined in Section 106 of the Insurance*  
21     *Code or health care service plan contract that provides medical,*  
22     *hospital, and surgical benefits. The term does not include a*  
23     *specialized health insurance policy, as defined in Section 106 of*  
24     *the Insurance Code, a specialized health care service plan contract,*  
25     *a health care service plan conversion contract offered pursuant*  
26     *to Section 1373.6, a health insurance conversion policy offered*  
27     *pursuant to Section 12682.1 of the Insurance Code, a health*  
28     *insurance policy or health care service plan contract provided in*  
29     *the Medi-Cal program (Chapter 7 (commencing with Section*  
30     *14000) of Part 3 of Division 9 of the Welfare and Institutions*  
31     *Code), the Healthy Families Program (Part 6.2 (commencing with*  
32     *Section 12693) of Division 2 of the Insurance Code), the Access*  
33     *for Infants and Mothers Program (Part 6.3 (commencing with*  
34     *Section 12695) of Division 2 of the Insurance Code), or the*  
35     *program under Part 6.4 (commencing with Section 12699.50) of*  
36     *Division 2 of the Insurance Code, a health care service plan*  
37     *contract or health insurance policy offered to a federally eligible*  
38     *defined individual under Article 4.6 (commencing with Section*  
39     *1366.35) of this code or Chapter 9.5 (commencing with Section*

1 10900) of Part 2 of Division 2 of the Insurance Code, or Medicare  
2 supplement coverage, to the extent consistent with PPACA.

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

8 (g) “Preexisting condition provision” means a contract  
9 provision that excludes coverage for charges or expenses incurred  
10 during a specified period following the enrollee’s effective date  
11 of coverage, as to a condition for which medical advice, diagnosis,  
12 care, or treatment was recommended or received during a specified  
13 period immediately preceding the effective date of coverage.

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

16 (i) “Rating period” means the period for which premium rates  
17 established by a plan are in effect.

18 1399.847. Every health care service plan offering individual  
19 health benefit plans shall, in addition to complying with the  
20 provisions of this chapter and rules adopted thereunder, comply  
21 with the provisions of this article.

22 1399.849. (a) (1) On and after October 1, 2013, a plan shall  
23 fairly and affirmatively offer, market, and sell all of the plan’s  
24 health benefit plans that are sold in the individual market to all  
25 individuals and dependents in each service area in which the plan  
26 provides or arranges for the provision of health care services. A  
27 plan shall limit enrollment in individual health benefit plans to  
28 open enrollment periods and special enrollment periods as  
29 provided in subdivisions (c) and (d).

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

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

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

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

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

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

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

18 (B) “Loss of minimum essential coverage” includes loss of that  
19 coverage due to the circumstances described in Section  
20 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of  
21 Federal Regulations. “Loss of minimum essential coverage” does  
22 not include loss of that coverage due to the individual’s failure to  
23 pay premiums on a timely basis or situations allowing for a  
24 rescission, subject to Section 1389.21.

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

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

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

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

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

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

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

39 (9) With respect to individual health benefit plans offered  
40 through the Exchange, in addition to the triggering events listed

1 *in this subdivision, the individual meets any of the requirements*  
2 *listed in Section 155.420(d) of Title 45 of the Code of Federal*  
3 *Regulations.*

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

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

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

34 *(3) With respect to an individual health benefit plan offered*  
35 *outside the Exchange for which an individual applies during the*  
36 *annual open enrollment period described in subdivision (c), when*  
37 *the individual submits a premium payment, based on the quoted*  
38 *premium charges, and that payment is delivered or postmarked,*  
39 *whichever occurs later, by December 15, coverage shall become*  
40 *effective as of the following January 1. When that payment is*

1 delivered or postmarked within the first 15 days of any subsequent  
2 month, coverage shall become effective no later than the first day  
3 of the following month. When that payment is delivered or  
4 postmarked between December 16 and December 31, inclusive,  
5 or after the 15th day of any subsequent month, coverage shall  
6 become effective no later than the first day of the second month  
7 following delivery or postmark of the payment.

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

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

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

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

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

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

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

37 (A) Health status.

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

39 (C) Claims experience.

40 (D) Receipt of health care.



- 1 (E) Medical history.
- 2 (F) Genetic information.
- 3 (G) Evidence of insurability, including conditions arising out
- 4 of acts of domestic violence.
- 5 (H) Disability.
- 6 (I) Any other health status-related factor as determined by any
- 7 federal regulations, rules, or guidance issued pursuant to Section
- 8 2705 of the federal Public Health Service Act.
- 9 (2) A health care service plan shall not require an individual
- 10 applicant or his or her dependent to fill out a health assessment
- 11 or medical questionnaire prior to enrollment under an individual
- 12 health benefit plan.
- 13 (h) A health care service plan offering coverage in the individual
- 14 market shall not reject the request of a subscriber during an open
- 15 enrollment period to include a dependent of the subscriber as a
- 16 dependent on an existing individual health benefit plan.
- 17 (i) This section shall not apply to an individual health benefit
- 18 plan that is a grandfathered health plan.
- 19 1399.851. (a) Commencing January 1, 2014, no health care
- 20 service plan or solicitor shall, directly or indirectly, engage in the
- 21 following activities:
- 22 (1) Encourage or direct an individual to refrain from filing an
- 23 application for individual coverage with a plan because of the
- 24 health status, claims experience, industry, occupation, or
- 25 geographic location, provided that the location is within the plan's
- 26 approved service area, of the individual.
- 27 (2) Encourage or direct an individual to seek individual
- 28 coverage from another plan or health insurer or the California
- 29 Health Benefit Exchange because of the health status, claims
- 30 experience, industry, occupation, or geographic location, provided
- 31 that the location is within the plan's approved service area, of the
- 32 individual.
- 33 (b) Commencing January 1, 2014, a health care service plan
- 34 shall not, directly or indirectly, enter into any contract, agreement,
- 35 or arrangement with a solicitor that provides for or results in the
- 36 compensation paid to a solicitor for the sale of an individual health
- 37 benefit plan to be varied because of the health status, claims
- 38 experience, industry, occupation, or geographic location of the
- 39 individual. This subdivision does not apply to a compensation
- 40 arrangement that provides compensation to a solicitor on the basis

1 of percentage of premium, provided that the percentage shall not  
2 vary because of the health status, claims experience, industry,  
3 occupation, or geographic area of the individual.

4 1399.853. (a) All individual health benefit plans shall conform  
5 to the requirements of Sections 1365, 1366.3, 1367.001, and  
6 1373.6, and any other requirements imposed by this chapter, and  
7 shall be renewable at the option of the enrollee except as permitted  
8 to be canceled, rescinded, or not renewed pursuant to Section  
9 1365.

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

14 1399.855. (a) With respect to individual health benefit plans  
15 issued, amended, or renewed on or after January 1, 2014, a health  
16 care service plan may use only the following characteristics of an  
17 individual, and any dependent thereof, for purposes of establishing  
18 the rate of the individual health benefit plan covering the individual  
19 and the eligible dependents thereof, along with the health benefit  
20 plan selected by the individual:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 1399.857. A health care service plan shall not be required to  
26 offer an individual health benefit plan or accept applications for  
27 the plan pursuant to this article in the case of any of the following:

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

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

36 (2) A health care service plan that cannot offer an individual  
37 health benefit plan to individuals because it is lacking in sufficient  
38 health care delivery resources within a service area or a portion  
39 of a service area may not offer a health benefit plan in the area in  
40 which the plan is not offering coverage to individuals to new

1 employer groups until the plan notifies the director that it has the  
2 ability to deliver services to individuals, and certifies to the director  
3 that from the date of the notice it will enroll all individuals  
4 requesting coverage in that area from the plan.

5 (3) Nothing in this article shall be construed to limit the  
6 director's authority to develop and implement a plan of  
7 rehabilitation for a health care service plan whose financial  
8 viability or organizational and administrative capacity has become  
9 impaired.

10 1399.859. The director may require a health care service plan  
11 to discontinue the offering of individual health benefit plans or  
12 acceptance of applications from any individual upon a  
13 determination by the director that the plan does not have sufficient  
14 financial viability or organizational and administrative capacity  
15 to ensure the delivery of health care services to its enrollees. In  
16 determining whether the conditions of this section have been met,  
17 the director shall consider, but not be limited to, the plan's  
18 compliance with the requirements of Section 1367, Article 6  
19 (commencing with Section 1375.1), and the rules adopted under  
20 those provisions.

21 1399.860. (a) On or before October 1, 2013, and annually  
22 thereafter, a health care service plan shall issue the following  
23 notice to all subscribers enrolled in an individual health benefit  
24 plan that is a grandfathered health plan:

25  
26 *Beginning on and after January 1, 2014, new improved health*  
27 *insurance options are available in California. You currently have*  
28 *health insurance that is exempt from many of the new requirements.*  
29 *You have the option to remain in your current plan or switch to a*  
30 *new plan. Under the new rules, a health insurance company cannot*  
31 *deny your application based on any health conditions you may*  
32 *have. For more information about your options, please contact*  
33 *the California Health Benefit Exchange, the Office of Patient*  
34 *Advocate, your plan or policy representative, an insurance broker,*  
35 *or a health care navigator.*

36  
37 (b) A health care service plan shall include the notice described  
38 in subdivision (a) in any marketing material of the individual  
39 grandfathered health plan.

1     *SEC. 20. Section 10113.9 of the Insurance Code is amended*  
2 *to read:*

3     10113.9. (a) This section shall not apply to short-term limited  
4 duration health insurance, vision-only, dental-only, or  
5 CHAMPUS-supplement insurance, or to hospital indemnity,  
6 hospital-only, accident-only, or specified disease insurance that  
7 does not pay benefits on a fixed benefit, cash payment only basis.

8     (b) (1) A health insurer that declines to offer coverage to or  
9 denies enrollment for an individual or his or her dependents  
10 applying for individual coverage or that offers individual coverage  
11 at a rate that is higher than the standard rate shall, at the time of  
12 the denial or offer of coverage, provide the applicant with the  
13 specific reason or reasons for the decision in writing, in clear,  
14 easily understandable language.

15     (2) No change in the premium rate or coverage for an individual  
16 health insurance policy shall become effective unless the insurer  
17 has delivered a written notice of the change at least 60 days prior  
18 to the effective date of the policy renewal or the date on which the  
19 rate or coverage changes. A notice of an increase in the premium  
20 rate shall include the reasons for the rate increase.

21     (3) The written notice required pursuant to paragraph (2) shall  
22 be delivered to the individual policyholder at his or her last address  
23 known to the insurer, at least 60 days prior to the effective date of  
24 the change. The notice shall state in italics and in 12-point type  
25 the actual dollar amount of the premium increase and the specific  
26 percentage by which the current premium will be increased. The  
27 notice shall describe in plain, understandable English any changes  
28 in the policy or any changes in benefits, including a reduction in  
29 benefits or changes to waivers, exclusions, or conditions, and  
30 highlight this information by printing it in italics. The notice shall  
31 specify in a minimum of 10-point bold typeface, the reason for a  
32 premium rate change or a change in coverage or benefits.

33     (4) If an insurer rejects an applicant or the dependents of an  
34 applicant for coverage or offers individual coverage at a rate that  
35 is higher than the standard rate, the insurer shall inform the  
36 applicant about the state's high-risk health insurance pool, the  
37 California Major Risk Medical Insurance Program (MRMIP) (Part  
38 6.5 (commencing with Section 12700)), and the federal temporary  
39 high risk pool established pursuant to Part 6.6 (commencing with  
40 Section 12739.5). The information provided to the applicant by

1 the insurer shall be in accordance with standards developed by the  
2 department, in consultation with the Managed Risk Medical  
3 Insurance Board, and shall specifically include the toll-free  
4 telephone number and Internet Web site address for MRMIP and  
5 the federal temporary high risk pool. The requirement to notify  
6 applicants of the availability of MRMIP and the federal temporary  
7 high risk pool shall not apply when a health plan rejects an  
8 applicant for Medicare supplement coverage.

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

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

19 SEC. 21. *Section 10113.9 is added to the Insurance Code, to*  
20 *read:*

21 *10113.9. (a) This section shall not apply to short-term limited*  
22 *duration health insurance, vision-only, dental-only, or*  
23 *CHAMPUS-supplement insurance, or to hospital indemnity,*  
24 *hospital-only, accident-only, or specified disease insurance that*  
25 *does not pay benefits on a fixed benefit, cash payment only basis.*

26 (b) (1) *No change in the premium rate or coverage for an*  
27 *individual health insurance policy shall become effective unless*  
28 *the insurer has delivered a written notice of the change at least*  
29 *60 days prior to the effective date of the plan renewal or the date*  
30 *on which the rate or coverage changes. A notice of an increase in*  
31 *the premium rate shall include the reasons for the rate increase.*

32 (2) *The written notice required pursuant to paragraph (1) shall*  
33 *be delivered to the individual policyholder at his or her last address*  
34 *known to the insurer, at least 60 days prior to the effective date of*  
35 *the change. The notice shall state in italics and in 12-point type*  
36 *the actual dollar amount of the premium increase and the specific*  
37 *percentage by which the current premium will be increased. The*  
38 *notice shall describe in plain, understandable English any changes*  
39 *in the policy or any changes in benefits, including a reduction in*  
40 *benefits or changes to waivers, exclusions, or conditions, and*

1 *highlight this information by printing it in italics. The notice shall*  
2 *specify in a minimum of 10-point bold typeface, the reason for a*  
3 *premium rate change or a change in coverage or benefits. For*  
4 *individual grandfathered health plans, the notice shall also inform*  
5 *the individual contractholder about the availability of coverage*  
6 *through the California Health Benefit Exchange established under*  
7 *Title 22 (commencing with Section 100500) of the Government*  
8 *Code and shall include the toll-free telephone number and Internet*  
9 *Web site for the California Health Benefit Exchange.*

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

18 (2) *If a health insurer rejects an applicant or the dependents of*  
19 *an applicant for an individual grandfathered health plan or offers*  
20 *an individual grandfathered health plan at a rate that is higher*  
21 *than the standard rate, the insurer shall inform the applicant about*  
22 *the California Health Benefit Exchange established under Title*  
23 *22 (commencing with Section 100500) of the Government Code.*  
24 *The information provided to the applicant by the insurer shall*  
25 *include the toll-free telephone number and Internet Web site for*  
26 *the California Health Benefit Exchange.*

27 (d) *A notice provided pursuant to this section is a private and*  
28 *confidential communication and, at the time of application, the*  
29 *insurer shall give the applicant the opportunity to designate the*  
30 *address for receipt of the written notice in order to protect the*  
31 *confidentiality of any personal or privileged information.*

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

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

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

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

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

4 10113.95. (a) A health insurer that issues, renews, or amends  
5 individual health insurance policies shall be subject to this section.

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

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

28 (d) Commencing January 1, 2011, the commissioner shall post  
29 on the department's Internet Web site, in a manner accessible and  
30 understandable to consumers, general, noncompany specific  
31 information about rating and underwriting criteria and practices  
32 in the individual market and information about the California Major  
33 Risk Medical Insurance Program (Part 6.5 (commencing with  
34 Section 12700)) and the federal temporary high risk pool  
35 established pursuant to Part 6.6 (commencing with Section  
36 12739.5). The commissioner shall develop the information for the  
37 Internet Web site in consultation with the Department of Managed  
38 Health Care to enhance the consistency of information provided  
39 to consumers. Information about individual health insurance shall  
40 also include the following notification:



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

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

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

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

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

19 10113.95. (a) *A health insurer that renews individual*  
20 *grandfathered health plans shall be subject to this section.*

21 (b) *An insurer subject to this section shall have written policies,*  
22 *procedures, or underwriting guidelines establishing the criteria*  
23 *and process whereby the insurer makes its decision to provide or*  
24 *to deny coverage to individuals applying for an individual*  
25 *grandfathered health plan and sets the rate for that coverage.*  
26 *These guidelines, policies, or procedures shall ensure that the plan*  
27 *rating and underwriting criteria comply with Sections 10140 and*  
28 *10291.5 and all other applicable provisions.*

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

1 *brokers, provided that those materials include the information*  
2 *required to be submitted by this section.*

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

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

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

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

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

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

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

20 10119.1. (a) This section shall apply to a health insurer that  
21 covers hospital, medical, or surgical expenses under an individual  
22 health benefit plan, as defined in subdivision (a) of Section  
23 10198.6, that is issued, amended, renewed, or delivered on or after  
24 January 1, 2007.

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

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

36 (c) The insurer shall establish, for the purposes of subdivision  
37 (b), a ranking of the individual health benefit plans it offers to  
38 individual purchasers and post the ranking on its Internet Web site  
39 or make the ranking available upon request. The insurer shall

1 update the ranking whenever a new benefit design for individual  
2 purchasers is approved.

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

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

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

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

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

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

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

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

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

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

39 10119.2. (a) Every health insurer that offers, issues, or renews  
40 health insurance under an individual health benefit plan, as defined

1 in subdivision (a) of Section 10198.6, shall offer to any individual,  
2 who was covered under an individual health benefit plan that was  
3 rescinded, a new individual health benefit plan without medical  
4 underwriting that provides equal benefits. A health insurer may  
5 also permit an individual, who was covered under an individual  
6 health benefit plan that was rescinded, to remain covered under  
7 that individual health benefit plan, with a revised premium rate  
8 that reflects the number of persons remaining on the health benefit  
9 plan.

10 (b) “Without medical underwriting” means that the health insurer  
11 shall not decline to offer coverage to, or deny enrollment of, the  
12 individual or impose any preexisting condition exclusion on the  
13 individual who is issued a new individual health benefit plan or  
14 remains covered under an individual health benefit plan pursuant  
15 to this section.

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

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

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

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

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

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

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

9 10119.2. (a) *Every health insurer that offers, issues, or renews*  
10 *health insurance under an individual health benefit plan, as defined*  
11 *in subdivision (a) of Section 10198.6, shall offer to any individual,*  
12 *who was covered under an individual health benefit plan that was*  
13 *rescinded, a new individual health benefit plan. A health insurer*  
14 *may also permit an individual, who was covered under an*  
15 *individual health benefit plan that was rescinded, to remain*  
16 *covered under that individual health benefit plan, with a revised*  
17 *premium rate that reflects the number of persons remaining on*  
18 *the health benefit plan consistent with Section 10965.9.*

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

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

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

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

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

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

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

1 10291.5. (a) The purpose of this section is to achieve both of  
2 the following:

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

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

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

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

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

30 (3) If it contains any provision for payment for disability caused  
31 by particular event or events (as distinguished from character of  
32 physical injury or illness of the insured) payable for a term more  
33 than twice the least term of payment provided by the policy for  
34 the same degree of disability caused by any other event or events;  
35 or if it contains any benefit for total nonconfining disability payable  
36 for lifetime or for more than 12 months and any benefit for partial  
37 disability, unless the benefit for partial disability is payable for at  
38 least three months; or if it contains any benefit for total confining  
39 disability payable for lifetime or for more than 12 months, unless  
40 it also contains benefit for total nonconfining disability caused by

1 the same event or events payable for at least three months, and, if  
2 it also contains any benefit for partial disability, unless the benefit  
3 for partial disability is payable for at least three months. The  
4 provisions of this paragraph shall apply separately to accident  
5 benefits and to sickness benefits.

6 (4) If it contains provision or provisions which would have the  
7 effect, upon any termination of the policy, of reducing or ending  
8 the liability as the insurer would have, but for the termination, for  
9 loss of time resulting from accident occurring while the policy is  
10 in force or for loss of time commencing while the policy is in force  
11 and resulting from sickness contracted while the policy is in force  
12 or for other losses resulting from accident occurring or sickness  
13 contracted while the policy is in force, and also contains provision  
14 or provisions reserving to the insurer the right to cancel or refuse  
15 to renew the policy, unless it also contains other provision or  
16 provisions the effect of which is that termination of the policy as  
17 the result of the exercise by the insurer of any such right shall not  
18 reduce or end the liability in respect to the hereinafter specified  
19 losses as the insurer would have had under the policy, including  
20 its other limitations, conditions, reductions, and restrictions, had  
21 the policy not been so terminated.

22 The specified losses referred to in the preceding paragraph are:

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

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

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

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

38 (5) If by any caption, label, title, or description of contents the  
39 policy states, implies, or infers without reasonable qualification  
40 that it provides loss of time indemnity for lifetime, or for any period

1 of more than two years, if the loss of time indemnity is made  
2 payable only when house confined or only under special  
3 contingencies not applicable to other total loss of time indemnity.

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

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

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

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

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

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

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

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

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

39 (A) Of substituting, upon the occurrence of the loss of both  
40 hands, both feet, one hand and one foot, the sight of both eyes or



1 the sight of one eye and the loss of one hand or one foot, some  
2 specified indemnity for any or all benefits under the policy unless  
3 the indemnity so specified is equal to or greater than the total of  
4 the benefit or benefits for which such specified indemnity is  
5 substituted and which, assuming in all cases that the insured would  
6 continue to live, could possibly accrue within four years from the  
7 date of such dismemberment under all other provisions of the  
8 policy applicable to the particular event or events (as distinguished  
9 from character of physical injury or illness) causing the  
10 dismemberment.

11 (B) Of substituting, upon the occurrence of any other  
12 dismemberment some specified indemnity for any or all benefits  
13 under the policy unless the indemnity so specified is equal to or  
14 greater than one-fourth of the total of the benefit or benefits for  
15 which the specified indemnity is substituted and which, assuming  
16 in all cases that the insured would continue to live, could possibly  
17 accrue within four years from the date of the dismemberment under  
18 all other provisions of the policy applicable to the particular event  
19 or events (as distinguished from character of physical injury or  
20 illness) causing the dismemberment.

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

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

29 (9) If it contains provision, other than as provided in Section  
30 10369.3, reducing any original benefit more than 50 percent on  
31 account of age of the insured.

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

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

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

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

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

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

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

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

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

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

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

32 (2) The application questions designed to ascertain the health  
33 condition or history of the applicant *in applications subject to*  
34 *paragraph (1)* shall be based on medical information that is  
35 reasonable and necessary for medical underwriting purposes. The  
36 application shall include a prominently displayed notice that states:  
37 “California law prohibits an HIV test from being required or  
38 used by health insurance companies as a condition of obtaining  
39 health insurance coverage.”

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

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

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

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

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

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

31 Any such withdrawal shall be in writing and shall specify  
32 reasons. An insurer adversely affected by any such withdrawal  
33 may, within a period of 30 days following mailing or delivery of  
34 the writing containing the withdrawal, by written request secure  
35 a hearing to determine whether the withdrawal should be annulled,  
36 modified, or confirmed. Unless, at any time, it is mutually agreed  
37 to the contrary, a hearing shall be granted and commenced within  
38 30 days following filing of the request and shall proceed with  
39 reasonable dispatch to determination. Unless the commissioner in  
40 writing in the withdrawal, or subsequent thereto, grants an

1 extension, any such withdrawal shall, in the absence of any such  
2 request, be effective, prospectively and not retroactively, on the  
3 91st day following the mailing or delivery of the withdrawal, and,  
4 if request for the hearing is filed, on the 91st day following mailing  
5 or delivery of written notice of the commissioner's determination.

6 (g) No proceeding under this section is subject to Chapter 5  
7 (commencing with Section 11500) of Part 1 of Division 3 of Title  
8 2 of the Government Code.

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

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

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

29 (j) This section shall be effective on and after July 1, 1950, as  
30 to all policies thereafter submitted and on and after January 1,  
31 1951, the commissioner may withdraw approval pursuant to  
32 subdivision (d) of any policy thereafter issued or delivered in this  
33 state irrespective of when its form may have been submitted or  
34 approved, and prior to those dates the provisions of law in effect  
35 on January 1, 1949, shall apply to those policies.

36 (k) Any such policy issued by an insurer to an insured on a form  
37 approved by the commissioner, and in accordance with the  
38 conditions, if any, contained in the approval, at a time when that  
39 approval is outstanding shall, as between the insurer and the

1 insured, or any person claiming under the policy, be conclusively  
2 presumed to comply with, and conform to, this section.

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

5 10901.3. (a) (1) After the federally eligible defined individual  
6 submits a completed application form for a health benefit plan,  
7 the carrier shall, within 30 days, notify the individual of the  
8 individual's actual premium charges for that health benefit plan  
9 design. In no case shall the premium charged for any health benefit  
10 plan identified in subdivision (d) of Section 10785 exceed the  
11 following amounts:

12 (A) For health benefit plans that offer services through a  
13 preferred provider arrangement, the average premium paid by a  
14 subscriber of the Major Risk Medical Insurance Program who is  
15 of the same age and resides in the same geographic area as the  
16 federally eligible defined individual. However, for federally  
17 qualified individuals who are between the ages of 60 and 64,  
18 inclusive, the premium shall not exceed the average premium paid  
19 by a subscriber of the Major Risk Medical Insurance Program who  
20 is 59 years of age and resides in the same geographic area as the  
21 federally eligible defined individual.

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

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

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

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

6 (b) When a federally eligible defined individual submits a  
7 premium payment, based on the quoted premium charges, and that  
8 payment is delivered or postmarked, whichever occurs earlier,  
9 within the first 15 days of the month, coverage shall begin no later  
10 than the first day of the following month. When that payment is  
11 neither delivered or postmarked until after the 15th day of a month,  
12 coverage shall become effective no later than the first day of the  
13 second month following delivery or postmark of the payment.

14 (c) During the first 30 days after the effective date of the health  
15 benefit plan, the individual shall have the option of changing  
16 coverage to a different health benefit plan design offered by the  
17 same carrier. If the individual notified the plan of the change within  
18 the first 15 days of a month, coverage under the new health benefit  
19 plan shall become effective no later than the first day of the  
20 following month. If an enrolled individual notified the carrier of  
21 the change after the 15th day of a month, coverage under the health  
22 benefit plan shall become effective no later than the first day of  
23 the second month following notification.

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

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

29 *10901.3. (a) After the federally eligible defined individual*  
30 *submits a completed application form for a health benefit plan,*  
31 *the carrier shall, within 30 days, notify the individual of the*  
32 *individual's actual premium charges for that health benefit plan*  
33 *design. In no case shall the premium charged for any health benefit*  
34 *plan identified in subdivision (d) of Section 10785 exceed the*  
35 *premium for the second lowest cost silver plan of the individual*  
36 *market in the rating area in which the individual resides which is*  
37 *offered through the California Health Benefit Exchange established*  
38 *under Title 22 (commencing with Section 100500) of the*  
39 *Government Code, as described in Section 36B(b)(3)(B) of Title*  
40 *26 of the United States Code.*

1 (b) When a federally eligible defined individual submits a  
2 premium payment, based on the quoted premium charges, and that  
3 payment is delivered or postmarked, whichever occurs earlier,  
4 within the first 15 days of the month, coverage shall begin no later  
5 than the first day of the following month. When that payment is  
6 neither delivered or postmarked until after the 15th day of a month,  
7 coverage shall become effective no later than the first day of the  
8 second month following delivery or postmark of the payment.

9 (c) During the first 30 days after the effective date of the health  
10 benefit plan, the individual shall have the option of changing  
11 coverage to a different health benefit plan design offered by the  
12 same carrier. If the individual notified the plan of the change within  
13 the first 15 days of a month, coverage under the new health benefit  
14 plan shall become effective no later than the first day of the  
15 following month. If an enrolled individual notified the carrier of  
16 the change after the 15th day of a month, coverage under the health  
17 benefit plan shall become effective no later than the first day of  
18 the second month following notification.

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

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

22 10901.9. Commencing January 1, 2001, premiums for health  
23 benefit plans offered, delivered, amended, or renewed by carriers  
24 shall be subject to the following requirements:

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

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

38 (2) For health benefit plans identified in subdivision (d) of  
39 Section 10785 that do not offer services through a preferred  
40 provider arrangement, 170 percent of the standard premium charged

1 to an individual who is of the same age and resides in the same  
2 geographic area as the federally eligible defined individual.  
3 However, for federally qualified individuals who are between the  
4 ages of 60 to 64, inclusive, the premium shall not exceed 170  
5 percent of the standard premium charged to an individual who is  
6 59 years of age and resides in the same geographic area as the  
7 federally eligible defined individual.

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

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

21 (2) For health benefit plans identified in subdivision (d) of  
22 Section 10785 that do not offer services through a preferred  
23 provider arrangement, 170 percent of the standard premium charged  
24 to an individual who is of the same age and resides in the same  
25 geographic area as the federally eligible defined individual.  
26 However, for federally qualified individuals who are between the  
27 ages of 60 and 64, inclusive, the premium shall not exceed 170  
28 percent of the standard premium charged to an individual who is  
29 59 years of age and resides in the same geographic area as the  
30 federally eligible defined individual. The premium effective on  
31 January 1, 2001, shall apply to in force business at the earlier of  
32 either the time of renewal or July 1, 2001.

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

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



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

8 ~~(2)~~

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

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

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

19 *10901.9. (a) Commencing January 1, 2014, premiums for*  
20 *health benefit plans offered, delivered, amended, or renewed by*  
21 *carriers shall be subject to the following requirements:*

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

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

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

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

38 *10902.4. (a) Carriers and health care service plans that offer*  
39 *contracts to individuals may elect to establish a mechanism or*  
40 *method to share in the financing of high-risk individuals. This*

1 mechanism or method shall be established through a committee  
 2 of all carriers and health care service plans offering coverage to  
 3 individuals by July 1, 2002, and shall be implemented by January  
 4 1, 2003. If carriers and health care service plans wish to establish  
 5 a risk-sharing mechanism but cannot agree on the terms and  
 6 conditions of such an agreement, the Managed Risk Medical  
 7 Insurance Board shall develop a risk-sharing mechanism or method  
 8 by January 1, 2003, and it shall be implemented by July 1, 2003.

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

12 *SEC. 33. The heading of Chapter 9.7 (commencing with Section*  
 13 *10950) of Part 2 of Division 2 of the Insurance Code is amended*  
 14 *to read:*

15  
 16 CHAPTER 9.7. ~~INDIVIDUAL~~ CHILD ACCESS TO HEALTH  
 17 INSURANCE  
 18

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

21 10954. (a) A carrier may use the following characteristics of  
 22 an eligible child for purposes of establishing the rate of the health  
 23 benefit plan for that child, where consistent with federal regulations  
 24 under PPACA: age, geographic region, and family composition,  
 25 plus the health benefit plan selected by the child or the responsible  
 26 party for a child.

27 (b) From the effective date of this chapter to December 31,  
 28 2013, inclusive, rates for a child applying for coverage shall be  
 29 subject to the following limitations:

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

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

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

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

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

15  
16 “Please consider your options carefully before failing to maintain  
17 or ~~renew~~ *renewing* coverage for a child for whom you are  
18 responsible. If you attempt to obtain new individual coverage for  
19 that child, the premium for the same coverage may be higher than  
20 the premium you pay now.”

21  
22 (d) A child who applied for coverage between September 23,  
23 2010, and the end of the initial enrollment period shall be deemed  
24 to have maintained coverage during that period.

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

28 ~~(f) Carriers may require documentation from applicants relating~~  
29 ~~to their coverage history.~~

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

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

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

39 *(B) An explanation that obtaining coverage during the open*  
40 *enrollment period described in Section 10965.3 will not affect the*

1 effective dates of coverage for coverage purchased pursuant to  
2 this chapter unless the applicant cancels that coverage.

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

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

10 (g) The department may adopt a model notice to be used by  
11 carriers in order to comply with this subdivision. Use of the model  
12 notice shall not require prior approval of the department. Any  
13 model notice designated by the department for purposes of this  
14 section shall not be subject to the Administrative Procedure Act  
15 (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
16 Division 3 of Title 2 of the Government Code).

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

19 10961. This chapter shall remain in effect only until January  
20 1, 2014, and as of that date is repealed, unless a later enacted  
21 statute, that is enacted before January 1, 2014, deletes or extends  
22 that date.

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

25

26 CHAPTER 9.9. INDIVIDUAL ACCESS TO HEALTH INSURANCE

27

28 10965. For purposes of this chapter, the following definitions  
29 shall apply:

30 (a) "Child" means a child described in Section 22775 of the  
31 Government Code and subdivisions (n) to (p), inclusive, of Section  
32 599.500 of Title 2 of the California Code of Regulations.

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

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

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

39 (e) "Health benefit plan" means any individual or group policy  
40 of health insurance, as defined in Section 106, or health care

1 *service plan contract that provides medical, hospital, and surgical*  
2 *benefits. The term does not include a health insurance policy*  
3 *consisting solely of coverage of excepted benefits, as described in*  
4 *Sections 2722 and 2791 of the federal Public Health Service Act*  
5 *(42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91), subject to*  
6 *Section 10965.01, a specialized health care service plan contract,*  
7 *as defined in Section 1345 of the Health and Safety Code, a health*  
8 *care service plan conversion contract offered pursuant to Section*  
9 *1373.6 of the Health and Safety Code, a health insurance*  
10 *conversion policy offered pursuant to Section 12682.1, a health*  
11 *insurance policy or health care service plan contract provided in*  
12 *the Medi-Cal program (Chapter 7 (commencing with Section*  
13 *14000) of Part 3 of Division 9 of the Welfare and Institutions*  
14 *Code), the Healthy Families Program (Part 6.2 (commencing with*  
15 *Section 12693) of Division 2), the Access for Infants and Mothers*  
16 *Program (Part 6.3 (commencing with Section 12695) of Division*  
17 *2), or the program under Part 6.4 (commencing with Section*  
18 *12699.50) of Division 2, a health care service plan contract or*  
19 *health insurance policy offered to a federally eligible defined*  
20 *individual under Article 4.6 (commencing with Section 1366.35)*  
21 *of Chapter 2.2 of Division 2 of the Health and Safety Code or*  
22 *Chapter 9.5 (commencing with Section 10900), or Medicare*  
23 *supplement coverage, to the extent consistent with PPACA.*

24 (f) “PPACA” means the federal Patient Protection and  
25 Affordable Care Act (Public Law 111-148), as amended by the  
26 federal Health Care and Education Reconciliation Act of 2010  
27 (Public Law 111-152), and any rules, regulations, or guidance  
28 issued pursuant to that law.

29 (g) “Preexisting condition provision” means a policy provision  
30 that excludes coverage for charges or expenses incurred during  
31 a specified period following the insured’s effective date of  
32 coverage, as to a condition for which medical advice, diagnosis,  
33 care, or treatment was recommended or received during a specified  
34 period immediately preceding the effective date of coverage.

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

37 (i) “Rating period” means the period for which premium rates  
38 established by an insurer are in effect.

39 10965.01. (a) For purposes of this chapter, “health benefit  
40 plan” does not include policies or certificates of specified disease

1 or hospital confinement indemnity provided that the carrier offering  
2 those policies or certificates complies with the following:

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

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

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

15  
16 “This is a supplement to health insurance. It is not a substitute  
17 for essential health benefits or minimum essential coverage as  
18 defined in PPACA. Commencing January 1, 2014, you may be  
19 subject to a federal tax if you do not obtain minimum essential  
20 coverage.”

21  
22 (B) A summary description of each policy or certificate  
23 described in this section, including the average annual premium  
24 rates, or range of premium rates in cases where premiums vary  
25 by age, gender, or other factors, charged for the policies and  
26 certificates in this state.

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

33 (b) As used in this section, “policies or certificates of specified  
34 disease” and “policies or certificates of hospital confinement  
35 indemnity” mean policies or certificates of insurance sold to an  
36 insured to supplement other health insurance coverage as specified  
37 in this section.

38 10965.1. Every health insurer offering individual health benefit  
39 plans shall, in addition to complying with the provisions of this

1 *part and rules adopted thereunder, comply with the provisions of*  
2 *this chapter.*

3 10965.3. (a) (1) *On and after October 1, 2013, a health*  
4 *insurer shall fairly and affirmatively offer, market, and sell all of*  
5 *the insurer's health benefit plans that are sold in the individual*  
6 *market to all individuals and dependents in each service area in*  
7 *which the insurer provides or arranges for the provision of health*  
8 *care services. An insurer shall limit enrollment in individual health*  
9 *benefit plans to open enrollment periods and special enrollment*  
10 *periods as provided in subdivisions (c) and (d).*

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

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

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

24 (c) *A health insurer shall provide an initial open enrollment*  
25 *period from October 1, 2013, to March 31, 2014, inclusive, and*  
26 *annual enrollment periods for plan years on or after January 1,*  
27 *2015, from October 15 to December 7, inclusive, of the preceding*  
28 *calendar year.*

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

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

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

39 (B) *"Loss of minimum essential coverage" includes loss of that*  
40 *coverage due to the circumstances described in Section*

1 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of  
2 Federal Regulations. “Loss of minimum essential coverage” does  
3 not include loss of that coverage due to the individual’s failure to  
4 pay premiums on a timely basis or situations allowing for a  
5 rescission, subject to Section 10384.17.

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

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

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

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

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

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

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

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

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

33 (f) (1) With respect to individual health benefit plans offered  
34 outside the Exchange, after an individual submits a completed  
35 application form for a plan, the insurer shall, within 30 days, notify  
36 the individual of the individual’s actual premium charges for that  
37 plan established in accordance with Section 10965.9. The  
38 individual shall have 30 days in which to exercise the right to buy  
39 coverage at the quoted premium charges.



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

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

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

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

39 (B) *When the premium payment is neither delivered nor*  
40 *postmarked until after the 15th day of the month, coverage shall*

1 *become effective no later than the first day of the second month*  
2 *following delivery or postmark of the payment.*

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

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

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

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

19 *(A) Health status.*

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

21 *(C) Claims experience.*

22 *(D) Receipt of health care.*

23 *(E) Medical history.*

24 *(F) Genetic information.*

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

27 *(H) Disability.*

28 *(I) Any other health status-related factor as determined by any*  
29 *federal regulations, rules, or guidance issued pursuant to Section*  
30 *2705 of the federal Public Health Service Act.*

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

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

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

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

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

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

15     (b) Commencing January 1, 2014, a health insurer shall not,  
16 directly or indirectly, enter into any contract, agreement, or  
17 arrangement with a broker or agent that provides for or results  
18 in the compensation paid to a broker or agent for the sale of an  
19 individual health benefit plan to be varied because of the health  
20 status, claims experience, industry, occupation, or geographic  
21 location of the individual. This subdivision does not apply to a  
22 compensation arrangement that provides compensation to a broker  
23 or agent on the basis of percentage of premium, provided that the  
24 percentage shall not vary because of the health status, claims  
25 experience, industry, occupation, or geographic area of the  
26 individual.

27     10965.7. (a) All individual health benefit plans shall conform  
28 to the requirements of Sections 10112.1, 10127.18, 10273.4, and  
29 12682.1, and any other requirements imposed by this code, and  
30 shall be renewable at the option of the insured except as permitted  
31 to be canceled, rescinded, or not renewed pursuant to Section  
32 10273.4.

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

37     10965.9. (a) With respect to individual health benefit plans  
38 issued, amended, or renewed on or after January 1, 2014, a health  
39 insurer may use only the following characteristics of an individual,  
40 and any dependent thereof, for purposes of establishing the rate

1 of the individual health benefit plan covering the individual and  
2 the eligible dependents thereof, along with the health benefit plan  
3 selected by the individual:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 10965.11. A health insurer shall not be required to offer an  
10 individual health benefit plan or accept applications for the plan  
11 pursuant to this chapter in the case of any of the following:

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

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

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

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

33 10965.13. The commissioner may require a health insurer to  
34 discontinue the offering of individual health benefit plans or  
35 acceptance of applications from any individual upon a  
36 determination by the commissioner that the insurer does not have  
37 sufficient financial viability or organizational and administrative  
38 capacity to ensure the delivery of health care services to its  
39 insureds. In determining whether the conditions of this section  
40 have been met, the commissioner shall consider, but not be limited

1 to, the insurer's compliance with the requirements of this part and  
2 the rules adopted under those provisions.

3 10965.14. (a) On or before October 1, 2013, and annually  
4 thereafter, a health insurer shall issue the following notice to all  
5 policyholders enrolled in an individual health benefit plan that is  
6 a grandfathered health plan:

7  
8 *Beginning on and after January 1, 2014, new improved health*  
9 *insurance options are available in California. You currently have*  
10 *health insurance that is exempt from many of the new requirements.*  
11 *You have the option to remain in your current plan or switch to a*  
12 *new plan. Under the new rules, a health insurance company cannot*  
13 *deny your application based on any health conditions you may*  
14 *have. For more information about your options, please contact*  
15 *the California Health Benefit Exchange, the Office of Patient*  
16 *Advocate, your plan or policy representative, an insurance broker,*  
17 *or a health care navigator.*

18  
19 (b) A health insurer shall include the notice described in  
20 subdivision (a) in any marketing material of the individual  
21 grandfathered health plan.

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

28 SEC. 38. No reimbursement is required by this act pursuant  
29 to Section 6 of Article XIII B of the California Constitution because  
30 the only costs that may be incurred by a local agency or school  
31 district will be incurred because this act creates a new crime or  
32 infraction, eliminates a crime or infraction, or changes the penalty  
33 for a crime or infraction, within the meaning of Section 17556 of  
34 the Government Code, or changes the definition of a crime within  
35 the meaning of Section 6 of Article XIII B of the California  
36 Constitution.

37 ~~SECTION 1. Section 1357.51 of the Health and Safety Code~~  
38 ~~is amended to read:~~

39 ~~1357.51. (a) No plan contract that covers three or more~~  
40 ~~enrollees shall exclude coverage for any individual on the basis~~

1 of a preexisting condition provision for a period greater than six  
2 months following the individual's effective date of coverage.  
3 Preexisting condition provisions contained in plan contracts may  
4 relate only to conditions for which medical advice, diagnosis, care,  
5 or treatment, including use of prescription drugs, was recommended  
6 or received from a licensed health practitioner during the six  
7 months immediately preceding the effective date of coverage.

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

20 (c) (1) Notwithstanding subdivision (a), a plan contract for  
21 group coverage shall not impose any preexisting condition  
22 provision upon any child under 19 years of age. A plan contract  
23 for group coverage issued, amended, or renewed on or after January  
24 1, 2014, shall not impose any preexisting condition provision upon  
25 any individual.

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

37 (d) A plan that does not utilize a preexisting condition provision  
38 may impose a waiting or affiliation period not to exceed 60 days;  
39 before the coverage issued subject to this article shall become  
40 effective. During the waiting or affiliation period, the plan is not

1 required to provide health care services and no premium shall be  
2 charged to the subscriber or enrollee.

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

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

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

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



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

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

7 ~~SEC. 2. The heading of Article 11.7 (commencing with Section~~  
8 ~~1399.825) of Chapter 2.2 of Division 2 of the Health and Safety~~  
9 ~~Code is amended to read:~~

10  
11 ~~Article 11.7. Child Access to Health Care Coverage~~  
12

13 ~~SEC. 3. Section 1399.829 of the Health and Safety Code is~~  
14 ~~amended to read:~~

15 ~~1399.829. (a) A health care service plan may use the following~~  
16 ~~characteristics of an eligible child for purposes of establishing the~~  
17 ~~rate of the plan contract for that child, where consistent with federal~~  
18 ~~regulations under PPACA: age, geographic region, and family~~  
19 ~~composition, plus the health care service plan contract selected by~~  
20 ~~the child or the responsible party for the child.~~

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

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

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

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

39 ~~(4) If expressly permitted under PPACA and any rules,~~  
40 ~~regulations, or guidance issued pursuant to that act, a health care~~

1 service plan may condition an offer or acceptance of coverage on  
2 any preexisting condition or other health status-related factor for  
3 a period other than an open enrollment period and for a child who  
4 is not a late enrollee.

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

9

10 “Please consider your options carefully before failing to maintain  
11 or renew coverage for a child for whom you are responsible. If  
12 you attempt to obtain new individual coverage for that child, the  
13 premium for the same coverage may be higher than the premium  
14 you pay now.”

15

16 (d) A child who applied for coverage between September 23,  
17 2010, and the end of the initial open enrollment period shall be  
18 deemed to have maintained coverage during that period.

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

21 SEC. 4. Section 1399.836 is added to the Health and Safety  
22 Code, to read:

23 1399.836. This article shall remain in effect only until January  
24 1, 2014, and as of that date is repealed, unless a later enacted  
25 statute, that is enacted before January 1, 2014, deletes or extends  
26 that date.

27 SEC. 5. Article 11.8 (commencing with Section 1399.845) is  
28 added to Chapter 2.2 of Division 2 of the Health and Safety Code,  
29 to read:

30

31 Article 11.8. Individual Access to Health Care Coverage

32

33 1399.845. For purposes of this article, the following definitions  
34 shall apply:

35 (a) “Dependent” means the spouse or child of an individual,  
36 subject to applicable terms of the health benefit plan.

37 (b) “Exchange” means the California Health Benefit Exchange  
38 created by Section 100500 of the Government Code.

39 (c) “Grandfathered health plan” has the same meaning as that  
40 term is defined in Section 1251 of PPACA.

1 (d) “Health benefit plan” means any individual or group health  
2 insurance policy or health care service plan contract that provides  
3 medical, hospital, and surgical benefits. The term does not include  
4 accident only, credit, disability income, coverage of Medicare  
5 services pursuant to contracts with the United States government,  
6 Medicare supplement, long-term care insurance, dental, vision,  
7 coverage issued as a supplement to liability insurance, insurance  
8 arising out of a workers’ compensation or similar law, automobile  
9 medical payment insurance, or insurance under which benefits are  
10 payable with or without regard to fault and that is statutorily  
11 required to be contained in any liability insurance policy or  
12 equivalent self-insurance.

13 (e) “PPACA” means the federal Patient Protection and  
14 Affordable Care Act (Public Law 111-148), as amended by the  
15 Health Care and Education Reconciliation Act of 2010 (Public  
16 Law 111-152), and any subsequent rules or regulations issued  
17 pursuant to that law.

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

24 (g) “Qualified health plan” has the same meaning as that term  
25 is defined in Section 1301 of PPACA.

26 (h) “Rating period” means the period for which premium rates  
27 established by a plan are in effect.

28 1399.847. Every health care service plan offering individual  
29 health benefit plans shall, in addition to complying with the  
30 provisions of this chapter and rules adopted thereunder, comply  
31 with the provisions of this article.

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

39 (2) A plan that offers qualified health plans through the  
40 Exchange shall be deemed to be in compliance with paragraph (1)

1 with respect to an individual health benefit plan offered through  
2 the Exchange in those geographic regions in which the plan offers  
3 health benefit plans through the Exchange.

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

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

12 (d) Subject to subdivision (c), a plan shall allow an individual  
13 to enroll in or change individual health benefit plans as a result of  
14 the following triggering events:

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

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

20 (B) “Loss of minimum essential coverage” includes loss of that  
21 coverage due to the circumstances described in Section  
22 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of  
23 Federal Regulations. “Loss of minimum essential coverage” does  
24 not include loss of that coverage due to the individual’s failure to  
25 pay premiums on a timely basis or situations allowing for a  
26 rescission, subject to Section 1389.21.

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

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

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

32 (5) With respect to individual health benefit plans offered  
33 through the Exchange, the individual meets any of the requirements  
34 listed in Section 155.420(d)(3) of Title 45 of the Code of Federal  
35 Regulations.

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

1 an individual shall have 63 days from the date of a triggering event  
2 to select a plan offered through the Exchange.

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

10 (2) ~~With respect to an individual health benefit plan offered~~  
11 ~~outside the Exchange for which an individual applies during the~~  
12 ~~initial open enrollment period described in subdivision (c), when~~  
13 ~~the subscriber submits a premium payment, based on the quoted~~  
14 ~~premium charges, and that payment is delivered or postmarked,~~  
15 ~~whichever occurs earlier, by December 15, 2013, coverage under~~  
16 ~~the individual health benefit plan shall become effective no later~~  
17 ~~than January 1, 2014, except that coverage for an individual under~~  
18 ~~19 years of age shall, at the option of the subscriber, become~~  
19 ~~effective as required under Section 1399.826. When that payment~~  
20 ~~is delivered or postmarked within the first 15 days of any~~  
21 ~~subsequent month, coverage shall become effective no later than~~  
22 ~~the first day of the following month. When that payment is~~  
23 ~~delivered or postmarked between December 16, 2013, and~~  
24 ~~December 31, 2013, inclusive, or after the 15th day of any~~  
25 ~~subsequent month, coverage shall become effective no later than~~  
26 ~~the first day of the second month following delivery or postmark~~  
27 ~~of the payment.~~

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

1 become effective no later than the first day of the second month  
2 following delivery or postmark of the payment.

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

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

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

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

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

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

28 ~~(g) On or after January 1, 2014, a health care service plan shall~~  
29 ~~not condition the issuance or offering of an individual health benefit~~  
30 ~~plan on any of the following factors:~~

31 ~~(1) Health status.~~

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

33 ~~(3) Claims experience.~~

34 ~~(4) Receipt of health care.~~

35 ~~(5) Medical history.~~

36 ~~(6) Genetic information.~~

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

39 ~~(8) Disability.~~

1 ~~(9) Any other health status-related factor as determined by~~  
2 ~~department.~~

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

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

9 ~~1399.851. (a) Commencing January 1, 2014, no health care~~  
10 ~~service plan or solicitor shall, directly or indirectly, engage in the~~  
11 ~~following activities:~~

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

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

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

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

34 ~~1399.853. (a) All individual health benefit plans shall conform~~  
35 ~~to the requirements of Sections 1365, 1366.3, 1367.001, and~~  
36 ~~1373.6, and shall be renewable at the option of the enrollee except~~  
37 ~~as permitted to be canceled, rescinded, or not renewed pursuant~~  
38 ~~to Section 1365.~~

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

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

3 1399.855.— (a) With respect to individual health benefit plans  
4 issued, amended, or renewed on or after January 1, 2014, a health  
5 care service plan may use only the following characteristics of an  
6 individual, and any dependent thereof, for purposes of establishing  
7 the rate of the individual health benefit plan covering the individual  
8 and the eligible dependents thereof, along with the health benefit  
9 plan selected by the individual:

10 (1) Age, as described in regulations adopted by the department  
11 in conjunction with the Department of Insurance that do not prevent  
12 the application of PPACA. Rates based on age shall be determined  
13 based on the individual's birthday and shall not vary by more than  
14 three to one for adults.

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

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

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

29 (c) The rating period for rates subject to this section shall be no  
30 less than 12 months.

31 (d) This section shall not apply to a grandfathered health plan.

32 1399.857.— A health care service plan shall not be required to  
33 offer an individual health benefit plan or accept applications for  
34 the plan pursuant to this article in the case of any of the following:

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

37 (b) (1) Within a specific service area or portion of a service  
38 area, if the plan reasonably anticipates and demonstrates to the  
39 satisfaction of the director that it will not have sufficient health  
40 care delivery resources to ensure that health care services will be



1 available and accessible to the individual because of its obligations  
2 to existing enrollees.

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

12 (3) Nothing in this article shall be construed to limit the  
13 director's authority to develop and implement a plan of  
14 rehabilitation for a health care service plan whose financial viability  
15 or organizational and administrative capacity has become impaired.

16 1399.859. The director may require a health care service plan  
17 to discontinue the offering of individual health benefit plans or  
18 acceptance of applications from any individual upon a  
19 determination by the director that the plan does not have sufficient  
20 financial viability or organizational and administrative capacity  
21 to ensure the delivery of health care services to its enrollees. In  
22 determining whether the conditions of this section have been met,  
23 the director shall consider, but not be limited to, the plan's  
24 compliance with the requirements of Section 1367, Article 6  
25 (commencing with Section 1375.1), and the rules adopted under  
26 those provisions.

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

29 10198.7. (a) No health benefit plan that covers three or more  
30 persons and that is issued, renewed, or written by any insurer,  
31 nonprofit hospital service plan, self-insured employee welfare  
32 benefit plan, fraternal benefits society, or any other entity shall  
33 exclude coverage for any individual on the basis of a preexisting  
34 condition provision for a period greater than six months following  
35 the individual's effective date of coverage, nor shall limit or  
36 exclude coverage for a specific insured person by type of illness,  
37 treatment, medical condition, or accident except for satisfaction  
38 of a preexisting clause pursuant to this article. Preexisting condition  
39 provisions contained in health benefit plans may relate only to  
40 conditions for which medical advice, diagnosis, care, or treatment,

1 including use of prescription drugs, was recommended or received  
2 from a licensed health practitioner during the six months  
3 immediately preceding the effective date of coverage.

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

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

24 (2) Notwithstanding subdivision (b), a health benefit plan for  
25 individual coverage that is not a grandfathered plan within the  
26 meaning of Section 1251 of the federal Patient Protection and  
27 Affordable Care Act (Public Law 111-148) shall not impose any  
28 preexisting condition provision upon any child under 19 years of  
29 age. A health benefit plan for individual coverage that is issued,  
30 amended, or renewed on or after January 1, 2014, and that is not  
31 a grandfathered health plan within the meaning of Section 1251  
32 of the federal Patient Protection and Affordable Care Act (Public  
33 Law 111-148) shall not impose any preexisting condition provision  
34 upon any individual.

35 (d) A carrier that does not utilize a preexisting condition  
36 provision may impose a waiting or affiliation period not to exceed  
37 60 days, before the coverage issued subject to this article shall  
38 become effective. During the waiting or affiliation period, the  
39 carrier is not required to provide health care services and no  
40 premium shall be charged to the subscriber or enrollee.

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

12 ~~(f) In determining whether a preexisting condition provision, a~~  
13 ~~waived condition provision, or a waiting or affiliation period~~  
14 ~~applies to any person, all health benefit plans shall credit the time~~  
15 ~~the person was covered under creditable coverage, provided the~~  
16 ~~person becomes eligible for coverage under the succeeding health~~  
17 ~~benefit plan within 62 days of termination of prior coverage,~~  
18 ~~exclusive of any waiting or affiliation period, and applies for~~  
19 ~~coverage under the succeeding plan within the applicable~~  
20 ~~enrollment period. A health benefit plan shall also credit any time~~  
21 ~~an eligible employee must wait before enrolling in the health~~  
22 ~~benefit plan, including any affiliation or employer-imposed waiting~~  
23 ~~period. However, if a person's employment has ended, the~~  
24 ~~availability of health coverage offered through employment or~~  
25 ~~sponsored by an employer has terminated or, an employer's~~  
26 ~~contribution toward health coverage has terminated, a carrier shall~~  
27 ~~credit the time the person was covered under creditable coverage~~  
28 ~~if the person becomes eligible for health coverage offered through~~  
29 ~~employment or sponsored by an employer within 180 days,~~  
30 ~~exclusive of any waiting or affiliation period, and applies for~~  
31 ~~coverage under the succeeding plan within the applicable~~  
32 ~~enrollment period.~~

33 ~~(g) No health benefit plan that covers three or more persons and~~  
34 ~~that is issued, renewed, or written by any insurer, nonprofit hospital~~  
35 ~~service plan, self-insured employee welfare benefit plan, fraternal~~  
36 ~~benefits society, or any other entity may exclude late enrollees~~  
37 ~~from coverage for more than 12 months from the date of the late~~  
38 ~~enrollee's application for coverage. No insurer, nonprofit hospital~~  
39 ~~service plan, self-insured employee welfare benefit plan, fraternal~~  
40 ~~benefits society, or any other entity shall require any premium or~~

1 other periodic charge to be paid by or on behalf of a late enrollee  
2 during the period of exclusion from coverage permitted by this  
3 subdivision.

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

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

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

15 SEC. 7. The heading of Chapter 9.7 (commencing with Section  
16 10950) of Part 2 of Division 2 of the Insurance Code is amended  
17 to read:

18  
19 ~~CHAPTER 9.7. CHILD ACCESS TO HEALTH INSURANCE~~

20  
21 SEC. 8. Section 10954 of the Insurance Code is amended to  
22 read:

23 10954. (a) A carrier may use the following characteristics of  
24 an eligible child for purposes of establishing the rate of the health  
25 benefit plan for that child, where consistent with federal regulations  
26 under PPACA: age, geographic region, and family composition,  
27 plus the health benefit plan selected by the child or the responsible  
28 party for a child.

29 (b) From the effective date of this chapter to December 31,  
30 2013, inclusive, rates for a child applying for coverage shall be  
31 subject to the following limitations:

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

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

1 for the 12-month period following the effective date of the child's  
2 coverage.

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

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

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

17  
18 ~~“Please consider your options carefully before failing to maintain~~  
19 ~~or renew coverage for a child for whom you are responsible. If~~  
20 ~~you attempt to obtain new individual coverage for that child, the~~  
21 ~~premium for the same coverage may be higher than the premium~~  
22 ~~you pay now.”~~

23  
24 ~~(d) A child who applied for coverage between September 23,~~  
25 ~~2010, and the end of the initial enrollment period shall be deemed~~  
26 ~~to have maintained coverage during that period.~~

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

29 ~~SEC. 9. Section 10961 is added to the Insurance Code, to read:~~  
30 ~~10961. This chapter shall remain in effect only until January~~  
31 ~~1, 2014, and as of that date is repealed, unless a later enacted~~  
32 ~~statute, that is enacted before January 1, 2014, deletes or extends~~  
33 ~~that date.~~

34 ~~SEC. 10. Chapter 9.8 (commencing with Section 10965) is~~  
35 ~~added to Part 2 of Division 2 of the Insurance Code, to read:~~

36  
37 ~~CHAPTER 9.8. INDIVIDUAL ACCESS TO HEALTH INSURANCE~~

38  
39 ~~10965. For purposes of this chapter, the following definitions~~  
40 ~~shall apply:~~

- 1 (a) ~~“Dependent” means the spouse or child of an individual,~~  
2 ~~subject to applicable terms of the health benefit plan.~~
- 3 (b) ~~“Exchange” means the California Health Benefit Exchange~~  
4 ~~created by Section 100500 of the Government Code.~~
- 5 (c) ~~“Grandfathered health plan” has the same meaning as that~~  
6 ~~term is defined in Section 1251 of PPACA.~~
- 7 (d) ~~“Health benefit plan” means any individual or group health~~  
8 ~~insurance policy or health care service plan contract that provides~~  
9 ~~medical, hospital, and surgical benefits. The term does not include~~  
10 ~~accident only, credit, disability income, coverage of Medicare~~  
11 ~~services pursuant to contracts with the United States government,~~  
12 ~~Medicare supplement, long-term care insurance, dental, vision,~~  
13 ~~coverage issued as a supplement to liability insurance, insurance~~  
14 ~~arising out of a workers’ compensation or similar law, automobile~~  
15 ~~medical payment insurance, or insurance under which benefits are~~  
16 ~~payable with or without regard to fault and that is statutorily~~  
17 ~~required to be contained in any liability insurance policy or~~  
18 ~~equivalent self-insurance.~~
- 19 (e) ~~“PPACA” means the federal Patient Protection and~~  
20 ~~Affordable Care Act (Public Law 111-148), as amended by the~~  
21 ~~Health Care and Education Reconciliation Act of 2010 (Public~~  
22 ~~Law 111-152), and any subsequent rules or regulations issued~~  
23 ~~pursuant to that law.~~
- 24 (f) ~~“Preexisting condition provision” means a policy provision~~  
25 ~~that excludes coverage for charges or expenses incurred during a~~  
26 ~~specified period following the insured’s effective date of coverage,~~  
27 ~~as to a condition for which medical advice, diagnosis, care, or~~  
28 ~~treatment was recommended or received during a specified period~~  
29 ~~immediately preceding the effective date of coverage.~~
- 30 (g) ~~“Qualified health plan” has the same meaning as that term~~  
31 ~~is defined in Section 1301 of PPACA.~~
- 32 (h) ~~“Rating period” means the period for which premium rates~~  
33 ~~established by an insurer are in effect.~~
- 34 10965.1. ~~Every health insurer offering individual health benefit~~  
35 ~~plans shall, in addition to complying with the provisions of this~~  
36 ~~part and rules adopted thereunder, comply with the provisions of~~  
37 ~~this chapter.~~
- 38 10965.3. (a) (1) ~~On and after January 1, 2014, a health insurer~~  
39 ~~shall fairly and affirmatively offer, market, and sell all of the~~  
40 ~~insurer’s health benefit plans that are sold in the individual market~~

1 to all individuals in each service area in which the insurer provides  
2 or arranges for the provision of health care services. An insurer  
3 shall limit enrollment to open enrollment periods and special  
4 enrollment periods as provided in subdivisions (c) and (d):

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

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

13 (c) A health insurer shall provide an initial open enrollment  
14 period from October 1, 2013, to March 31, 2014, inclusive, and  
15 annual enrollment periods for plan years on or after January 1,  
16 2015, from October 15 to December 7, inclusive, of the preceding  
17 calendar year.

18 (d) Subject to subdivision (c), a health insurer shall allow an  
19 individual to enroll in or change individual health benefit plans as  
20 a result of the following triggering events:

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

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

26 (B) “Loss of minimum essential coverage” includes loss of that  
27 coverage due to the circumstances described in Section  
28 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of  
29 Federal Regulations. “Loss of minimum essential coverage” does  
30 not include loss of that coverage due to the individual’s failure to  
31 pay premiums on a timely basis or situations allowing for a  
32 rescission, subject to Section 10384.17.

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

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

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

38 (5) With respect to individual health benefit plans offered  
39 through the Exchange, the individual meets any of the requirements

1 listed in Section 155.420(d)(3) of Title 45 of the Code of Federal  
2 Regulations.

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

10 ~~(f) (1) With respect to individual health benefit plans offered~~  
11 ~~outside the Exchange, after an individual submits a completed~~  
12 ~~application form for a plan, the insurer shall, within 30 days, notify~~  
13 ~~the individual of the individual's actual premium charges for that~~  
14 ~~plan established in accordance with Section 10965.9. The~~  
15 ~~individual shall have 30 days in which to exercise the right to buy~~  
16 ~~coverage at the quoted premium charges.~~

17 ~~(2) With respect to an individual health benefit plan offered~~  
18 ~~outside the Exchange for which an individual applies during the~~  
19 ~~initial open enrollment period described in subdivision (e), when~~  
20 ~~the individual submits a premium payment, based on the quoted~~  
21 ~~premium charges, and that payment is delivered or postmarked,~~  
22 ~~whichever occurs earlier, by December 15, 2013, coverage under~~  
23 ~~the individual health benefit plan shall become effective no later~~  
24 ~~than January 1, 2014, except that coverage for an individual under~~  
25 ~~19 years of age shall, at the option of the policyholder, become~~  
26 ~~effective as required under Section 10951. When that payment is~~  
27 ~~delivered or postmarked within the first 15 days of any subsequent~~  
28 ~~month, coverage shall become effective no later than the first day~~  
29 ~~of the following month. When that payment is delivered or~~  
30 ~~postmarked between December 16, 2013, and December 31, 2013,~~  
31 ~~inclusive, or after the 15th day of any subsequent month, coverage~~  
32 ~~shall become effective no later than the first day of the second~~  
33 ~~month following delivery or postmark of the payment.~~

34 ~~(3) With respect to an individual health benefit plan offered~~  
35 ~~outside the Exchange for which an individual applies during the~~  
36 ~~annual open enrollment period described in subdivision (e), when~~  
37 ~~the individual submits a premium payment, based on the quoted~~  
38 ~~premium charges, and that payment is delivered or postmarked,~~  
39 ~~whichever occurs later, by December 15, coverage shall become~~  
40 ~~effective as of the following January 1. When that payment is~~



1 delivered or postmarked within the first 15 days of any subsequent  
2 month, coverage shall become effective no later than the first day  
3 of the following month. When that payment is delivered or  
4 postmarked between December 16 and December 31, inclusive,  
5 or after the 15th day of any subsequent month, coverage shall  
6 become effective no later than the first day of the second month  
7 following delivery or postmark of the payment.

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

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

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

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

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

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

33 (g) ~~On or after January 1, 2014, a health insurer shall not~~  
34 ~~condition the issuance or offering of an individual health benefit~~  
35 ~~plan on any of the following factors:~~

36 (1) ~~Health status.~~

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

38 (3) ~~Claims experience.~~

39 (4) ~~Receipt of health care.~~

40 (5) ~~Medical history.~~

1 ~~(6) Genetic information.~~

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

4 ~~(8) Disability.~~

5 ~~(9) Any other health status-related factor as determined by~~  
6 ~~department.~~

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

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

13 ~~10965.5. (a) Commencing January 1, 2014, no health insurer~~  
14 ~~or agent or broker shall, directly or indirectly, engage in the~~  
15 ~~following activities:~~

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

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

27 ~~(b) Commencing January 1, 2014, a health insurer shall not,~~  
28 ~~directly or indirectly, enter into any contract, agreement, or~~  
29 ~~arrangement with a broker or agent that provides for or results in~~  
30 ~~the compensation paid to a broker or agent for the sale of an~~  
31 ~~individual health benefit plan to be varied because of the health~~  
32 ~~status, claims experience, industry, occupation, or geographic~~  
33 ~~location of the individual. This subdivision does not apply to a~~  
34 ~~compensation arrangement that provides compensation to a broker~~  
35 ~~or agent on the basis of percentage of premium, provided that the~~  
36 ~~percentage shall not vary because of the health status, claims~~  
37 ~~experience, industry, occupation, or geographic area of the~~  
38 ~~individual.~~

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

1     ~~10965.7. (a) All individual health benefit plans shall conform~~  
2 ~~to the requirements of Sections 10112.1, 10127.18, 10273.4, and~~  
3 ~~12682.1, and shall be renewable at the option of the insured except~~  
4 ~~as permitted to be canceled, rescinded, or not renewed pursuant~~  
5 ~~to Section 10273.4.~~

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

10     ~~10965.9. (a) With respect to individual health benefit plans~~  
11 ~~issued, amended, or renewed on or after January 1, 2014, a health~~  
12 ~~insurer may use only the following characteristics of an individual,~~  
13 ~~and any dependent thereof, for purposes of establishing the rate~~  
14 ~~of the individual health benefit plan covering the individual and~~  
15 ~~the eligible dependents thereof, along with the health benefit plan~~  
16 ~~selected by the individual:~~

17     ~~(1) Age, as described in regulations adopted by the department~~  
18 ~~in conjunction with the Department of Managed Health Care that~~  
19 ~~do not prevent the application of PPACA. Rates based on age shall~~  
20 ~~be determined based on the individual's birthday and shall not~~  
21 ~~vary by more than three to one for adults.~~

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

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

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

36     ~~(e) The rating period for rates subject to this section shall be no~~  
37 ~~less than 12 months.~~

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

1     ~~10965.11.— A health insurer shall not be required to offer an~~  
2 ~~individual health benefit plan or accept applications for the plan~~  
3 ~~pursuant to this chapter in the case of any of the following:~~

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

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

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

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

25     ~~10965.13.— The commissioner may require a health insurer to~~  
26 ~~discontinue the offering of individual health benefit plans or~~  
27 ~~acceptance of applications from any individual upon a~~  
28 ~~determination by the commissioner that the insurer does not have~~  
29 ~~sufficient financial viability or organizational and administrative~~  
30 ~~capacity to ensure the delivery of health care services to its~~  
31 ~~insureds. In determining whether the conditions of this section~~  
32 ~~have been met, the commissioner shall consider, but not be limited~~  
33 ~~to, the insurer's compliance with the requirements of this part and~~  
34 ~~the rules adopted under those provisions.~~

35     ~~SEC. 11.— No reimbursement is required by this act pursuant to~~  
36 ~~Section 6 of Article XIII B of the California Constitution because~~  
37 ~~the only costs that may be incurred by a local agency or school~~  
38 ~~district will be incurred because this act creates a new crime or~~  
39 ~~infraction, eliminates a crime or infraction, or changes the penalty~~  
40 ~~for a crime or infraction, within the meaning of Section 17556 of~~

1 ~~the Government Code, or changes the definition of a crime within~~  
2 ~~the meaning of Section 6 of Article XIII B of the California~~  
3 ~~Constitution.~~

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