

AMENDED IN ASSEMBLY AUGUST 24, 2012

AMENDED IN ASSEMBLY AUGUST 20, 2012

AMENDED IN SENATE APRIL 9, 2012

SENATE BILL

No. 961

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

January 10, 2012

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 Section 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 Section 10902.4 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

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

~~(1) Existing~~

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~~

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

This bill would require a ~~plan or~~ *health* insurer, on and after October 1, 2013, to offer, market, and sell all of the ~~plan's insurer's~~ health benefit plans that are sold in the individual market to all individuals and dependents in each service area in which the ~~plan insurer~~ 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~~ *health* 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. The bill would make certain of these provisions inoperative if the corresponding provisions of PPACA are repealed and would make other conforming changes. The bill would provide that it shall become operative only if AB 1461 is also enacted.~~

~~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.~~

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

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.~~

23 ~~(3) The full premium cost of the plan.~~

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

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

- 1 ~~(6) A statement that the disclosure form is a summary only, and~~
2 ~~that the plan contract itself should be consulted to determine~~
3 ~~governing contractual provisions. The first page of the disclosure~~
4 ~~form shall contain a notice that conforms with all of the following~~
5 ~~conditions:~~
6 ~~(A) (i) States that the evidence of coverage discloses the terms~~
7 ~~and conditions of coverage.~~
8 ~~(ii) States, with respect to individual plan contracts, small group~~
9 ~~plan contracts, and any other group plan contracts for which health~~
10 ~~care services are not negotiated, that the applicant has a right to~~
11 ~~view the evidence of coverage prior to enrollment, and, if the~~
12 ~~evidence of coverage is not combined with the disclosure form,~~
13 ~~the notice shall specify where the evidence of coverage can be~~
14 ~~obtained prior to enrollment.~~
15 ~~(B) Includes a statement that the disclosure and the evidence of~~
16 ~~coverage should be read completely and carefully and that~~
17 ~~individuals with special health care needs should read carefully~~
18 ~~those sections that apply to them.~~
19 ~~(C) Includes the plan's telephone number or numbers that may~~
20 ~~be used by an applicant to receive additional information about~~
21 ~~the benefits of the plan or a statement where the telephone number~~
22 ~~or numbers are located in the disclosure form.~~
23 ~~(D) For individual contracts, and small group plan contracts as~~
24 ~~defined in Article 3.1 (commencing with Section 1357), the~~
25 ~~disclosure form shall state where the health plan benefits and~~
26 ~~coverage matrix is located.~~
27 ~~(E) Is printed in type no smaller than that used for the remainder~~
28 ~~of the disclosure form and is displayed prominently on the page.~~
29 ~~(7) A statement as to when benefits shall cease in the event of~~
30 ~~nonpayment of the prepaid or periodic charge and the effect of~~
31 ~~nonpayment upon an enrollee who is hospitalized or undergoing~~
32 ~~treatment for an ongoing condition.~~
33 ~~(8) To the extent that the plan permits a free choice of provider~~
34 ~~to its subscribers and enrollees, the statement shall disclose the~~
35 ~~nature and extent of choice permitted and the financial liability~~
36 ~~that is, or may be, incurred by the subscriber, enrollee, or a third~~
37 ~~party by reason of the exercise of that choice.~~
38 ~~(9) A summary of the provisions required by subdivision (g) of~~
39 ~~Section 1373, if applicable.~~

- 1 ~~(10) If the plan utilizes arbitration to settle disputes, a statement~~
2 ~~of that fact.~~
- 3 ~~(11) A summary of, and a notice of the availability of, the~~
4 ~~process the plan uses to authorize, modify, or deny health care~~
5 ~~services under the benefits provided by the plan, pursuant to~~
6 ~~Sections 1363.5 and 1367.01.~~
- 7 ~~(12) A description of any limitations on the patient's choice of~~
8 ~~primary care physician, specialty care physician, or nonphysician~~
9 ~~health care practitioner, based on service area and limitations on~~
10 ~~the patient's choice of acute care hospital care, subacute or~~
11 ~~transitional inpatient care, or skilled nursing facility.~~
- 12 ~~(13) General authorization requirements for referral by a primary~~
13 ~~care physician to a specialty care physician or a nonphysician~~
14 ~~health care practitioner.~~
- 15 ~~(14) Conditions and procedures for disenrollment.~~
- 16 ~~(15) A description as to how an enrollee may request continuity~~
17 ~~of care as required by Section 1373.96 and request a second opinion~~
18 ~~pursuant to Section 1383.15.~~
- 19 ~~(16) Information concerning the right of an enrollee to request~~
20 ~~an independent review in accordance with Article 5.55~~
21 ~~(commencing with Section 1374.30).~~
- 22 ~~(17) A notice as required by Section 1364.5.~~
- 23 ~~(b) (1) As of July 1, 1999, the director shall require each plan~~
24 ~~offering a contract to an individual or small group to provide with~~
25 ~~the disclosure form for individual and small group plan contracts~~
26 ~~a uniform health plan benefits and coverage matrix containing the~~
27 ~~plan's major provisions in order to facilitate comparisons between~~
28 ~~plan contracts. The uniform matrix shall include the following~~
29 ~~category descriptions together with the corresponding copayments~~
30 ~~and limitations in the following sequence:~~
- 31 ~~(A) Deductibles.~~
- 32 ~~(B) Lifetime maximums.~~
- 33 ~~(C) Professional services.~~
- 34 ~~(D) Outpatient services.~~
- 35 ~~(E) Hospitalization services.~~
- 36 ~~(F) Emergency health coverage.~~
- 37 ~~(G) Ambulance services.~~
- 38 ~~(H) Prescription drug coverage.~~
- 39 ~~(I) Durable medical equipment.~~
- 40 ~~(J) Mental health services.~~

1 ~~(K) Chemical dependency services.~~

2 ~~(L) Home health services.~~

3 ~~(M) Other.~~

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

6
7 ~~THIS MATRIX IS INTENDED TO BE USED TO HELP YOU~~
8 ~~COMPARE COVERAGE BENEFITS AND IS A SUMMARY~~
9 ~~ONLY. THE EVIDENCE OF COVERAGE AND PLAN~~
10 ~~CONTRACT SHOULD BE CONSULTED FOR A DETAILED~~
11 ~~DESCRIPTION OF COVERAGE BENEFITS AND~~
12 ~~LIMITATIONS.~~

13
14 ~~(e) Nothing in this section shall prevent a plan from using~~
15 ~~appropriate footnotes or disclaimers to reasonably and fairly~~
16 ~~describe coverage arrangements in order to clarify any part of the~~
17 ~~matrix that may be unclear.~~

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

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

26 ~~(f) Group contractholders shall disseminate copies of the~~
27 ~~completed disclosure form to all persons eligible to be a subscriber~~
28 ~~under the group contract at the time those persons are offered the~~
29 ~~plan. If the individual group members are offered a choice of plans,~~
30 ~~separate disclosure forms shall be supplied for each plan available.~~
31 ~~Each group contractholder shall also disseminate or cause to be~~
32 ~~disseminated copies of the evidence of coverage to all applicants,~~
33 ~~upon request, prior to enrollment and to all subscribers enrolled~~
34 ~~under the group contract.~~

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

1 (h) ~~In addition to the other disclosures required by this section,~~
2 ~~every health care service plan and any agent or employee of the~~
3 ~~plan shall, when presenting a plan for examination or sale to any~~
4 ~~individual purchaser or the representative of a group consisting of~~
5 ~~25 or fewer individuals, disclose in writing the ratio of premium~~
6 ~~costs to health services paid for plan contracts with individuals~~
7 ~~and with groups of the same or similar size for the plan's preceding~~
8 ~~fiscal year. A plan may report that information by geographic area,~~
9 ~~provided the plan identifies the geographic area and reports~~
10 ~~information applicable to that geographic area.~~

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

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

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

31 1389.11. (a) ~~The director shall not approve any plan contract~~
32 ~~unless the director finds that the application conforms to the~~
33 ~~following requirements, as applicable:~~

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

38 (2) ~~The application questions related to an applicant's health in~~
39 ~~applications described in paragraph (1) shall be based on medical~~
40 ~~information that is reasonable and necessary for medical~~

1 underwriting purposes. The application shall include a prominently
2 displayed notice that shall read:

3 ~~“California law prohibits an HIV test from being required or~~
4 ~~used by health care service plans as a condition of obtaining~~
5 ~~coverage.”~~

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

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

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

14 ~~1389.1. (a) For purposes of this article, the following~~
15 ~~definitions shall apply:~~

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

21 ~~(2) “Grandfathered health plan” has the same meaning as that~~
22 ~~term is defined in Section 1251 of PPACA.~~

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

24 ~~SEC. 4. Section 1389.25 of the Health and Safety Code is~~
25 ~~amended to read:~~

26 ~~1389.25. (a) (1) This section shall apply only to a full service~~
27 ~~health care service plan offering health coverage in the individual~~
28 ~~market in California and shall not apply to a specialized health~~
29 ~~care service plan, a health care service plan contract in the~~
30 ~~Medi-Cal program (Chapter 7 (commencing with Section 14000)~~
31 ~~of Part 3 of Division 9 of the Welfare and Institutions Code), a~~
32 ~~health care service plan conversion contract offered pursuant to~~
33 ~~Section 1373.6, a health care service plan contract in the Healthy~~
34 ~~Families Program (Part 6.2 (commencing with Section 12693) of~~
35 ~~Division 2 of the Insurance Code), or a health care service plan~~
36 ~~contract offered to a federally eligible defined individual under~~
37 ~~Article 4.6 (commencing with Section 1366.35).~~

38 ~~(2) A local initiative, as defined in subdivision (v) of Section~~
39 ~~53810 of Title 22 of the California Code of Regulations, that is~~
40 ~~awarded a contract by the State Department of Health Care Services~~

1 pursuant to subdivision (b) of Section 53800 of Title 22 of the
2 California Code of Regulations, shall not be subject to this section
3 unless the plan offers coverage in the individual market to persons
4 not covered by Medi-Cal or the Healthy Families Program.

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

12 (2) No change in the premium rate or coverage for an individual
13 plan contract shall become effective unless the plan has delivered
14 a written notice of the change at least 60 days prior to the effective
15 date of the contract renewal or the date on which the rate or
16 coverage changes. A notice of an increase in the premium rate
17 shall include the reasons for the rate increase.

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

31 (4) If a plan rejects an applicant or the dependents of an
32 applicant for coverage or offers individual coverage at a rate that
33 is higher than the standard rate, the plan shall inform the applicant
34 about the state's high-risk health insurance pool, the California
35 Major Risk Medical Insurance Program (MRMIP) (Part 6.5
36 (commencing with Section 12700) of Division 2 of the Insurance
37 Code), and the federal temporary high risk pool established
38 pursuant to Part 6.6 (commencing with Section 12739.5) of
39 Division 2 of the Insurance Code. The information provided to the
40 applicant by the plan shall be in accordance with standards

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

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

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

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

20 1389.25. (a) (1) This section shall apply only to a full service
21 health care service plan contract in the individual market in
22 California and shall not apply to a specialized health care service
23 plan contract, a health care service plan contract in the Medi-Cal
24 program (Chapter 7 (commencing with Section 14000) of Part 3
25 of Division 9 of the Welfare and Institutions Code), a health care
26 service plan conversion contract offered pursuant to Section 1373.6,
27 a health care service plan contract in the Healthy Families Program
28 (Part 6.2 (commencing with Section 12693) of Division 2 of the
29 Insurance Code) or the Access for Infants and Mothers Program
30 (Part 6.3 (commencing with Section 12695) of Division 2 of the
31 Insurance Code), a health care service plan contract offered under
32 Part 6.4 (commencing with Section 12699.50) of Division 2 of the
33 Insurance Code, or a health care service plan contract offered to
34 a federally eligible defined individual under Article 4.6
35 (commencing with Section 1366.35).

36 (2) A local initiative, as defined in subdivision (v) of Section
37 53810 of Title 22 of the California Code of Regulations, that is
38 awarded a contract by the State Department of Health Care Services
39 pursuant to subdivision (b) of Section 53800 of Title 22 of the
40 California Code of Regulations, shall not be subject to this section

1 unless the plan offers coverage in the individual market to persons
2 not covered by Medi-Cal or the Healthy Families Program.

3 ~~(b) (1) No change in the premium rate or coverage for an~~
4 ~~individual health care service plan contract shall become effective~~
5 ~~unless the plan has delivered a written notice of the change at least~~
6 ~~60 days prior to the effective date of the contract renewal or the~~
7 ~~date on which the rate or coverage changes. A notice of an increase~~
8 ~~in the premium rate shall include the reasons for the rate increase.~~

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

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

36 ~~(2) If a plan rejects the dependents of an applicant for an~~
37 ~~individual grandfathered health plan or offers an individual~~
38 ~~grandfathered health plan at a rate that is higher than the standard~~
39 ~~rate, the plan shall inform the applicant about the new coverage~~
40 ~~options and the potential for subsidized coverage in the California~~

1 ~~Health Benefit Exchange. The plan shall direct persons seeking~~
2 ~~more information to the California Health Benefit Exchange, the~~
3 ~~Office of Patient Advocate, plan or policy representatives, and~~
4 ~~insurance brokers or health navigators.~~

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

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

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

13 ~~1389.4. (a) A full service health care service plan that issues,~~
14 ~~renews, or amends individual health plan contracts shall be subject~~
15 ~~to this section.~~

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

24 ~~(c) On or before June 1, 2006, and annually thereafter, every~~
25 ~~health care service plan shall file with the department a general~~
26 ~~description of the criteria, policies, procedures, or guidelines the~~
27 ~~plan uses for rating and underwriting decisions related to individual~~
28 ~~health plan contracts, which means automatic declinable health~~
29 ~~conditions, health conditions that may lead to a coverage decline,~~
30 ~~height and weight standards, health history, health care utilization,~~
31 ~~lifestyle, or behavior that might result in a decline for coverage or~~
32 ~~severely limit the plan products for which they would be eligible.~~
33 ~~A plan may comply with this section by submitting to the~~
34 ~~department underwriting materials or resource guides provided to~~
35 ~~plan solicitors or solicitor firms, provided that those materials~~
36 ~~include the information required to be submitted by this section.~~

37 ~~(d) Commencing January 1, 2011, the director shall post on the~~
38 ~~department's Internet Web site, in a manner accessible and~~
39 ~~understandable to consumers, general, noncompany specific~~
40 ~~information about rating and underwriting criteria and practices~~

1 in the individual market and information about the California Major
2 Risk Medical Insurance Program (Part 6.5 (commencing with
3 Section 12700) of Division 2 of the Insurance Code) and the federal
4 temporary high risk pool established pursuant to Part 6.6
5 (commencing with Section 12739.5) of Division 2 of the Insurance
6 Code. The director shall develop the information for the Internet
7 Web site in consultation with the Department of Insurance to
8 enhance the consistency of information provided to consumers.
9 Information about individual health coverage shall also include
10 the following notification:

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

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

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

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

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

29 1389.4. (a) A full service health care service plan that renews
30 individual grandfathered health plans shall be subject to this
31 section.

32 (b) A health care service plan subject to this section shall have
33 written policies, procedures, or underwriting guidelines establishing
34 the criteria and process whereby the plan makes its decision to
35 provide or to deny coverage to individuals applying for an
36 individual grandfathered health plan and sets the rate for that
37 coverage. These guidelines, policies, or procedures shall ensure
38 that the plan rating and underwriting criteria comply with Sections
39 1365.5 and 1389.11 and all other applicable provisions of state
40 and federal law.

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

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

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

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

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

23 ~~1389.5. (a) This section shall apply to a health care service~~
24 ~~plan that provides coverage under an individual plan contract that~~
25 ~~is issued, amended, delivered, or renewed on or after January 1,~~
26 ~~2007.~~

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

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

38 ~~(c) The plan shall establish, for the purposes of subdivision (b),~~
39 ~~a ranking of the individual plan contracts it offers to individual~~
40 ~~purchasers and post the ranking on its Internet Web site or make~~

~~1 the ranking available upon request. The plan shall update the
2 ranking whenever a new benefit design for individual purchasers
3 is approved.~~

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

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

~~17 (1) A federally eligible defined individual, as defined in
18 subdivision (c) of Section 1399.801, who is enrolled in an
19 individual health benefit plan contract offered pursuant to Section
20 1366.35.~~

~~21 (2) An individual offered conversion coverage pursuant to
22 Section 1373.6.~~

~~23 (3) Individual coverage under a specialized health care service
24 plan contract.~~

~~25 (4) An individual enrolled in the Medi-Cal program pursuant
26 to Chapter 7 (commencing with Section 14000) of Division 9 of
27 Part 3 of the Welfare and Institutions Code.~~

~~28 (5) An individual enrolled in the Access for Infants and Mothers
29 Program pursuant to Part 6.3 (commencing with Section 12695)
30 of Division 2 of the Insurance Code.~~

~~31 (6) An individual enrolled in the Healthy Families Program
32 pursuant to Part 6.2 (commencing with Section 12693) of Division
33 2 of the Insurance Code.~~

~~34 (f) It is the intent of the Legislature that individuals shall have
35 more choice in their health coverage when health care service plans
36 guarantee the right of an individual to transfer to another product
37 based on the plan's own ranking system. The Legislature does not
38 intend for the department to review or verify the plan's ranking
39 for actuarial or other purposes.~~

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

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

6 ~~1389.7. (a) Every health care service plan that offers, issues,~~
7 ~~or renews individual plan contracts shall offer to any individual,~~
8 ~~who was covered under an individual plan contract that was~~
9 ~~rescinded, a new individual plan contract, without medical~~
10 ~~underwriting, that provides equal benefits. A health care service~~
11 ~~plan may also permit an individual, who was covered under an~~
12 ~~individual plan contract that was rescinded, to remain covered~~
13 ~~under that individual plan contract, with a revised premium rate~~
14 ~~that reflects the number of persons remaining on the plan contract.~~

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

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

24 ~~(d) Notwithstanding subdivision (a) and (b), if an individual~~
25 ~~was subject to a preexisting condition provision or a waiting or an~~
26 ~~affiliation period under the individual plan contract that was~~
27 ~~rescinded, the health care service plan may apply the same~~
28 ~~preexisting condition provision or waiting or affiliation period in~~
29 ~~the new individual plan contract. The time period in the new~~
30 ~~individual plan contract for the preexisting condition provision or~~
31 ~~waiting or affiliation period shall not be longer than the one in the~~
32 ~~individual plan contract that was rescinded and the health care~~
33 ~~service plan shall credit any time that the individual was covered~~
34 ~~under the rescinded individual plan contract.~~

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

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

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

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

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

13 1389.7. (a) Every health care service plan that offers, issues,
14 or renews individual plan contracts shall offer to any individual,
15 who was covered under an individual plan contract that was
16 rescinded, a new individual plan contract that provides equal
17 benefits. A health care service plan may also permit an individual,
18 who was covered under an individual plan contract that was
19 rescinded, to remain covered under that individual plan contract,
20 with a revised premium rate that reflects the number of persons
21 remaining on the plan contract consistent with Section 1399.855.

22 (b) If a new individual plan contract is issued, the plan may
23 revise the premium rate to reflect only the number of persons
24 covered on the new individual plan contract consistent with Section
25 1399.855.

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

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

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

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

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

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

3 ~~1399.805. (a) (1) 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 following amounts:~~

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

21 ~~(B) For health care service plan contracts identified in~~
22 ~~subdivision (d) of Section 1366.35 that do not offer services~~
23 ~~through a preferred provider arrangement, 170 percent of the~~
24 ~~standard premium charged to an individual who is of the same age~~
25 ~~and resides in the same geographic area as the federally eligible~~
26 ~~defined individual. However, for federally qualified individuals~~
27 ~~who are between the ages of 60 and 64, inclusive, the premium~~
28 ~~shall not exceed 170 percent of the standard premium charged to~~
29 ~~an individual who is 59 years of age and resides in the same~~
30 ~~geographic area as the federally eligible defined individual. The~~
31 ~~individual shall have 30 days in which to exercise the right to buy~~
32 ~~coverage at the quoted premium rates.~~

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

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

1 ~~(B) For health care service plans identified in subdivision (d)~~
2 ~~of Section 1366.35 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 plan~~
15 ~~contract, the individual shall have the option of changing coverage~~
16 ~~to a different plan contract offered by the same health care service~~
17 ~~plan. If the individual notified the plan of the change within the~~
18 ~~first 15 days of a month, coverage under the new plan contract~~
19 ~~shall become effective no later than the first day of the following~~
20 ~~month. If an enrolled individual notified the plan of the change~~
21 ~~after the 15th day of a month, coverage under the new plan contract~~
22 ~~shall become effective no later than the first day of the second~~
23 ~~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. 12. Section 1399.805 is added to the Health and Safety~~
28 ~~Code, to read:~~

29 ~~1399.805. (a) After the federally eligible defined individual~~
30 ~~submits a completed application form for a plan contract, the plan~~
31 ~~shall, within 30 days, notify the individual of the individual's actual~~
32 ~~premium charges for that plan contract, unless the plan has~~
33 ~~provided notice of the premium charge prior to the application~~
34 ~~being filed. In no case shall the premium charged for any health~~
35 ~~care service plan contract identified in subdivision (d) of Section~~
36 ~~1366.35 exceed the premium for the second lowest cost silver plan~~
37 ~~of the individual market in the rating area in which the individual~~
38 ~~resides which is offered through the California Health Benefit~~
39 ~~Exchange established under Title 22 (commencing with Section~~

1 ~~100500) of the Government Code, as described in Section~~
2 ~~36B(b)(3)(B) of Title 26 of the United States Code.~~

3 ~~(b) When a federally eligible defined individual submits a~~
4 ~~premium payment, based on the quoted premium charges, and that~~
5 ~~payment is delivered or postmarked, whichever occurs earlier,~~
6 ~~within the first 15 days of the month, coverage shall begin no later~~
7 ~~than the first day of the following month. When that payment is~~
8 ~~neither delivered nor postmarked until after the 15th day of a~~
9 ~~month, coverage shall become effective no later than the first day~~
10 ~~of the second month following delivery or postmark of the~~
11 ~~payment.~~

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

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

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

25 ~~1399.811. Premiums for contracts offered, delivered, amended,~~
26 ~~or renewed by plans on or after January 1, 2001, shall be subject~~
27 ~~to the following requirements:~~

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

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

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

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

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

24 ~~(2) For health care service plan contracts identified in~~
25 ~~subdivision (d) of Section 1366.35 that do not offer services~~
26 ~~through a preferred provider arrangement, 170 percent of the~~
27 ~~standard premium charged to an individual who is of the same age~~
28 ~~and resides in the same geographic area as the federally eligible~~
29 ~~defined individual. However, for federally qualified individuals~~
30 ~~who are between the ages of 60 and 64 years, inclusive, the~~
31 ~~premium shall not exceed 170 percent of the standard premium~~
32 ~~charged to an individual who is 59 years of age and resides in the~~
33 ~~same geographic area as the federally eligible defined individual.~~
34 ~~The premium effective on January 1, 2001, shall apply to in force~~
35 ~~business at the earlier of either the time of renewal or July 1, 2001.~~

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

38 ~~(1) For health care service plan contracts identified in~~
39 ~~subdivision (d) of Section 1366.35 that offer services through a~~
40 ~~preferred provider arrangement, the average increase in the~~

1 ~~premiums charged to a subscriber of the Major Risk Medical~~
2 ~~Insurance Program who is of the same age and resides in the same~~
3 ~~geographic area as the federally eligible defined individual.~~

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

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

16 ~~(4) 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. 14. Section 1399.811 is added to the Health and Safety~~
20 ~~Code, to read:~~

21 ~~1399.811. (a) Premiums for contracts offered, delivered,~~
22 ~~amended, or renewed by plans on or after January 1, 2014, shall~~
23 ~~be subject to the following requirements:~~

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

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

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

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

1 ~~1399.816. (a) Carriers and health care service plans that offer~~
 2 ~~contracts to individuals may elect to establish a mechanism or~~
 3 ~~method to share in the financing of high-risk individuals. This~~
 4 ~~mechanism or method shall be established through a committee~~
 5 ~~of all carriers and health care service plans offering coverage to~~
 6 ~~individuals by July 1, 2002, and shall be implemented by January~~
 7 ~~1, 2003. If carriers and health care service plans wish to establish~~
 8 ~~a risk-sharing mechanism but cannot agree on the terms and~~
 9 ~~conditions of such an agreement, the Managed Risk Medical~~
 10 ~~Insurance Board shall develop a risk-sharing mechanism or method~~
 11 ~~by January 1, 2003, and it shall be implemented by July 1, 2003.~~

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

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

18

19 ~~Article 11.7. Child Access to Health Care Coverage~~

20

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

23 ~~1399.829. (a) A health care service plan may use the following~~
 24 ~~characteristics of an eligible child for purposes of establishing the~~
 25 ~~rate of the plan contract for that child, where consistent with federal~~
 26 ~~regulations under PPACA: age, geographic region, and family~~
 27 ~~composition, plus the health care service plan contract selected by~~
 28 ~~the child or the responsible party for the child.~~

29 ~~(b) From the effective date of this article to December 31, 2013,~~
 30 ~~inclusive, rates for a child applying for coverage shall be subject~~
 31 ~~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 health care service plan or health insurer for the 90-day period~~
 39 ~~prior to the date of the child's application. The surcharge shall~~

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

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

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

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

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

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

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

30 ~~(f)~~

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

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

38 ~~(B) An explanation that obtaining coverage during the open~~
39 ~~enrollment period described in Section 1399.849 will not affect~~

1 the effective dates of coverage for coverage purchased pursuant
2 to this article 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 1399.826 and that such coverage shall not prevent an
6 applicant from obtaining new coverage during the open enrollment
7 period described in Section 1399.849.

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

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

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

19 1399.836. This article 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. 19. Article 11.8 (commencing with Section 1399.845)
24 is added to Chapter 2.2 of Division 2 of the Health and Safety
25 Code, to read:

26
27 Article 11.8. Individual Access to Health Care Coverage

28
29 1399.845. For purposes of this article, the following definitions
30 shall apply:

31 (a) "Child" means a child described in Section 22775 of the
32 Government Code and subdivisions (n) to (p), inclusive, of Section
33 599.500 of Title 2 of the California Code of Regulations.

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

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

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

1 (e) “Health benefit plan” means any individual or group policy
2 of health insurance as defined in Section 106 of the Insurance Code
3 or health care service plan contract that provides medical, hospital,
4 and surgical benefits. The term does not include a specialized
5 health insurance policy, as defined in Section 106 of the Insurance
6 Code, a specialized health care service plan contract, a health care
7 service plan conversion contract offered pursuant to Section 1373.6,
8 a health insurance conversion policy offered pursuant to Section
9 12682.1 of the Insurance Code, a health insurance policy or health
10 care service plan contract provided in the Medi-Cal program
11 (Chapter 7 (commencing with Section 14000) of Part 3 of Division
12 9 of the Welfare and Institutions Code), the Healthy Families
13 Program (Part 6.2 (commencing with Section 12693) of Division
14 2 of the Insurance Code), the Access for Infants and Mothers
15 Program (Part 6.3 (commencing with Section 12695) of Division
16 2 of the Insurance Code), or the program under Part 6.4
17 (commencing with Section 12699.50) of Division 2 of the
18 Insurance Code, a health care service plan contract or health
19 insurance policy offered to a federally eligible defined individual
20 under Article 4.6 (commencing with Section 1366.35) of this code
21 or Chapter 9.5 (commencing with Section 10900) of Part 2 of
22 Division 2 of the Insurance Code, or Medicare supplement
23 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 contract provision
30 that excludes coverage for charges or expenses incurred during a
31 specified period following the enrollee’s effective date of coverage;
32 as to a condition for which medical advice, diagnosis, care, or
33 treatment was recommended or received during a specified period
34 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 a plan are in effect.

39 1399.847. Every health care service plan offering individual
40 health benefit plans shall, in addition to complying with the

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

3 ~~1399.849. (a) (1) On and after October 1, 2013, a plan shall~~
4 ~~fairly and affirmatively offer, market, and sell all of the plan's~~
5 ~~health benefit plans that are sold in the individual market to all~~
6 ~~individuals and dependents in each service area in which the plan~~
7 ~~provides or arranges for the provision of health care services. A~~
8 ~~plan shall limit enrollment in individual health benefit plans to~~
9 ~~open enrollment periods and special enrollment periods as provided~~
10 ~~in subdivisions (c) and (d).~~

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

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

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

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

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

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

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

38 ~~(B) "Loss of minimum essential coverage" includes loss of that~~
39 ~~coverage due to the circumstances described in Section~~
40 ~~54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of~~

1 Federal Regulations. “Loss of minimum essential coverage” does
2 not include loss of that coverage due to the individual’s failure to
3 pay premiums on a timely basis or situations allowing for a
4 rescission, subject to Section 1389.21.

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

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

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

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

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

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

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

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

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

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

39 (2) With respect to an individual health benefit plan offered
40 outside the Exchange for which an individual applies during the

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

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

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

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

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

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

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

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

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

17 ~~(A) Health status.~~

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

19 ~~(C) Claims experience.~~

20 ~~(D) Receipt of health care.~~

21 ~~(E) Medical history.~~

22 ~~(F) Genetic information.~~

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

25 ~~(H) Disability.~~

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

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

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

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

1 ~~1399.851. (a) Commencing January 1, 2014, no health care~~
2 ~~service plan or solicitor 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 a plan because of the~~
6 ~~health status, claims experience, industry, occupation, or~~
7 ~~geographic location, provided that the location is within the plan's~~
8 ~~approved service area, of the individual.~~

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

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

25 ~~1399.853. (a) All individual health benefit plans shall conform~~
26 ~~to the requirements of Sections 1365, 1366.3, 1367.001, and~~
27 ~~1373.6, and any other requirements imposed by this chapter, and~~
28 ~~shall be renewable at the option of the enrollee except as permitted~~
29 ~~to be canceled, rescinded, or not renewed pursuant to Section 1365.~~

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

34 ~~1399.855. (a) With respect to individual health benefit plans~~
35 ~~issued, amended, or renewed on or after January 1, 2014, a health~~
36 ~~care service plan may use only the following characteristics of an~~
37 ~~individual, and any dependent thereof, for purposes of establishing~~
38 ~~the rate of the individual health benefit plan covering the individual~~
39 ~~and the eligible dependents thereof, along with the health benefit~~
40 ~~plan selected by the individual:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 ~~1399.857. A health care service plan shall not be required to~~
6 ~~offer an individual health benefit plan or accept applications for~~
7 ~~the plan pursuant to this article in the case of any of the following:~~

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

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

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

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

29 ~~1399.859. The director may require a health care service plan~~
30 ~~to discontinue the offering of individual health benefit plans or~~
31 ~~acceptance of applications from any individual upon a~~
32 ~~determination by the director that the plan does not have sufficient~~
33 ~~financial viability or organizational and administrative capacity~~
34 ~~to ensure the delivery of health care services to its enrollees. In~~
35 ~~determining whether the conditions of this section have been met,~~
36 ~~the director shall consider, but not be limited to, the plan's~~
37 ~~compliance with the requirements of Section 1367, Article 6~~
38 ~~(commencing with Section 1375.1), and the rules adopted under~~
39 ~~those provisions.~~

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

5
6 ~~Beginning on and after January 1, 2014, new improved health~~
7 ~~insurance options are available in California. You currently have~~
8 ~~health insurance that is exempt from many of the new requirements.~~
9 ~~You have the option to remain in your current plan or switch to a~~
10 ~~new plan. Under the new rules, a health insurance company cannot~~
11 ~~deny your application based on any health conditions you may~~
12 ~~have. For more information about your options, please contact the~~
13 ~~California Health Benefit Exchange, the Office of Patient~~
14 ~~Advocate, your plan or policy representative, an insurance broker,~~
15 ~~or a health care navigator.~~

16
17 ~~(b) A health care service plan shall include the notice described~~
18 ~~in subdivision (a) in any marketing material of the individual~~
19 ~~grandfathered health plan.~~

20 ~~SEC. 20. Section 10113.9 of the Insurance Code is amended~~
21 ~~to read:~~

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

27 ~~(b) (1) A health insurer that declines to offer coverage to or~~
28 ~~denies enrollment for an individual or his or her dependents~~
29 ~~applying for individual coverage or that offers individual coverage~~
30 ~~at a rate that is higher than the standard rate shall, at the time of~~
31 ~~the denial or offer of coverage, provide the applicant with the~~
32 ~~specific reason or reasons for the decision in writing, in clear,~~
33 ~~easily understandable language.~~

34 ~~(2) No change in the premium rate or coverage for an individual~~
35 ~~health insurance policy shall become effective unless the insurer~~
36 ~~has delivered a written notice of the change at least 60 days prior~~
37 ~~to the effective date of the policy renewal or the date on which the~~
38 ~~rate or coverage changes. A notice of an increase in the premium~~
39 ~~rate shall include the reasons for the rate increase.~~

1 ~~(3) The written notice required pursuant to paragraph (2) shall~~
2 ~~be delivered to the individual policyholder at his or her last address~~
3 ~~known to the insurer, at least 60 days prior to the effective date of~~
4 ~~the change. The notice shall state in italics and in 12-point type~~
5 ~~the actual dollar amount of the premium increase and the specific~~
6 ~~percentage by which the current premium will be increased. The~~
7 ~~notice shall describe in plain, understandable English any changes~~
8 ~~in the policy or any changes in benefits, including a reduction in~~
9 ~~benefits or changes to waivers, exclusions, or conditions, and~~
10 ~~highlight this information by printing it in italics. The notice shall~~
11 ~~specify in a minimum of 10-point bold typeface, the reason for a~~
12 ~~premium rate change or a change in coverage or benefits.~~

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

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

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

39 ~~SEC. 21. Section 10113.9 is added to the Insurance Code, to~~
40 ~~read:~~

1 10113.9. ~~(a) This section shall not apply to short-term limited~~
2 ~~duration health insurance, vision-only, dental-only, or~~
3 ~~CHAMPUS-supplement insurance, or to hospital indemnity,~~
4 ~~hospital-only, accident-only, or specified disease insurance that~~
5 ~~does not pay benefits on a fixed benefit, cash payment only basis.~~

6 ~~(b) (1) No change in the premium rate or coverage for an~~
7 ~~individual health insurance policy shall become effective unless~~
8 ~~the insurer has delivered a written notice of the change at least 60~~
9 ~~days prior to the effective date of the plan renewal or the date on~~
10 ~~which the rate or coverage changes. A notice of an increase in the~~
11 ~~premium rate shall include the reasons for the rate increase.~~

12 ~~(2) The written notice required pursuant to paragraph (1) shall~~
13 ~~be delivered to the individual policyholder at his or her last address~~
14 ~~known to the insurer, at least 60 days prior to the effective date of~~
15 ~~the change. The notice shall state in italics and in 12-point type~~
16 ~~the actual dollar amount of the premium increase and the specific~~
17 ~~percentage by which the current premium will be increased. The~~
18 ~~notice shall describe in plain, understandable English any changes~~
19 ~~in the policy or any changes in benefits, including a reduction in~~
20 ~~benefits or changes to waivers, exclusions, or conditions, and~~
21 ~~highlight this information by printing it in italics. The notice shall~~
22 ~~specify in a minimum of 10-point bold typeface, the reason for a~~
23 ~~premium rate change or a change in coverage or benefits. For~~
24 ~~individual grandfathered health plans, the notice shall also inform~~
25 ~~the individual contractholder about the availability of coverage~~
26 ~~through the California Health Benefit Exchange established under~~
27 ~~Title 22 (commencing with Section 100500) of the Government~~
28 ~~Code and shall include the toll-free telephone number and Internet~~
29 ~~Web site for the California Health Benefit Exchange.~~

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

37 ~~(2) If a health insurer rejects an applicant or the dependents of~~
38 ~~an applicant for an individual grandfathered health plan or offers~~
39 ~~an individual grandfathered health plan at a rate that is higher than~~
40 ~~the standard rate, the insurer shall inform the applicant about the~~

1 California Health Benefit Exchange established under Title 22
 2 (commencing with Section 100500) of the Government Code. The
 3 information provided to the applicant by the insurer shall include
 4 the toll-free telephone number and Internet Web site for the
 5 California Health Benefit Exchange.

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

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

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

18 (2) ~~“Grandfathered health plan” has the same meaning as that~~
 19 ~~term is defined in Section 1251 of PPACA.~~

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

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

23 10113.95. (a) A health insurer that issues, renews, or amends
 24 individual health insurance policies shall be subject to this section.

25 (b) ~~An insurer subject to this section shall have written policies,~~
 26 ~~procedures, or underwriting guidelines establishing the criteria~~
 27 ~~and process whereby the insurer makes its decision to provide or~~
 28 ~~to deny coverage to individuals applying for coverage and sets the~~
 29 ~~rate for that coverage. These guidelines, policies, or procedures~~
 30 ~~shall ensure that the plan rating and underwriting criteria comply~~
 31 ~~with Sections 10140 and 10291.5 and all other applicable~~
 32 ~~provisions.~~

33 (c) ~~On or before June 1, 2006, and annually thereafter, every~~
 34 ~~insurer shall file with the commissioner a general description of~~
 35 ~~the criteria, policies, procedures, or guidelines that the insurer uses~~
 36 ~~for rating and underwriting decisions related to individual health~~
 37 ~~insurance policies, which means automatic declinable health~~
 38 ~~conditions, health conditions that may lead to a coverage decline,~~
 39 ~~height and weight standards, health history, health care utilization,~~
 40 ~~lifestyle, or behavior that might result in a decline for coverage or~~

1 severely limit the health insurance products for which individuals
2 applying for coverage would be eligible. An insurer may comply
3 with this section by submitting to the department underwriting
4 materials or resource guides provided to agents and brokers,
5 provided that those materials include the information required to
6 be submitted by this section.

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

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

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

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

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

36 ~~SEC. 23.— Section 10113.95 is added to the Insurance Code, to~~
37 ~~read:~~

38 ~~10113.95.—(a) A health insurer that renews individual~~
39 ~~grandfathered health plans shall be subject to this section.~~

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

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

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

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

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

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

35 ~~(2) “Grandfathered health plan” has the same meaning as that~~
36 ~~term is defined in Section 1251 of PPACA.~~

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

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

1 ~~10119.1. (a) This section shall apply to a health insurer that~~
2 ~~covers hospital, medical, or surgical expenses under an individual~~
3 ~~health benefit plan, as defined in subdivision (a) of Section~~
4 ~~10198.6, that is issued, amended, renewed, or delivered on or after~~
5 ~~January 1, 2007.~~

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

12 ~~“Without medical underwriting” means that the health insurer~~
13 ~~shall not decline to offer coverage to, or deny enrollment of, the~~
14 ~~individual or impose any preexisting condition exclusion on the~~
15 ~~individual who transfers to another individual health benefit plan~~
16 ~~pursuant to this section.~~

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

23 ~~(d) The insurer shall notify in writing all insureds of the right~~
24 ~~to transfer to another individual health benefit plan pursuant to~~
25 ~~this section, at a minimum, when the insurer changes the insured’s~~
26 ~~premium rate. Posting this information on the insurer’s Internet~~
27 ~~Web site shall not constitute notice for purposes of this subdivision.~~
28 ~~The notice shall adequately inform insureds of the transfer rights~~
29 ~~provided under this section including information on the process~~
30 ~~to obtain details about the individual health benefit plans available~~
31 ~~to that insured and advising that the insured may be unable to~~
32 ~~return to his or her current individual health benefit plan if the~~
33 ~~insured transfers to another individual health benefit plan.~~

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

36 ~~(1) A federally eligible defined individual, as defined in~~
37 ~~subdivision (c) of Section 10900, who purchases individual~~
38 ~~coverage pursuant to Section 10785.~~

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

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

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

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

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

14 ~~(g) 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. 25. Section 10119.2 of the Insurance Code is amended~~
18 ~~to read:~~

19 ~~10119.2. (a) Every health insurer that offers, issues, or renews~~
20 ~~health insurance under an individual health benefit plan, as defined~~
21 ~~in subdivision (a) of Section 10198.6, shall offer to any individual,~~
22 ~~who was covered under an individual health benefit plan that was~~
23 ~~rescinded, a new individual health benefit plan without medical~~
24 ~~underwriting that provides equal benefits. A health insurer may~~
25 ~~also permit an individual, who was covered under an individual~~
26 ~~health benefit plan that was rescinded, to remain covered under~~
27 ~~that individual health benefit plan, with a revised premium rate~~
28 ~~that reflects the number of persons remaining on the health benefit~~
29 ~~plan.~~

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

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

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

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

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

15 (f) ~~The insurer shall provide 60 days for insureds to accept the~~
16 ~~offered new individual health benefit plan and this plan shall be~~
17 ~~effective as of the effective date of the original individual health~~
18 ~~benefit plan and 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. 26. Section 10119.2 is added to the Insurance Code, to~~
26 ~~read:~~

27 ~~10119.2. (a) Every health insurer that offers, issues, or renews~~
28 ~~health insurance under an individual health benefit plan, as defined~~
29 ~~in subdivision (a) of Section 10198.6, shall offer to any individual,~~
30 ~~who was covered under an individual health benefit plan that was~~
31 ~~rescinded, a new individual health benefit plan. A health insurer~~
32 ~~may also permit an individual, who was covered under an~~
33 ~~individual health benefit plan that was rescinded, to remain covered~~
34 ~~under that individual health benefit plan, with a revised premium~~
35 ~~rate that reflects the number of persons remaining on the health~~
36 ~~benefit plan consistent with Section 10965.9.~~

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

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

6 ~~(d) The insurer shall provide 60 days for insureds to accept the~~
7 ~~offered new individual health benefit plan and this plan shall be~~
8 ~~effective as of the effective date of the original individual health~~
9 ~~benefit plan and 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 10965.3.~~

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

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

18 ~~10291.5. (a) The purpose of this section is to achieve both of~~
19 ~~the following:~~

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

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

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

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

32 ~~(2) If it contains any provision for payment at a rate, or in an~~
33 ~~amount (other than the product of rate times the periods for which~~
34 ~~payments are promised) for loss caused by particular event or~~
35 ~~events (as distinguished from character of physical injury or illness~~
36 ~~of the insured) more than triple the lowest rate, or amount,~~
37 ~~promised in the policy for the same loss caused by any other event~~
38 ~~or events (loss caused by sickness, loss caused by accident, and~~
39 ~~different degrees of disability each being considered, for the~~
40 ~~purpose of this paragraph, a different loss); or if it contains any~~

1 provision for payment for any confining loss of time at a rate more
2 than six times the least rate payable for any partial loss of time or
3 more than twice the least rate payable for any nonconfining total
4 loss of time; or if it contains any provision for payment for any
5 nonconfining total loss of time at a rate more than three times the
6 least rate payable for any partial loss of time.

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

23 (4) If it contains provision or provisions which would have the
24 effect, upon any termination of the policy, of reducing or ending
25 the liability as the insurer would have, but for the termination, for
26 loss of time resulting from accident occurring while the policy is
27 in force or for loss of time commencing while the policy is in force
28 and resulting from sickness contracted while the policy is in force
29 or for other losses resulting from accident occurring or sickness
30 contracted while the policy is in force, and also contains provision
31 or provisions reserving to the insurer the right to cancel or refuse
32 to renew the policy, unless it also contains other provision or
33 provisions the effect of which is that termination of the policy as
34 the result of the exercise by the insurer of any such right shall not
35 reduce or end the liability in respect to the hereinafter specified
36 losses as the insurer would have had under the policy, including
37 its other limitations, conditions, reductions, and restrictions, had
38 the policy not been so terminated.

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

- 1 (i) ~~Loss of time which commences while the policy is in force~~
2 ~~and results from sickness contracted while the policy is in force.~~
- 3 (ii) ~~Loss of time which commences within 20 days following~~
4 ~~and results from accident occurring while the policy is in force.~~
- 5 (iii) ~~Losses which result from accident occurring or sickness~~
6 ~~contracted while the policy is in force and arise out of the care or~~
7 ~~treatment of illness or injury and which occur within 90 days from~~
8 ~~the termination of the policy or during a period of continuous~~
9 ~~compensable loss or losses which period commences prior to the~~
10 ~~end of such 90 days.~~
- 11 (iv) ~~Losses other than those specified in clause (i), (ii), or (iii)~~
12 ~~of this paragraph which result from accident occurring or sickness~~
13 ~~contracted while the policy is in force and which losses occur~~
14 ~~within 90 days following the accident or the contraction of the~~
15 ~~sickness.~~
- 16 (5) ~~If by any caption, label, title, or description of contents the~~
17 ~~policy states, implies, or infers without reasonable qualification~~
18 ~~that it provides loss of time indemnity for lifetime, or for any period~~
19 ~~of more than two years, if the loss of time indemnity is made~~
20 ~~payable only when house confined or only under special~~
21 ~~contingencies not applicable to other total loss of time indemnity.~~
- 22 (6) ~~If it contains any benefit for total confining disability payable~~
23 ~~only upon condition that the confinement be of an abnormally~~
24 ~~restricted nature unless the caption of the part containing any such~~
25 ~~benefit is accurately descriptive of the nature of the confinement~~
26 ~~required and unless, if the policy has a description of contents,~~
27 ~~label, or title, at least one of them contain reference to the nature~~
28 ~~of the confinement required.~~
- 29 (7) (A) ~~If, irrespective of the premium charged therefor, any~~
30 ~~benefit of the policy is, or the benefits of the policy as a whole are,~~
31 ~~not sufficient to be of real economic value to the insured.~~
- 32 (B) ~~In determining whether benefits are of real economic value~~
33 ~~to the insured, the commissioner shall not differentiate between~~
34 ~~insureds of the same or similar economic or occupational classes~~
35 ~~and shall give due consideration to all of the following:~~
- 36 (i) ~~The right of insurers to exercise sound underwriting judgment~~
37 ~~in the selection and amounts of risks.~~
- 38 (ii) ~~Amount of benefit, length of time of benefit, nature or extent~~
39 ~~of benefit, or any combination of those factors.~~

1 ~~(iii) The relative value in purchasing power of the benefit or~~
2 ~~benefits:~~

3 ~~(iv) Differences in insurance issued on an industrial or other~~
4 ~~special basis:~~

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

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

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

30 ~~(B) Of substituting, upon the occurrence of any other~~
31 ~~dismemberment some specified indemnity for any or all benefits~~
32 ~~under the policy unless the indemnity so specified is equal to or~~
33 ~~greater than one-fourth of the total of the benefit or benefits for~~
34 ~~which the specified indemnity is substituted and which, assuming~~
35 ~~in all cases that the insured would continue to live, could possibly~~
36 ~~accrue within four years from the date of the dismemberment under~~
37 ~~all other provisions of the policy applicable to the particular event~~
38 ~~or events (as distinguished from character of physical injury or~~
39 ~~illness) causing the dismemberment:~~

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

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

9 ~~(9) If it contains provision, other than as provided in Section~~
 10 ~~10369.3, reducing any original benefit more than 50 percent on~~
 11 ~~account of age of the insured.~~

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

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

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

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

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

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

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

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

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

3 ~~(e) The commissioner shall not approve any disability policy~~
4 ~~covering hospital, medical, or surgical expenses unless the~~
5 ~~commissioner finds that the application conforms to the following~~
6 ~~requirements, as applicable:~~

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

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

17 ~~“California law prohibits an HIV test from being required or~~
18 ~~used by health insurance companies as a condition of obtaining~~
19 ~~health insurance coverage.”~~

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

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

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

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

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

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

11 Any such withdrawal shall be in writing and shall specify
12 reasons. An insurer adversely affected by any such withdrawal
13 may, within a period of 30 days following mailing or delivery of
14 the writing containing the withdrawal, by written request secure
15 a hearing to determine whether the withdrawal should be annulled,
16 modified, or confirmed. Unless, at any time, it is mutually agreed
17 to the contrary, a hearing shall be granted and commenced within
18 30 days following filing of the request and shall proceed with
19 reasonable dispatch to determination. Unless the commissioner in
20 writing in the withdrawal, or subsequent thereto, grants an
21 extension, any such withdrawal shall, in the absence of any such
22 request, be effective, prospectively and not retroactively, on the
23 91st day following the mailing or delivery of the withdrawal, and,
24 if request for the hearing is filed, on the 91st day following mailing
25 or delivery of written notice of the commissioner's determination.

26 (g) No proceeding under this section is subject to Chapter 5
27 (commencing with Section 11500) of Part 1 of Division 3 of Title
28 2 of the Government Code.

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

33 Notwithstanding any other provision of law to the contrary,
34 petition for any such review may be filed at any time before the
35 effective date of the action taken by the commissioner. No action
36 of the commissioner shall become effective before the expiration
37 of 20 days after written notice and a copy thereof are mailed or
38 delivered to the person adversely affected, and any action so
39 submitted for review shall not become effective for a further period

1 of 15 days after the filing of the petition in court. The court may
2 stay the effectiveness thereof for a longer period.

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

10 (j) ~~This section shall be effective on and after July 1, 1950, as~~
11 ~~to all policies thereafter submitted and on and after January 1,~~
12 ~~1951, the commissioner may withdraw approval pursuant to~~
13 ~~subdivision (d) of any policy thereafter issued or delivered in this~~
14 ~~state irrespective of when its form may have been submitted or~~
15 ~~approved, and prior to those dates the provisions of law in effect~~
16 ~~on January 1, 1949, shall apply to those policies.~~

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

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

25 ~~10901.3. (a) (1) After the federally eligible defined individual~~
26 ~~submits a completed application form for a health benefit plan,~~
27 ~~the carrier shall, within 30 days, notify the individual of the~~
28 ~~individual's actual premium charges for that health benefit plan~~
29 ~~design. In no case shall the premium charged for any health benefit~~
30 ~~plan identified in subdivision (d) of Section 10785 exceed the~~
31 ~~following amounts:~~

32 (A) ~~For health benefit plans that offer services through a~~
33 ~~preferred provider arrangement, the average premium paid by a~~
34 ~~subscriber of the Major Risk Medical Insurance Program who is~~
35 ~~of the same age and resides in the same geographic area as the~~
36 ~~federally eligible defined individual. However, for federally~~
37 ~~qualified individuals who are between the ages of 60 and 64,~~
38 ~~inclusive, the premium shall not exceed the average premium paid~~
39 ~~by a subscriber of the Major Risk Medical Insurance Program who~~

1 is 59 years of age and resides in the same geographic area as the
2 federally eligible defined individual.

3 (B) For health benefit plans identified in subdivision (d) of
4 Section 10785 that do not offer services through a preferred
5 provider arrangement, 170 percent of the standard premium charged
6 to an individual who is of the same age and resides in the same
7 geographic area as the federally eligible defined individual.
8 However, for federally qualified individuals who are between the
9 ages of 60 and 64, inclusive, the premium shall not exceed 170
10 percent of the standard premium charged to an individual who is
11 59 years of age and resides in the same geographic area as the
12 federally eligible defined individual. The individual shall have 30
13 days in which to exercise the right to buy coverage at the quoted
14 premium rates.

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

17 (A) For health benefit plans that offer services through a
18 preferred provider arrangement, the average of the Major Risk
19 Medical Insurance Program rate for families of the same size that
20 reside in the same geographic area as the federally eligible defined
21 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 a family that is of the same size and resides in the same
26 geographic area as the federally eligible defined individual.

27 (b) When a federally eligible defined individual submits a
28 premium payment, based on the quoted premium charges, and that
29 payment is delivered or postmarked, whichever occurs earlier,
30 within the first 15 days of the month, coverage shall begin no later
31 than the first day of the following month. When that payment is
32 neither delivered or postmarked until after the 15th day of a month,
33 coverage shall become effective no later than the first day of the
34 second month following delivery or postmark of the payment.

35 (c) During the first 30 days after the effective date of the health
36 benefit plan, the individual shall have the option of changing
37 coverage to a different health benefit plan design offered by the
38 same carrier. If the individual notified the plan of the change within
39 the first 15 days of a month, coverage under the new health benefit
40 plan shall become effective no later than the first day of the

1 following month. If an enrolled individual notified the carrier of
2 the change after the 15th day of a month, coverage under the health
3 benefit plan shall become effective no later than the first day of
4 the second month following notification.

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

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

10 10901.3. (a) After the federally eligible defined individual
11 submits a completed application form for a health benefit plan,
12 the carrier shall, within 30 days, notify the individual of the
13 individual's actual premium charges for that health benefit plan
14 design. In no case shall the premium charged for any health benefit
15 plan identified in subdivision (d) of Section 10785 exceed the
16 premium for the second lowest cost silver plan of the individual
17 market in the rating area in which the individual resides which is
18 offered through the California Health Benefit Exchange established
19 under Title 22 (commencing with Section 100500) of the
20 Government Code, as described in Section 36B(b)(3)(B) of Title
21 26 of the United States Code.

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

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

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

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

3 ~~10901.9.~~ Commencing January 1, 2001, premiums for health
4 benefit plans offered, delivered, amended, or renewed by carriers
5 shall be subject to the following requirements:

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

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

19 ~~(2)~~ For health benefit plans identified in subdivision (d) of
20 Section 10785 that do not offer services through a preferred
21 provider arrangement, 170 percent of the standard premium charged
22 to an individual who is of the same age and resides in the same
23 geographic area as the federally eligible defined individual.
24 However, for federally qualified individuals who are between the
25 ages of 60 to 64, inclusive, the premium shall not exceed 170
26 percent of the standard premium charged to an individual who is
27 59 years of age and resides in the same geographic area as the
28 federally eligible defined individual.

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

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

1 and resides in the same geographic area as the federally eligible
2 defined individual.

3 (2) For health benefit plans identified in subdivision (d) of
4 Section 10785 that do not offer services through a preferred
5 provider arrangement, 170 percent of the standard premium charged
6 to an individual who is of the same age and resides in the same
7 geographic area as the federally eligible defined individual.
8 However, for federally qualified individuals who are between the
9 ages of 60 and 64, inclusive, the premium shall not exceed 170
10 percent of the standard premium charged to an individual who is
11 59 years of age and resides in the same geographic area as the
12 federally eligible defined individual. The premium effective on
13 January 1, 2001, shall apply to in force business at the earlier of
14 either the time of renewal or July 1, 2001.

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

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

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

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

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

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

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

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

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

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

20 10902.4.— (a) Carriers and health care service plans that offer
21 contracts to individuals may elect to establish a mechanism or
22 method to share in the financing of high-risk individuals. This
23 mechanism or method shall be established through a committee
24 of all carriers and health care service plans offering coverage to
25 individuals by July 1, 2002, and shall be implemented by January
26 1, 2003. If carriers and health care service plans wish to establish
27 a risk-sharing mechanism but cannot agree on the terms and
28 conditions of such an agreement, the Managed Risk Medical
29 Insurance Board shall develop a risk-sharing mechanism or method
30 by January 1, 2003, and it shall be implemented by July 1, 2003.

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

34 SECTION 1. Section 10902.4 of the Insurance Code is repealed.

35 10902.4.— Carriers and health care service plans that offer
36 contracts to individuals may elect to establish a mechanism or
37 method to share in the financing of high-risk individuals. This
38 mechanism or method shall be established through a committee
39 of all carriers and health care service plans offering coverage to
40 individuals by July 1, 2002, and shall be implemented by January

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

6 ~~SEC. 33.~~

7 *SEC. 2.* The heading of Chapter 9.7 (commencing with Section
8 10950) of Part 2 of Division 2 of the Insurance Code is amended
9 to read:

10
11 CHAPTER 9.7. CHILD ACCESS TO HEALTH INSURANCE

12
13 ~~SEC. 34.~~

14 *SEC. 3.* Section 10954 of the Insurance Code is amended to
15 read:

16 10954. (a) A carrier may use the following characteristics of
17 an eligible child for purposes of establishing the rate of the health
18 benefit plan for that child, where consistent with federal regulations
19 under PPACA: age, geographic region, and family composition,
20 plus the health benefit plan selected by the child or the responsible
21 party for a child.

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

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

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

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

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

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

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

9

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

15

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

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

22 (e)

23 (f) Carriers ~~may~~ *shall not* require documentation from applicants
24 relating to their coverage history.

25 (f)

26 (g) (1) On and after January 1, 2013, *and until January 1, 2014,*
27 a carrier shall provide a notice to all applicants for coverage under
28 this chapter and to all insureds, or the responsible party for an
29 insured, renewing coverage under this chapter that contains the
30 following information:

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

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

37 (C) An explanation that coverage purchased pursuant to this
38 section shall be effective as required under subdivision (d) of
39 Section 10951 and that such coverage shall not prevent an applicant

1 from obtaining new coverage during the open enrollment period
2 described in Section 10965.3.

3 (D) *Information about the Medi-Cal program and the Healthy
4 Families Program and about subsidies available through the
5 California Health Benefit Exchange.*

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

8 ~~(g)~~

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

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

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

24 ~~SEC. 4. Section 10960.5 is added to the Insurance Code, to
25 read:~~

26 ~~10960.5. Commencing January 1, 2014, in the event of a
27 conflict between the provisions of this chapter and the provisions
28 of Chapter 9.9 (commencing with Section 10965), the provisions
29 of Chapter 9.9 (commencing with Section 10965) shall prevail,
30 except where subdivision (j) of Section 10965.3 or subdivision (e)
31 of Section 10965.9 makes any of the provisions of Chapter 9.9
32 (commencing with Section 10965) inoperative, in which case the
33 provisions of this chapter and the operative provisions of Chapter
34 9.9 (commencing with Section 10965) shall be harmonized to the
35 extent permitted by federal law.~~

36 ~~SEC. 36.~~

37 ~~SEC. 5. Chapter 9.9 (commencing with Section 10965) is added
38 to Part 2 of Division 2 of the Insurance Code, to read:~~

1 CHAPTER 9.9. INDIVIDUAL ACCESS TO HEALTH INSURANCE

2
3 10965. For purposes of this chapter, the following definitions
4 shall apply:

5 (a) “Child” means a child described in Section 22775 of the
6 Government Code and subdivisions (n) to (p), inclusive, of Section
7 599.500 of Title 2 of the California Code of Regulations.

8 (b) “Dependent” means the spouse *or registered domestic*
9 *partner*, or child, of an individual, subject to applicable terms of
10 the health benefit plan.

11 (c) “Exchange” means the California Health Benefit Exchange
12 created by Section 100500 of the Government Code.

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

15 (e) “Health benefit plan” means any individual or group policy
16 of health insurance, as defined in Section 106, ~~or health care service~~
17 ~~plan contract that provides medical, hospital, and surgical benefits.~~
18 ~~The term does not include a health insurance policy consisting~~
19 ~~solely of coverage of that provides~~ excepted benefits, as described
20 in Sections 2722 and 2791 of the federal Public Health Service
21 Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91), subject
22 to Section 10965.01, ~~a specialized health care service plan contract,~~
23 ~~as defined in Section 1345 of the Health and Safety Code, a health~~
24 ~~care service plan conversion contract offered pursuant to Section~~
25 ~~1373.6 of the Health and Safety Code, a health insurance~~
26 ~~conversion policy offered pursuant to Section 12682.1, a health~~
27 ~~insurance policy or health care service plan contract provided in~~
28 the Medi-Cal program (Chapter 7 (commencing with Section
29 14000) of Part 3 of Division 9 of the Welfare and Institutions
30 Code), the Healthy Families Program (Part 6.2 (commencing with
31 Section 12693) of Division 2), the Access for Infants and Mothers
32 Program (Part 6.3 (commencing with Section 12695) of Division
33 2), or the program under Part 6.4 (commencing with Section
34 12699.50) of Division 2, ~~or a health care service plan contract or~~
35 ~~health insurance policy offered to a federally eligible defined~~
36 ~~individual under Article 4.6 (commencing with Section 1366.35)~~
37 ~~of Chapter 2.2 of Division 2 of the Health and Safety Code or~~
38 ~~Chapter 9.5 (commencing with Section 10900), or Medicare~~
39 ~~supplement coverage, Chapter 8.5 (commencing with Section~~
40 ~~10785), to the extent consistent with PPACA.~~

1 (f) “Policy year” has the meaning set forth in Section 144.103
2 of Title 45 of the Code of Federal Regulations.

3 ~~(f)~~

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

9 ~~(g)~~

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

16 ~~(h)~~

17 (i) “Qualified health plan” has the same meaning as that term
18 is defined in Section 1301 of PPACA.

19 ~~(i)~~

20 (j) “Rating period” means the period for which premium rates
21 established by an insurer are in effect.

22 (k) “Registered domestic partner” means a person who has
23 established a domestic partnership as described in Section 297 of
24 the Family Code.

25 10965.01. (a) For purposes of this chapter, “health benefit
26 plan” does not include policies or certificates of specified disease
27 or hospital confinement indemnity provided that the carrier offering
28 those policies or certificates complies with the following:

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

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

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

1
2 “This is a supplement to health insurance. It is not a substitute
3 for essential health benefits or minimum essential coverage as
4 defined in ~~PPACA. Commencing January 1, 2014, you may be~~
5 ~~subject to a federal tax if you do not obtain minimum essential~~
6 ~~coverage.” federal law.”~~
7

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

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

19 (b) As used in this section, “policies or certificates of specified
20 disease” and “policies or certificates of hospital confinement
21 indemnity” mean policies or certificates of insurance sold to an
22 insured to supplement other health insurance coverage as specified
23 in this section.

24 10965.1. Every health insurer offering individual health benefit
25 plans shall, in addition to complying with the provisions of this
26 part and rules adopted thereunder, comply with the provisions of
27 this chapter.

28 10965.3. (a) (1) On and after October 1, 2013, a health insurer
29 shall fairly and affirmatively offer, market, and sell all of the
30 insurer’s health benefit plans that are sold in the individual market
31 *for policy years on or after January 1, 2014*, to all individuals and
32 dependents in each service area in which the insurer provides or
33 arranges for the provision of health care services. An insurer shall
34 limit enrollment in individual health benefit plans to open
35 enrollment periods and special enrollment periods as provided in
36 subdivisions (c) and (d).

37 (2) A health insurer that offers qualified health plans through
38 the Exchange shall be deemed to be in compliance with paragraph
39 (1) with respect to an individual health benefit plan offered through

1 the Exchange in those geographic regions in which the insurer
2 offers health benefit plans through the Exchange.

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

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

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

15 (c) A health insurer shall provide an initial open enrollment
16 period from October 1, 2013, to March 31, 2014, inclusive, and
17 annual enrollment periods for plan years on or after January 1,
18 2015, from October 15 to December 7, inclusive, of the preceding
19 calendar year.

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

24 (1)

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

28 (A)

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

32 (B)

33 (ii) “Loss of minimum essential coverage” includes loss of that
34 coverage due to the circumstances described in Section
35 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of
36 Federal Regulations. “Loss of minimum essential coverage” does
37 not include loss of that coverage due to the individual’s failure to
38 pay premiums on a timely basis or situations allowing for a
39 rescission, subject to Section 10384.17.

40 (2)

- 1 (B) He or she gains a dependent or becomes a dependent through
 2 marriage, birth, adoption, or placement for adoption.
 3 ~~(3) He or she becomes a California resident.~~
 4 ~~(4)~~
 5 (C) He or she is mandated to be covered pursuant to a valid
 6 state or federal court order.
 7 ~~(5)~~
 8 (D) He or she has been released from incarceration.
 9 ~~(6)~~
 10 (E) His or her health benefit plan substantially violated a
 11 material provision of the policy
 12 ~~(7)~~
 13 (F) He or she gains access to new health benefit plans as a result
 14 of a permanent move.
 15 ~~(8)~~
 16 (G) He or she was receiving services from a contracting provider
 17 under another health benefit plan, *as defined in Section 10965 or*
 18 *Section 1399.845 of the Health and Safety Code*, for one of the
 19 conditions described in subdivision (a) of Section 10133.56 and
 20 that provider is terminated.
 21 ~~(9) With respect to~~
 22 *(2) Subject to subdivision (e), commencing January 1, 2014, a*
 23 *health insurer shall allow an individual to enroll in or change*
 24 *individual health benefit plans offered through the Exchange, in*
 25 *addition to the triggering events listed in this subdivision, the*
 26 *individual meets any of the requirements as a result of the*
 27 *triggering events listed in Section 155.420(d) of Title 45 of the*
 28 *Code of Federal Regulations. To the extent permitted by federal*
 29 *law, any triggering event described in paragraph (1) that is not*
 30 *listed in Section 155.420(d)(1) to (8), inclusive, of Title 45 of the*
 31 *Code of Federal Regulations shall be considered an exceptional*
 32 *circumstance under Section 155.420(d)(9) of Title 45 of the Code*
 33 *of Federal Regulations.*
 34 (e) With respect to individual health benefit plans offered outside
 35 the Exchange, an individual shall have ~~63~~ 60 days from the date
 36 of a triggering event identified in subdivision (d) to apply for
 37 coverage from a health benefit plan subject to this section. With
 38 respect to individual health benefit plans offered through the
 39 Exchange, an individual shall have ~~63~~ 60 days from the date of a

1 triggering event identified in subdivision (d) to select a plan offered
2 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 insurer shall, within 30 days, notify
6 the individual of the individual’s actual premium charges for that
7 plan established in accordance with Section 10965.9. The
8 individual shall have 30 days in which to exercise the right to buy
9 coverage at the quoted premium charges.

10 ~~(2)~~

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

26 ~~(3)~~

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

1 ~~(4)~~

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

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

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

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

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

23 ~~(5)~~

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

29 ~~(g)~~

30 (h) (1) On or after January 1, 2014, a health insurer shall not
31 establish rules for eligibility, including continued eligibility, of
32 any individual to enroll under the terms of an individual health
33 benefit plan based on any of the following factors:

34 (A) Health status.

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

36 (C) Claims experience.

37 (D) Receipt of health care.

38 (E) Medical history.

39 (F) Genetic information.

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

3 (H) Disability.

4 (I) Any other health status-related factor as determined by any
5 federal regulations, rules, or guidance issued pursuant to Section
6 2705 of the federal Public Health Service Act.

7 (2) ~~A~~ *Notwithstanding subdivision (c) of Section 10291.5, a*
8 *health insurer shall not require an individual applicant or his or*
9 *her dependent to fill out a health assessment or medical*
10 *questionnaire prior to enrollment under an individual health benefit*
11 *plan. A health insurer shall not acquire or request information*
12 *that relates to a health status-related factor from the applicant or*
13 *his or her dependent or any other source prior to enrollment of*
14 *the individual.*

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

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

21 (j) *The following provisions of this section shall become*
22 *inoperative if Section 2702 of the federal Public Health Service*
23 *Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA,*
24 *is repealed:*

25 (1) *Subdivision (a).*

26 (2) *Subdivisions (c), (d), (e), and (g), except as they relate to*
27 *health benefit plans offered through the Exchange.*

28 10965.5. (a) Commencing January 1, 2014, no health insurer
29 or agent or broker shall, directly or indirectly, engage in the
30 following activities:

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

36 (2) Encourage or direct an individual to seek individual coverage
37 from another health care service plan or health insurer or the
38 California Health Benefit Exchange because of the health status,
39 claims experience, industry, occupation, or geographic location,

1 provided that the location is within the insurer's approved service
2 area, of the individual.

3 (b) Commencing January 1, 2014, a health insurer shall not,
4 directly or indirectly, enter into any contract, agreement, or
5 arrangement with a broker or agent that provides for or results in
6 the compensation paid to a broker or agent for the sale of an
7 individual health benefit plan to be varied because of the health
8 status, claims experience, industry, occupation, or geographic
9 location of the individual. This subdivision does not apply to a
10 compensation arrangement that provides compensation to a broker
11 or agent on the basis of percentage of premium, provided that the
12 percentage shall not vary because of the health status, claims
13 experience, industry, occupation, or geographic area of the
14 individual.

15 (c) *This section shall be enforced in the same manner as Section*
16 *790.03, including through Sections 790.05 and 790.035.*

17 10965.7. (a) All individual health benefit plans shall conform
18 to the requirements of Sections 10112.1, 10127.18, ~~10273.4,~~
19 *10273.6*, and 12682.1, and any other requirements imposed by this
20 code, and shall be renewable at the option of the insured except
21 as permitted to be canceled, rescinded, or not renewed pursuant
22 to Section ~~10273.4.~~ *10273.6.*

23 (b) Any insurer that ceases to offer for sale new individual health
24 benefit plans pursuant to Section ~~10273.4~~ *10273.6* shall continue
25 to be governed by this chapter with respect to business conducted
26 under this chapter.

27 10965.9. (a) With respect to individual health benefit plans
28 issued, amended, or renewed on or after January 1, 2014, a health
29 insurer may use only the following characteristics of an individual,
30 and any dependent thereof, for purposes of establishing the rate
31 of the individual health benefit plan covering the individual and
32 the eligible dependents thereof, along with the health benefit plan
33 selected by the individual:

34 (1) Age, ~~as described in regulations adopted by the department~~
35 ~~in conjunction with the Department of Managed Health Care that~~
36 ~~do not prevent the application of PPACA pursuant to the age bands~~
37 ~~established by the United States Secretary of Health and Human~~
38 ~~Services pursuant to Section 2701(a)(3) of the federal Public~~
39 ~~Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).~~ Rates based on
40 age shall be determined based on the individual's birthday *and*

1 *shall not vary by more than three to one for adults.* ~~A plan shall~~
2 ~~not use any age bands for rating purposes that are inconsistent with~~
3 ~~the age bands established by the United States Secretary of Health~~
4 ~~and Human Services pursuant to Section 2701(a)(3) of the federal~~
5 ~~Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).~~

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

8 (A)

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

13 (B)

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

16 (C)

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

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

21 (iv) *Region 4 shall consist of the County of San Francisco.*

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

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

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

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

26 (E)

27 ~~(ix) Region-5 9 shall consist of the Counties of Santa Cruz,~~
28 ~~Monterey, and San Benito.~~

29 (F)

30 ~~(x) Region-6 10 shall consist of the Counties of San Joaquin,~~
31 ~~Stanislaus, Merced, Mariposa, Madera, Fresno, Kings, and Tulare.~~

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

34 (G)

35 ~~(xii) Region-7 12 shall consist of the Counties of San Luis~~
36 ~~Obispo, Santa Barbara, and Ventura.~~

37 (H)

38 ~~(xiii) Region-8 13 shall consist of the Counties of Mono, Inyo,~~
39 ~~Kern, and Imperial.~~

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

1 ~~(I)~~
2 (xv) Region-9 15 shall consist of the ZIP Codes in Los Angeles
3 County starting with 906 to 912, inclusive, 915, 917, 918, and 935.
4 ~~(J)~~
5 (xvi) Region-10 16 shall consist of the ZIP Codes in Los Angeles
6 County other than those identified in ~~subparagraph (I)~~ clause (xv).
7 ~~(K)~~
8 (xvii) Region-11 17 shall consist of the Counties of San
9 Bernardino and Riverside.
10 ~~(L)~~
11 (xviii) Region-12 18 shall consist of the County of Orange.
12 ~~(M)~~
13 (xix) Region-13 19 shall consist of the County of San Diego.
14 (B) *No later than June 1, 2017, the department, in collaboration*
15 *with the Exchange and the Department of Managed Health Care,*
16 *shall review the geographic rating regions specified in this*
17 *paragraph and the impacts of those regions on the health care*
18 *coverage market in California, and make a report to the*
19 *appropriate policy committees of the Legislature.*
20 (3) Whether the health benefit plan covers an individual or
21 family, *as described in PPACA.*
22 (b) The rate for a health benefit plan subject to this section shall
23 not vary by any factor not described in this section.
24 (c) The rating period for rates subject to this section shall be
25 from January 1 to December 31, inclusive.
26 (d) This section shall not apply to an individual health benefit
27 plan that is a grandfathered health plan.
28 (e) *This section shall become inoperative if Section 2701 of the*
29 *federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added*
30 *by Section 1201 of PPACA, is repealed.*
31 10965.11. A health insurer shall not be required to offer an
32 individual health benefit plan or accept applications for the plan
33 pursuant to this chapter in the case of any of the following:
34 (a) To an individual who does not work or reside within the
35 insurer’s approved service areas.
36 (b) (1) Within a specific service area or portion of a service
37 area, if the insurer reasonably anticipates and demonstrates to the
38 satisfaction of the commissioner that it will not have sufficient
39 health care delivery resources to ensure that health care services

1 will be available and accessible to the individual because of its
2 obligations to existing insureds.

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

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

16 10965.13. The commissioner may require a health insurer to
17 discontinue the offering of individual health benefit plans or
18 acceptance of applications from any individual upon a
19 determination by the commissioner that the insurer does not have
20 sufficient financial viability or organizational and administrative
21 capacity to ensure the delivery of health care services to its
22 insureds. In determining whether the conditions of this section
23 have been met, the commissioner shall consider, but not be limited
24 to, the insurer's compliance with the requirements of this part and
25 the rules adopted under those provisions.

26 10965.14. (a) On or before October 1, 2013, and annually
27 thereafter, a health insurer shall issue the following notice to all
28 policyholders enrolled in an individual health benefit plan that is
29 a grandfathered health plan:

30
31 ~~Beginning on and after January 1, 2014, new~~ *New* improved
32 health insurance options are available in California. You currently
33 have health insurance that is exempt from many of the new
34 requirements. *For instance, your policy may not include certain*
35 *consumer protections that apply to other policies, such as the*
36 *requirement for the provision of preventive health services without*
37 *any cost sharing and the prohibition against increasing your rates*
38 *based on your health status.* You have the option to remain in your
39 current ~~plan~~ *policy* or switch to a new ~~plan~~ *policy*. Under the new
40 rules, a health insurance company cannot deny your application

1 based on any health conditions you may have. For more
2 information about your options, please contact the California
3 Health Benefit Exchange, the Office of Patient Advocate, your
4 plan or policy representative, an insurance broker, or a health care
5 navigator.
6

7 (b) A health insurer shall include the notice described in
8 subdivision (a) in any ~~marketing~~ *renewal* material of the individual
9 grandfathered health plan *and in any application for dependent*
10 *coverage under the individual grandfathered health plan.*

11 *10965.15. Except as otherwise provided in this chapter, this*
12 *chapter shall be implemented to the extent that it meets or exceeds*
13 *the requirements set forth in the federal Patient Protection and*
14 *Affordable Care Act (Public Law 111-148), as amended by the*
15 *federal Health Care and Education Reconciliation Act of 2010*
16 *(Public Law 111-152), and any rules, regulations, or guidance*
17 *issued pursuant to that law.*

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

24 *SEC. 6. This act shall become operative only if Assembly Bill*
25 *1461 of the 2011–12 Regular Session is also enacted and becomes*
26 *operative.*

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