ASSEMBLY BILL No. 2

Introduced by Assembly Member Pan

January 29, 2013

An act to amend Sections 1357.51, 1357.503, 1357.504, 1357.509, 1357.512, 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 and add Sections 1389.4 and 1389.7 of, to amend and repeal Section 1389.5 of, to amend, repeal, and add Sections 1399.805 and 1399.811 of, to add Sections 1348.96 and 1399.836 to, to add Article 11.8 (commencing with Section 1399.845) to Chapter 2.2 of Division 2 of, and to repeal Sections 1357.510 and 1399.816 of, the Health and Safety Code, and to amend Sections 10198.7, 10753.05, 10753.06.5, 10753.11, 10753.12, 10753.14, and 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, to amend and add Sections 10113.95 and 10119.2 of, to amend and repeal Section 10119.1 of, to amend, repeal, and add Sections 10901.3 and 10901.9 of, to add Sections 10127.21 and 10960.5 to, to add Chapter 9.9 (commencing with Section 10965) to Part 2 of Division 2 of, to add Part 6.25 (commencing with Section 12694.50) to Division 2 of, and to repeal Section 10902.4 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2, as introduced, Pan. Health care coverage.

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in

the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate charged by a health insurance issuer offering small group or individual coverage to vary only by rating area, age, tobacco use, and whether the coverage is for an individual or family and prohibits discrimination against individuals based on health status, as specified. PPACA requires an issuer to consider all enrollees in its individual market plans to be part of a single risk pool and to consider all enrollees in its small group market plans to be part of a single risk pool, as specified. PPACA also requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires plans and insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements. Existing law establishes the California Health Benefit Exchange (Exchange) to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014.

This bill would require a plan or insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's or insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan or insurer provides or arranges for the provision of health care services, 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 and from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified. The bill would require a health care service plan or health insurer to

consider the claims experience of all enrollees or insureds of its nongrandfathered individual health benefit plans to be part of a single risk pool, would require the plan or insurer to establish a specified index rate for that market, and would authorize the plan or insurer to vary premiums from the index rate based only on specified factors. The bill would authorize plans and insurers to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans, as specified. The bill would require plans and insurers to provide specified information regarding the Exchange to applicants for and subscribers of individual health benefit plans offered outside the Exchange. The bill would prohibit a plan or insurer from advertising or marketing an individual grandfathered health plan for the purpose of enrolling a dependent of the subscriber or policyholder in the plan and would also require plans and insurers to annually issue a specified notice to subscribers and policyholders enrolled in a grandfathered plan.

Existing law requires plans and insurers to guarantee issue their small employer health benefit plans, as specified. With respect to nongrandfathered small employer health benefit plans for plan years on or after January 1, 2014, among other things, existing law provides certain exceptions from the guarantee issue requirement, allows the premium for small employer health benefit plans to vary only by age, geographic region, and family size, as specified, and requires plans and insurers to provide special enrollment periods and coverage effective dates consistent with the individual nongrandfathered market in the state. Existing law provides that these provisions shall be inoperative if specified provisions of PPACA are repealed.

This bill would modify the small employer special enrollment periods and coverage effective dates for purposes of consistency with the individual market reforms described above. The bill would also modify the exceptions from the guarantee issue requirement and the manner in which a plan or insurer determines premium rates for a small employer health benefit plan, as specified. The bill would also require a plan or insurer to consider the claims experience of all enrollees of its nongrandfathered small employer health benefit plans to be part of a single risk pool, would require the plan or insurer to establish a specified index rate for that market, and would authorize the plan or insurer to vary premiums from the index rate based only on specified factors. The bill would delete the provisions making these provisions inoperative if specified provisions of PPACA are repealed.

Because a willful violation of these requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

(2) PPACA requires a state or the United States Secretary of Health and Human Services to implement a risk adjustment program for the 2014 benefit year and every benefit year thereafter, under which a charge is assessed on low actuarial risk plans and a payment is made to high actuarial risk plans, as specified. If a state that elects to operate an American Health Benefit Exchange elects not to administer this risk adjustment program, the secretary will operate the program and issuers will be required to submit data for purposes of the program to the secretary.

This bill would require that any data submitted by health care service plans and health insurers to the secretary for purposes of the risk adjustment program also be submitted to the Department of Managed Health Care or the Department of Insurance.

(3) 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 issued by the plan, including the benefits and coverage of the contract, and the exceptions, reductions, and limitations that apply to the contract. 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 to waive or modify those requirements for purposes of compliance with PPACA through issuance of all-plan letters until January 1, 2015.

(4) 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 instead prohibit the premium for those policies and contracts from exceeding the premium for a specified plan offered in the individual market through the California Health Benefit Exchange in the rating area in which the individual resides. The bill would make this requirement operative on the later of January 1, 2014, or the 91st day following the adjournment of the 2013–14 First Extraordinary Session. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(5) Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care services to eligible children through participating health, dental, and vision care plans, as defined. To be eligible for the program, existing law requires applicants to, among other requirements, be less than 19 years of age and have a limited gross household income, as specified. Existing law provides for the transition of specified enrollees of the Healthy Families Program to the Medi-Cal program, to the extent that those individuals are otherwise eligible, no sooner than January 1, 2013.

This bill would require plans offering coverage to Healthy Families Program enrollees, on or after January 1, 2012, including those transitioned to the Medi-Cal program, to offer 18 months of coverage, until a specified date, to individuals who were or are disenrolled from the program due to ineligibility because of age and are not eligible for full scope coverage under Medi-Cal. The bill would require plans to provide notice of eligibility for this coverage within a specified period of time and would require beneficiaries electing this coverage to pay no more than 110% of the average per subscriber payment made to all participating health, dental, or vision plans for program coverage, as specified.

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

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

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

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

SECTION 1. Section 1348.96 is added to the Health and Safety Code, to read:

1348.96. Any data submitted by a health care service plan to the United States Secretary of Health and Human Services, or his or her designee, for purposes of the risk adjustment program described in Section 1343 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18063) shall be concurrently submitted to the department.

SEC. 2. Section 1357.51 of the Health and Safety Code, as added by Chapter 852 of the Statutes of 2012, is amended to read:

1357.51. (a) ~~A nongrandfathered health benefit plan for group or individual coverage or a grandfathered~~ health benefit plan for group coverage shall not impose any preexisting condition *provision* or waivered condition *provision* upon any enrollee.

(b) *A nongrandfathered health benefit plan for individual coverage shall not impose any preexisting condition provision or waivered condition provision upon any enrollee.* A grandfathered health benefit plan for individual coverage shall not exclude coverage on the basis of a waivered condition provision or preexisting condition provision for a period greater than 12 months following the enrollee's effective date of coverage, nor limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition ~~clause~~ *provision* or waivered condition provision pursuant to this article. Waivered condition provisions or preexisting condition provisions contained in individual grandfathered health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) A health benefit plan for group coverage may apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents and if consistent with PPACA. A health benefit plan for group coverage through a health maintenance organization, as defined in Section 2791 of the federal Public Health Service Act, shall not impose any affiliation period that exceeds 60 days. A waiting or affiliation

period shall not be based on a preexisting condition of an employee or dependent, the health status of an employee or dependent, or any other factor listed in Section 1357.52. An affiliation period shall run concurrently with a waiting period. During the waiting or affiliation period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollees.

(2) A health benefit plan for individual coverage shall not impose any waiting or affiliation period.

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

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

(e) An individual's period of creditable coverage shall be certified pursuant to Section 2704(e) of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

SEC. 3. Section 1357.503 of the Health and Safety Code is amended to read:

1357.503. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan's small employer health care service plan contracts for plan years on or after January 1, 2014, to all small employers in each service area in which the plan provides or arranges for the provision of health care services.

(2) On and after October 1, 2013, a plan shall make available to each small employer all small employer health care service plan contracts that the plan offers and sells to small employers or to associations that include small employers in this state for plan years on or after January 1, 2014.

(3) A plan that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraphs (1) and (2) with respect to small employer health care service plan contracts offered through the Exchange in those geographic regions in which the plan offers plan contracts through the Exchange.

(b) A plan shall provide enrollment periods consistent with PPACA and ~~set forth~~ *described* in Section 155.725 of Title 45 of the Code of Federal Regulations. ~~A~~ *Commencing January 1, 2014, a* plan shall provide special enrollment periods consistent with the special enrollment periods ~~required in the individual nongrandfathered market in the state under~~ *described in* Section 1399.849, except for the triggering events identified in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of Federal Regulations with respect to plan contracts offered through the Exchange.

(c) No plan or solicitor shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with employee's employment or membership in a guaranteed association.

(d) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in Section 1357.500 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan to reject an otherwise eligible small employer because of the number of persons that waive coverage

due to coverage through another employer. Members of an association eligible for health coverage under subdivision (m) of Section 1357.500, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

(e) The plan shall not reject an application from a small employer for a small employer health care service plan contract if all of the following conditions are met:

(1) The small employer offers health benefits to 100 percent of its eligible employees. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(3) The small employer agrees to inform the small employer's employees of the availability of coverage and the provision that those not electing coverage must wait until the next open enrollment or a special enrollment period to obtain coverage through the group if they later decide they would like to have coverage.

(4) The employees and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(f) No plan or solicitor shall, directly or indirectly, engage in the following activities:

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

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

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

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

(h) (1) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the policy or contract based on any of the following health status-related factors:

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire prior to enrollment under a small employer health care service plan contract. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(i) (1) A health care service plan shall consider the claims experience of all enrollees in all nongrandfathered small employer health care service plan contracts offered in the state that are

subject to subdivision (a), including those enrollees who do not enroll in the contracts through the Exchange, to be members of a single risk pool.

(2) Each plan year, a health care service plan shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the health care service plan's nongrandfathered small employer health care service plan contracts shall use the applicable index rate, as adjusted for total expected market-wide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premiums rates for a particular nongrandfathered small employer health care service plan contract from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the plan contract.

(B) The plan contract's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the plan contract that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plan contracts that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

~~(i)~~

(j) A plan shall comply with the requirements of Section 1374.3.

~~(j) (1) Except as provided in paragraph (2), this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, in which case health care services plans subject to this section shall instead be governed by Section 1357.03 to the extent permitted by federal law, and all references in this article to this section shall instead refer to Section 1357.03 except for purposes of paragraph (2).~~

~~(2) Subdivision (b) of this section shall remain operative with respect to health care service plan contracts offered through the Exchange.~~

SEC. 4. Section 1357.504 of the Health and Safety Code is amended to read:

1357.504. (a) With respect to small employer health care service plan contracts offered outside the Exchange, after a small employer submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the employer of the employer's actual premium charges for that plan contract established in accordance with Section 1357.512. The employer shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(b) ~~(1)~~ Except as provided in ~~paragraph (2)~~ *subdivision (c)*, when a small employer submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

~~(2) A health care service plan shall apply coverage effective dates for plan contracts subject to this article consistent with the coverage effective dates applicable to nongrandfathered individual health care service plan contracts pursuant to Section 1399.849.~~

(c) (1) With respect to a small employer health care service plan contract offered through the Exchange, a plan shall apply coverage effective dates consistent with those required under Section 155.720 of Title 45 of the Code of Federal Regulations and paragraph (2) of subdivision (e) of Section 1399.849.

(2) With respect to a small employer health care service plan contract offered outside the Exchange for which an individual applies during a special enrollment period described in subdivision (b) of Section 1357.503, the following provisions shall apply:

(A) Coverage under the plan contract shall become effective no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, coverage under the plan contract shall become effective on the date of birth, adoption, or placement for adoption.

~~(c)~~

(d) During the first 30 days after the effective date of the plan contract, the small employer shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If a small employer notifies the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If a small employer notifies the plan of the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.

SEC. 5. Section 1357.509 of the Health and Safety Code is amended to read:

1357.509. *(a)* To the extent permitted by PPACA, no plan shall be required to offer a health care service plan contract or accept applications for the contract pursuant to this article in the case of any of the following:

~~(a)~~

(1) To a small employer~~, if the small employer is not physically located in a plan's approved service areas, or~~ if ~~an~~ *the* eligible ~~employee~~ *employees* and dependents who are to be covered by the plan contract do not *live,* work or reside within a plan's approved service areas.

~~(b) (1)~~

(2) (A) Within a specific service area or portion of a service area, if a plan reasonably anticipates and demonstrates to the satisfaction of the director ~~that it~~ *both of the following:*

(i) It will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to

the eligible employee and dependents of the employee because of its obligations to existing enrollees.

(ii) It is applying this subparagraph uniformly to all employers without regard to the claims experience of those employers, and their employees and dependents, or any health status-related factor relating to those employees and dependents.

~~(2)~~

(B) A plan that cannot offer a health care service plan contract to small employers because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area *pursuant to subparagraph (A)* may not offer a contract in the area in which the plan is not offering coverage to small employers to new employer groups with more than 50 eligible employees until the *later of the following dates:*

(i) The 181st day after the date that coverage is denied pursuant to this paragraph.

(ii) The date the plan notifies the director that it has the ability to deliver services to small employer groups, and certifies to the director that from the date of the notice it will enroll all small employer groups requesting coverage in that area from the plan ~~unless the plan has met the requirements of subdivision (d)~~.

(C) Subparagraph (B) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to the requirements of this section.

(b) (1) A health care service plan may decline to offer a health care service plan contract to a small employer if the plan demonstrates to the satisfaction of the director both of the following:

(A) It does not have the financial reserves necessary to underwrite additional coverage. In determining whether this subparagraph has been satisfied, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(B) It is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and

their employees and dependents or any health status-related factor relating to those employees and dependents.

(2) A plan that denies coverage to a small employer under paragraph (1) shall not offer coverage in the group market before the later of the following dates:

(A) The 181st day after the date that coverage is denied pursuant to paragraph (1).

(B) The date the plan demonstrates to the satisfaction of the director that the plan has sufficient financial reserves necessary to underwrite additional coverage.

(3) Paragraph (2) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(4) Coverage offered within a service area after the period specified in paragraph (2) shall be subject to the requirements of this section.

~~(3)~~

(c) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired *to the extent permitted by PPACA*.

~~(c) Offer coverage to a small employer or an eligible employee as defined in paragraph (2) of subdivision (c) of Section 1357.500 that, within 12 months of application for coverage, disenrolled from a plan contract offered by the plan.~~

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

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

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

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

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

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

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

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

~~(B) The director shall, within 45 days, approve or disapprove the certified statement. If the certified statement is disapproved, the plan shall continue to issue coverage as required by Section 1357.503 and be subject to disciplinary action as set forth in Article 7 (commencing with Section 1386).~~

~~(e) A health care service plan that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and 50 percent or more of the plan's total enrollment have premiums paid by the Medi-Cal program.~~

~~(f) A social health maintenance organization, as described in subsection (a) of Section 2355 of the federal Deficit Reduction Act of 1984 (Public Law 98-369), that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and has 50 percent or more of the organization's total enrollment premiums paid by the Medi-Cal program or Medicare Program, or by a combination of Medi-Cal and Medicare. In no event shall this exemption be based upon enrollment in Medicare supplement~~

~~contracts, as described in Article 3.5 (commencing with Section 1358).~~

SEC. 6. Section 1357.510 of the Health and Safety Code is repealed.

~~1357.510. The director may require a plan to discontinue the offering of contracts or acceptance of applications from any small employer or group upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.~~

SEC. 7. Section 1357.512 of the Health and Safety Code is amended to read:

1357.512. (a) The premium rate for a small employer health care service plan contract shall vary with respect to the particular coverage involved only by the following:

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services *and the age rating curve established by the Centers for Medicare and Medicaid Services* pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined ~~based on the individual's birthday~~ *using the individual's age as of the date of the contract issuance or renewal, as applicable,* and shall not vary by more than three to one for ~~adults~~ *like individuals of different age who are 21 years of age or older as described in federal regulations adopted pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3))*.

(2) (A) Geographic region. ~~The~~ *Except as provided in subparagraph (B), the* geographic regions for purposes of rating shall be the following:

(i) Region 1 shall consist of the Counties of Alpine, *Amador, Butte, Calaveras, Colusa,* Del Norte, *El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra,* Siskiyou, ~~Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn,~~ Sutter, *Tehama,*

Trinity, Tulare, Tuol umne, Yolo, and Yuba ~~, Colusa, Amador, Calaveras, and Tuolumne~~.

(ii) Region 2 shall consist of the Counties of *Fresno, Imperial, Kern, Madera, Mariposa, Merced,* Napa, *Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano,* Sonoma, ~~Solano, and Marin~~ *and Stanislaus*.

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

~~(iv)~~

(iii) Region ~~4~~ *3* shall consist of the ~~County~~ *Counties* of *Alameda, Contra Costa, Marin,* San Francisco*, San Mateo, and Santa Clara.*

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

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

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

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

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

~~(x) Region 10 shall consist of the Counties of San Joaquin, Stanislaus, Merced, Mariposa, and Tulare~~.

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

~~(xii)~~

(iv) Region ~~12~~ *4* shall consist of the Counties of ~~San Luis Obispo,~~ *Orange,* Santa Barbara, and Ventura.

~~(xiii) Region 13 shall consist of the Counties of Mono, Inyo, and Imperial.~~

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

~~(xv)~~

(v) Region ~~15~~ *5* shall consist of the ~~ZIP Codes in~~ *County of* Los Angeles ~~County starting with 906 to 912, inclusive, 915, 917, 918, and 935~~.

~~(xvi) Region 16 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (xv).~~

~~(xvii)~~

(vi) Region ~~17~~ *6* shall consist of the Counties of *Riverside,* San Bernardino, and ~~Riverside~~ *San Diego*.

~~(xviii) Region 18 shall consist of the County of Orange.~~

~~(xix) Region 19 shall consist of the County of San Diego.~~

(B) For the 2015 plan year and plan years thereafter, the geographic regions for purposes of rating shall be the following,

subject to federal approval if required pursuant to Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and obtained by the department and the Department of Insurance by July 1, 2014:

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

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

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

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

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

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

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

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

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

(x) Region 10 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (ix).

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

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

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

~~(B)~~

(C) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Insurance, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and submit a report to the appropriate policy committees of the Legislature.

(3) Whether the contract covers an individual or family, as described in PPACA.

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

(c) The total premium charged to a small employer pursuant to this section shall be determined by summing the premiums of covered employees and dependents in accordance with Section 147.102(c)(1) of Title 45 of the Code of Federal Regulations.

~~(c)~~

(d) The rating period for rates subject to this section shall be no less than 12 months from the date of issuance or renewal of the plan contract.

~~(d) This section shall become inoperative if Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added by Section 1201 of PPACA, is repealed, in which case rates for health care service plan contracts subject to this section shall instead be subject to Section 1357.12, to the extent permitted by federal law, and all references to this section shall be deemed to be references to Section 1357.12.~~

SEC. 8. Section 1363 of the Health and Safety Code is amended to read:

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

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

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

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

(3) The full premium cost of the plan.

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

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

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

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

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

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

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

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

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

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

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

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

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

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

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

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

(14) Conditions and procedures for disenrollment.

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

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

(17) A notice as required by Section 1364.5.

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

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.
(E) Hospitalization services.
(F) Emergency health coverage.
(G) Ambulance services.
(H) Prescription drug coverage.
(I) Durable medical equipment.
(J) Mental health services.
(K) Chemical dependency services.
(L) Home health services.
(M) Other.

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

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

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

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

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

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

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

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

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

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

(j) Until January 1, 2015, the department may waive or modify the requirements of this section for the purpose of resolving duplication or conflict with federal requirements for uniform benefit disclosure in effect pursuant to Section 2715 of the federal Public Health Service Act and the regulations adopted thereunder. The department shall implement this subdivision in a manner that preserves disclosure requirements of this section that exceed or are not in direct conflict with federal requirements. Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department shall implement this subdivision through issuance of all-plan letters.

SEC. 9. Section 1389.4 of the Health and Safety Code is amended to read:

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

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to

provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 1365.5 and 1389.1 and all other applicable provisions of state and federal law.

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

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

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

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

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

(g) This section shall become inoperative on November 1, 2013, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 10. Section 1389.4 is added to the Health and Safety Code, to read:

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

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

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

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

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

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

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

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

(g) This section shall become operative on November 1, 2013, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 11. Section 1389.5 of the Health and Safety Code is amended to read:

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

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

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

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

(d) The plan shall notify in writing all enrollees of the right to transfer to another individual plan contract pursuant to this section, at a minimum, when the plan changes the enrollee's premium rate.

Posting this information on the plan's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform enrollees of the transfer rights provided under this section, including information on the process to obtain details about the individual plan contracts available to that enrollee and advising that the enrollee may be unable to return to his or her current individual plan contract if the enrollee transfers to another individual plan contract.

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

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

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

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

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

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

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

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

(g) This section shall remain in effect only until January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later, and as of that date is repealed, unless a later enacted statute, that becomes operative on or before that date, deletes or extends the date on which it is repealed.

SEC. 12. Section 1389.7 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

(h) This section shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 13. Section 1389.7 is added to the Health and Safety Code, to read:

1389.7. (a) Every health care service plan that offers, issues, or renews individual plan contracts shall offer to any individual, who was covered by the plan under an individual plan contract that was rescinded, a new individual plan contract that provides the most equivalent benefits.

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

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

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

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

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

(g) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 14. Section 1399.805 of the Health and Safety Code is amended to read:

1399.805. (a) (1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has

provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the following amounts:

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

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

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

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

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

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that

payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

(d) This section shall remain in effect only until January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later, and as of that date is repealed, unless a later enacted statute, that becomes operative on or before that date, deletes or extends the date on which it is repealed.

SEC. 15. Section 1399.805 is added to the Health and Safety Code, to read:

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

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier,

within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

(d) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 16. Section 1399.811 of the Health and Safety Code is amended to read:

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

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

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

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the

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

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

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

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

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

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

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

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

(d) This section shall remain in effect only until January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later, and as of that date is repealed, unless a later enacted statute, that becomes operative on or before that date, deletes or extends the date on which it is repealed.

SEC. 17. Section 1399.811 is added to the Health and Safety Code, to read:

1399.811. (a) Premiums for contracts offered, delivered, amended, or renewed by plans on or after the operative date of this section shall be subject to the following requirements:

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

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

(b) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 18. Section 1399.816 of the Health and Safety Code is repealed.

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

SEC. 19. The heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of the Health and Safety Code is amended to read:

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

SEC. 20. Section 1399.829 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

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

(f) Health care service plans ~~may~~ *shall not* require documentation from applicants relating to their coverage history.

(g) (1) On and after the operative date of the act adding this subdivision, and until January 1, 2014, a health care service plan shall provide a notice to all applicants for coverage under this article and to all enrollees, or the responsible party for an enrollee, renewing coverage under this article that contains the following information:

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

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

the effective dates of coverage for coverage purchased pursuant to this article unless the applicant cancels that coverage.

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

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

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

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

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

1399.836. This article shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 22. Article 11.8 (commencing with Section 1399.845) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.8. Individual Access to Health Care Coverage

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

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

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

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

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

(e) "Health benefit plan" means any individual or group health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include a specialized health care service plan contract, a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35), or Medicare supplement coverage, to the extent consistent with PPACA.

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

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

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

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

(j) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

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

1399.849. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment in individual health benefit plans to open enrollment periods and special enrollment periods as provided in subdivisions (c) and (d).

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

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

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

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

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

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

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

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described

in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 1389.7 and 1389.21.

(B) He or she gains a dependent or becomes a dependent.

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

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

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

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

(G) He or she was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 or Section 10965 of the Insurance Code, for one of the conditions described in subdivision (c) of Section 1373.96 and that provider is no longer participating in the health benefit plan.

(H) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.

(I) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 63 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 63 days from the date of a triggering event identified in paragraph (1) to select a plan offered

through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the following provisions shall apply:

(1) The effective date of coverage selected pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(2) Notwithstanding paragraph (1), in the case where an individual acquires or becomes a dependent by entering into a registered domestic partnership pursuant to Section 297 of the Family Code and applies for coverage of that domestic partner consistent with subdivision (d), the coverage effective date shall be the first day of the month following the date he or she selects a plan through the Exchange, unless an earlier date is agreed to under Section 155.420(b)(3) of Title 45 of the Code of Federal Regulations.

(f) With respect to individual health benefit plans offered outside the Exchange, the following provisions shall apply:

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

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

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

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

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the plan receives the request for special enrollment.

(g) (1) A health care service plan shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

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

(C) Claims experience.
(D) Receipt of health care.
(E) Medical history.
(F) Genetic information.
(G) Evidence of insurability, including conditions arising out of acts of domestic violence.
(H) Disability.
(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment under an individual health benefit plan. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(h) (1) A health care service plan shall consider the claims experience of all enrollees in all individual health benefit plans offered in the state that are subject to subdivision (a), including those enrollees who do not enroll in the plans through the Exchange, to be members of a single risk pool.

(2) Each policy year, a health care service plan shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the health care service plan's health benefit plans in the individual market shall use the applicable index rate, as adjusted for total expected market-wide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premiums rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

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

1399.851. (a) No health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

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

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

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

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

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

(c) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

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

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

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

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services and the age rating curve established by the federal Centers for Medicare and Medicaid Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined using the individual's age as of the date of the plan issuance or renewal, as applicable, and shall not vary by more than three to one for like individuals of different age who are age 21 or older as described in federal regulations adopted pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).

(2) (A) Geographic region. Except as provided in subparagraph (B), the geographic regions for purposes of rating shall be the following:

(i) Region 1 shall consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey,

Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolomne, Yolo, and Yuba.

(ii) Region 2 shall consist of the Counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(iii) Region 3 shall consist of the Counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(iv) Region 4 shall consist of the Counties of Orange, Santa Barbara, and Ventura.

(v) Region 5 shall consist of the County of Los Angeles.

(vi) Region 6 shall consist of the Counties of Riverside, San Bernardino, and San Diego.

(B) For the 2015 plan year and plan years thereafter, the geographic regions for purposes of rating shall be the following, subject to federal approval if required pursuant to Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and obtained by the department and the Department of Insurance by July 1, 2014:

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

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

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

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

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

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

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

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

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

(x) Region 10 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (ix).

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

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

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

(C) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Insurance, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and make a report to the appropriate policy committees of the Legislature.

(3) Whether the plan covers an individual or family, as described in PPACA.

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

(c) With respect to family coverage under an individual health benefit plan, the rating variation permitted under paragraph (1) of subdivision (a) shall be applied based on the portion of the premium attributable to each family member covered under the plan. The total premium for family coverage shall be determined by summing the premiums for each individual family member. In determining the total premium for family members, premiums for no more than the three oldest family members who are under age 21 shall be taken into account.

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

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

(f) The requirement for submitting a report imposed under subparagraph (B) of paragraph (2) of subdivision (a) is inoperative on June 1, 2021, pursuant to Section 10231.5 of the Government Code.

1399.857. (a) A health care service plan shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to Section 1399.849 in the case of any of the following:

(1) To an individual who does not live or reside within the plan's approved service areas.

(2) (A) Within a specific service area or portion of a service area, if the plan reasonably anticipates and demonstrates to the satisfaction of the director both of the following:

(i) It will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual because of its obligations to existing enrollees.

(ii) It is applying this subparagraph uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(B) A health care service plan that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area pursuant to subparagraph (A) shall not offer a health benefit plan in that area to individuals until the later of the following dates:

(i) The 181st day after the date coverage is denied pursuant to this paragraph.

(ii) The date the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan.

(C) Subparagraph (B) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to this section.

(b) (1) A health care service plan may decline to offer an individual health benefit plan to an individual if the plan demonstrates to the satisfaction of the director both of the following:

(A) It does not have the financial reserves necessary to underwrite additional coverage. In determining whether this subparagraph has been satisfied, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(B) It is applying this subdivision uniformly to all individuals without regard to the claims experience of those individuals any health status-related factor relating to those individuals.

(2) A plan that denies coverage to an individual under paragraph (1) shall not offer coverage in the individual market before the later of the following dates:

(A) The 181st day after the date that coverage is denied pursuant to paragraph (1).

(B) The date the plan demonstrates to the satisfaction of the director that the plan has sufficient financial reserves necessary to underwrite additional coverage.

(3) Paragraph (2) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(4) Coverage offered within a service area after the period specified in paragraph (2) shall be subject to this section.

(c) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired to the extent permitted by PPACA.

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

1399.859. (a) A health care service plan that receives an application for an individual health benefit plan outside the Exchange during the initial open enrollment period, an annual enrollment period, or a special enrollment period described in Section 1399.849 shall inform the applicant that he or she may be eligible for lower cost coverage through the Exchange and shall inform the applicant of the applicable enrollment period provided through the Exchange described in Section 1399.849.

(b) On or before October 1, 2013, and annually thereafter, a health care service plan shall issue a notice to a subscriber enrolled in an individual health benefit plan offered outside the Exchange. The notice shall inform the subscriber that he or she may be eligible for lower cost coverage through the Exchange and shall inform the subscriber of the applicable open enrollment period provided through the Exchange described in Section 1399.849.

(c) This section shall not apply where the individual health benefit plan described in subdivision (a) or (b) is a grandfathered health plan.

1399.861. (a) On or before October 1, 2013, and annually thereafter, a health care service plan shall issue the following notice to all subscribers enrolled in an individual health benefit plan that is a grandfathered health plan:

New improved health insurance options are available in California. You currently have health insurance that is exempt from many of the new requirements. For instance, your plan may not include certain consumer protections that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing and the prohibition against increasing your rates based on your health status. You have the option to remain in your current plan or switch to a new plan. Under the new rules, a health plan cannot deny your application based on any health conditions you may have. For more information about your options, please contact the California Health Benefit Exchange, the Office of Patient Advocate, your plan representative, an insurance broker, or a health care navigator.

(b) Commencing October 1, 2013, a health care service plan shall include the notice described in subdivision (a) in any renewal material of the individual grandfathered health plan and in any application for dependent coverage under the individual grandfathered health plan.

(c) A health care service plan shall not advertise or market an individual health benefit plan that is a grandfathered health plan for purposes of enrolling a dependent of a subscriber into the plan for policy years on or after January 1, 2014. Nothing in this subdivision shall be construed to prohibit an individual enrolled in an individual grandfathered health plan from adding a dependent to that plan to the extent permitted by PPACA.

1399.862. Except as otherwise provided in this article, this article shall only be implemented to the extent that it meets or exceeds the requirements set forth in PPACA.

SEC. 23. Section 10113.95 of the Insurance Code is amended to read:

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

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

with Sections 10140 and 10291.5 and all other applicable provisions.

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

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

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

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

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

(g) This section shall become inoperative on November 1, 2013, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 24. Section 10113.95 is added to the Insurance Code, to read:

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

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

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

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

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

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

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

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

(g) This section shall become operative on November 1, 2013, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 25. Section 10119.1 of the Insurance Code is amended to read:

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

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

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

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

(d) The insurer shall notify in writing all insureds of the right to transfer to another individual health benefit plan pursuant to this section, at a minimum, when the insurer changes the insured's premium rate. Posting this information on the insurer's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform insureds of the transfer rights

provided under this section including information on the process to obtain details about the individual health benefit plans available to that insured and advising that the insured may be unable to return to his or her current individual health benefit plan if the insured transfers to another individual health benefit plan.

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

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

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

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

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

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

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

(g) This section shall remain in effect only until January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later, and as of that date is repealed, unless a later enacted statute, that becomes operative on or before that date, deletes or extends the date on which it is repealed.

SEC. 26. Section 10119.2 of the Insurance Code is amended to read:

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

health benefit plan that was rescinded, to remain covered under that individual health benefit plan, with a revised premium rate that reflects the number of persons remaining on the health benefit plan.

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

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

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

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

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

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

(h) This section shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 27. Section 10119.2 is added to the Insurance Code, to read:

10119.2. (a) Every health insurer that offers, issues, or renews health insurance under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, through the California Health Benefit Exchange shall offer to any individual, who was covered by the insurer under an individual health benefit plan that was rescinded, a new individual health benefit plan through the Exchange that provides the most equivalent benefits.

(b) A health insurer that offers, issues, or renews individual health benefit plans inside or outside the California Health Benefit Exchange may also permit an individual, who was covered by the insurer under an individual health benefit plan that was rescinded, to remain covered under that individual health benefit plan, with a revised premium rate that reflects the number of persons remaining on the health benefit plan consistent with Section 10965.9.

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

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

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

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

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

(h) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 28. Section 10127.21 is added to the Insurance Code, to read:

10127.21. Any data submitted by a health insurer to the United States Secretary of Health and Human Services, or his or her designee, for purposes of the risk adjustment program described in Section 1343 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18063) shall be concurrently submitted to the department.

SEC. 29. Section 10198.7 of the Insurance Code is amended to read:

10198.7. (a) A ~~nongrandfathered health benefit plan for group or individual coverage or a grandfathered~~ health benefit plan for group coverage shall not impose any preexisting condition provision or waivered condition provision upon any individual.

(b) *A nongrandfathered health benefit plan for individual coverage shall not impose any preexisting condition provision or waivered condition provision upon any individual.* A grandfathered health benefit plan for individual coverage shall not exclude coverage on the basis of a waivered condition provision or preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor limit or exclude coverage for a specific insured by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition ~~clause~~ *provision* or waivered condition provision pursuant to this article. Waivered condition provisions or preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) A health benefit plan for group coverage may apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents and if consistent with PPACA. A ~~waitingperiod~~ *waiting period* shall not be based on a preexisting condition of an employee or dependent, the health status of an employee or dependent, or any other factor listed in Section 10198.9. During the waiting period, the health benefit plan is not required to provide health care services and no premium shall be charged to the policyholder or insureds.

(2) A health benefit plan for individual coverage shall not impose a waiting period.

(d) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting period applies to a person, a health benefit plan shall credit the time the person was covered under creditable coverage, provided that the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage under the succeeding plan within the applicable enrollment period. A plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting period, and applies for coverage under the succeeding plan within the applicable enrollment period.

(e) An individual's period of creditable coverage shall be certified pursuant to Section 2704(e) of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

SEC. 30. Section 10753.05 of the Insurance Code is amended to read:

10753.05. (a) No group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10753.17.

(b) (1) On and after October 1, 2013, each carrier shall fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are sold to, offered through, or sponsored by, small employers or associations that include small employers for

plan years on or after January 1, 2014, to all small employers in each geographic region in which the carrier makes coverage available or provides benefits.

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

(3) A carrier shall provide enrollment periods consistent with PPACA and ~~set forth~~ *described* in Section 155.725 of Title 45 of the Code of Federal Regulations. ~~A~~ *Commencing January 1, 2014, a* carrier shall provide special enrollment periods consistent with the special enrollment periods ~~required in the individual nongrandfathered market in the state, as set forth~~ *described* in Section 10965.3, except for the triggering events identified in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of Federal Regulations with respect to health benefit plans offered through the Exchange.

(4) Nothing in this section shall be construed to require an association, or a trust established and maintained by an association to receive a master insurance policy issued by an admitted insurer and to administer the benefits thereof solely for association members, to offer, market or sell a benefit plan design to those who are not members of the association. However, if the association markets, offers or sells a benefit plan design to those who are not members of the association it is subject to the requirements of this section. This shall apply to an association that otherwise meets the requirements of paragraph (8) formed by merger of two or more associations after January 1, 1992, if the predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and met the requirements of paragraph (5).

(5) A carrier which (A) effective January 1, 1992, and at least 20 years prior to that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer or sell any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers or sells any benefit plan design or any other individual, selected

group, or group policy or contract providing medical, hospital and surgical benefits to those who are not members of the association it is subject to the requirements of this section.

(6) Each carrier that sells health benefit plans to members of one association pursuant to paragraph (5) shall submit an annual statement to the commissioner which states that the carrier is selling health benefit plans pursuant to paragraph (5) and which, for the one association, lists all the information required by paragraph (7).

(7) Each carrier that sells health benefit plans to members of any association shall submit an annual statement to the commissioner which lists each association to which the carrier sells health benefit plans, the industry or profession which is served by the association, the association's membership criteria, a list of officers, the state in which the association is organized, and the site of its principal office.

(8) For purposes of paragraphs (4) and (6), an association is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to that date, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

(c) On and after October 1, 2013, each carrier shall make available to each small employer all health benefit plans that the carrier offers or sells to small employers or to associations that include small employers for plan years on or after January 1, 2014. Notwithstanding subdivision (d) of Section 10753, for purposes of this subdivision, companies that are affiliated companies or that

are eligible to file a consolidated income tax return shall be treated as one carrier.

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

(1) Prepare a brochure that summarizes all of its health benefit plans and make this summary available to small employers, agents, and brokers upon request. The summary shall include for each plan information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, an explanation of how creditable coverage is calculated if a waiting period is imposed, and a telephone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send copies to agents and brokers representing the carrier. Any entity that provides administrative services only with regard to a health benefit plan written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan.

(2) For each health benefit plan, prepare a more detailed evidence of coverage and make it available to small employers, agents and brokers upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making selections of benefit plan designs. An entity that provides administrative services only with regard to a health benefit plan written or issued by another carrier shall not be required to prepare an evidence of coverage for that health benefit plan.

(3) Provide copies of the current summary brochure to all agents or brokers who represent the carrier and, upon updating the brochure, send copies of the updated brochure to agents and brokers representing the carrier for the purpose of selling health benefit plans.

(4) Notwithstanding subdivision (c) of Section 10753, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(e) Every agent or broker representing one or more carriers for the purpose of selling health benefit plans to small employers shall do all of the following:

(1) When providing information on a health benefit plan to a small employer but making no specific recommendations on particular benefit plan designs:

(A) Advise the small employer of the carrier's obligation to sell to any small employer any of the health benefit plans it offers to small employers, consistent with PPACA, and provide them, upon request, with the actual rates that would be charged to that employer for a given health benefit plan.

(B) Notify the small employer that the agent or broker will procure rate and benefit information for the small employer on any health benefit plan offered by a carrier for whom the agent or broker sells health benefit plans.

(C) Notify the small employer that, upon request, the agent or broker will provide the small employer with the summary brochure required in paragraph (1) of subdivision (d) for any benefit plan design offered by a carrier whom the agent or broker represents.

(D) Notify the small employer of the availability of coverage and the availability of tax credits for certain employers consistent with PPACA and state law, including any rules, regulations, or guidance issued in connection therewith.

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

(3) Prior to filing an application for a small employer for a particular health benefit plan:

(A) For each of the health benefit plans offered by the carrier whose health benefit plan the agent or broker is presenting, provide the small employer with the benefit summary required in paragraph (1) of subdivision (d) and the premium for that particular employer.

(B) Notify the small employer that, upon request, the agent or broker will provide the small employer with an evidence of coverage brochure for each health benefit plan the carrier offers.

(C) Obtain a signed statement from the small employer acknowledging that the small employer has received the disclosures required by this paragraph and Section 10753.16.

(f) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of

an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10753, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section 10753, is provided in connection with a guaranteed association.

(g) No carrier shall reject an application from a small employer for a health benefit plan provided:

(1) The small employer as defined by subparagraph (A) of paragraph (1) of subdivision (q) of Section 10753 offers health benefits to 100 percent of its eligible employees as defined in paragraph (1) of subdivision (f) of Section 10753. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(h) No carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(2) Encourage or direct small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

(i) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer or the small employer's employees. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage

shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(j) (1) A health benefit plan offered to a small employer, as defined in Section 1304(b) of PPACA and in Section 10753, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

(2) Notwithstanding Section 10291.5, a carrier shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire prior to enrollment under a health benefit plan. A carrier shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(k) (1) A carrier shall consider the claims experience of all insureds in all nongrandfathered health benefit plans offered in the state that are subject to subdivision (a), including those insureds who do not enroll in the plans through the Exchange, to be members of a single risk pool.

(2) Each plan year, a carrier shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the carrier's

nongrandfathered health benefit plans shall use the applicable index rate, as adjusted for total expected market-wide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A carrier may vary premiums rates for a particular nongrandfathered health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for health benefit plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

~~(k)~~

(l) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

~~*(l)* (1) With respect to the obligation to provide coverage newly issued under subdivision (c), to the extent permitted by PPACA, the carrier may cease enrolling new small employer groups and new eligible employees as defined by paragraph (2) of subdivision (f) of Section 10753 if it certifies to the commissioner that the number of eligible employees and dependents, of the employers newly enrolled or insured during the current calendar year by the carrier equals or exceeds: (A) in the case of a carrier that administers any self-funded health benefits arrangement in California, 10 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or~~

~~insured in California by that carrier as of December 31 of the preceding year, or (B) in the case of a carrier that does not administer any self-funded health benefit arrangements in California, 8 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured by the carrier in California as of December 31 of the preceding year.~~

~~(2) Certification shall be deemed approved if not disapproved within 45 days after submission to the commissioner. If that certification is approved, the small employer carrier shall not offer coverage to any small employers under any health benefit plans during the remainder of the current year. If the certification is not approved, the carrier shall continue to issue coverage as required by subdivision (c) and be subject to administrative penalties as established in Section 10753.18.~~

(m) (1) Except as provided in paragraph (2), this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, in which case carriers subject to this section shall instead be governed by Section 10705 to the extent permitted by federal law, and all references in this chapter to this section shall instead refer to Section 10705, except for purposes of paragraph (2).

(2) Paragraph (3) of subdivision (b) of this section shall remain operative as it relates to health benefit plans offered through the Exchange.

SEC. 31. Section 10753.06.5 of the Insurance Code is amended to read:

10753.06.5. (a) With respect to health benefit plans offered outside the Exchange, after a small employer submits a completed application, the carrier shall, within 30 days, notify the employer of the employer's actual rates in accordance with Section 10753.14. The employer shall have 30 days in which to exercise the right to buy coverage at the quoted rates.

(b) ~~(1)~~ Except as required under ~~paragraph (2)~~ *subdivision (c)*, when a small employer submits a premium payment, based on the quoted rates, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of a month, coverage shall become effective no later than the first day of the following month. When that payment is neither delivered nor

postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

~~(2) A carrier shall apply coverage effective dates for health benefit plans subject to this chapter consistent with the coverage effective dates applicable to nongrandfathered individual health benefit plans set forth in Section 10965.3.~~

(c) (1) With respect to a health benefit plan offered through the Exchange, a carrier shall apply coverage effective dates consistent with those required under Section 155.720 of Title 45 of the Code of Federal Regulations and paragraph (2) of subdivision (e) of Section 10965.3.

(2) With respect to a health benefit plan offered outside the Exchange for which an individual applies during a special enrollment period described in paragraph (3) of subdivision (b) of Section 10753.05, the following provisions shall apply:

(A) Coverage under the plan shall become effective no later than the first day of the first calendar month beginning after the date the carrier receives the request for special enrollment.

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

~~(c)~~

(d) During the first 30 days of coverage, the small employer shall have the option of changing coverage to a different health benefit plan offered by the same carrier. If a small employer notifies the carrier of the change within the first 15 days of a month, coverage under the new health benefit plan shall become effective no later than the first day of the following month. If a small employer notifies the carrier of the change after the 15th day of a month, coverage under the new health benefit plan shall become effective no later than the first day of the second month following notification.

~~(d)~~

(e) All eligible employees and dependents listed on the small employer's completed application shall be covered on the effective date of the health benefit plan.

SEC. 32. Section 10753.11 of the Insurance Code is amended to read:

10753.11. *(a)* To the extent permitted by PPACA, no carrier shall be required by the provisions of this chapter *to do any of the following*:

~~(a) To offer coverage to, or accept applications from, a small employer as defined in subparagraph (A) of paragraph (1) of subdivision (q) of Section 10753, where the small employer is not physically located in a carrier's approved service areas.~~

~~(b)~~

(1) To offer coverage to or accept applications from a small employer ~~as defined in subparagraph (B) of paragraph (1) of subdivision (q) of Section 10753~~ where the small employer is seeking coverage for eligible employees who do not *live,* work, or reside in a carrier's approved service areas.

~~(c) To include in a health benefit plan an otherwise eligible employee or dependent, when the eligible employee or dependent does not work or reside within a carrier's approved service area, except as provided in Section 10753.02.1.~~

~~(d)~~

(2) (A) To offer coverage to, or accept applications from, a small employer for a benefits plan design within an area if the commissioner has found ~~that the carrier will~~ *all of the following:*

(i) The carrier will not have the capacity within the area in its network of providers to deliver service adequately to the eligible employees and dependents of that employee because of its obligations to existing group contractholders and enrollees ~~and that the~~.

(ii) The carrier is applying this paragraph uniformly to all employers without regard to the claims experience of those employers, and their employees and dependents, or any health status-related factor relating to those employees and dependents.

(iii) The action is not unreasonable or clearly inconsistent with the intent of this chapter.

~~A carrier~~

(B) A carrier that cannot offer coverage to small employers in a specific service area because it is lacking sufficient capacity *as described in this paragraph* may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the *later of the following dates:*

(i) The 181st day after the date that coverage is denied pursuant to this paragraph.

(ii) The date the carrier notifies the commissioner that it has regained capacity to deliver services to small employers, and certifies to the commissioner that from the date of the notice it will enroll all small groups requesting coverage from the carrier until the carrier has met the requirements of subdivision ~~(h)~~ *(g)* of Section 10753.05.

(C) Subparagraph (B) shall not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage as described in Sections 10273.4 and 10753.13.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to the requirements of this section.

~~(e) To offer coverage to a small employer, or an eligible employee as defined in paragraph (2) of subdivision (f) of Section 10753, who within 12 months of application for coverage terminated from a health benefit plan offered by the carrier.~~

SEC. 33. Section 10753.12 of the Insurance Code is amended to read:

10753.12. (a) A carrier shall not be required to offer coverage or accept applications for benefit plan designs pursuant to this chapter where the ~~commissioner determines that the~~ *carrier demonstrates to the satisfaction of the commissioner both of the following:*

(1) The acceptance of an application or applications would place the carrier in a financially impaired condition.

(2) The carrier is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees and dependents or any health status-related factor relating to those employees and dependents.

(b) The commissioner's determination *under subdivision (a)* shall follow an evaluation that includes a certification by the commissioner that the acceptance of an application or applications would place the carrier in a financially impaired condition.

(c) A carrier that has not offered coverage or accepted applications pursuant to this chapter shall not offer coverage or accept applications for any individual or group health benefit plan until the ~~commissioner has determined that~~ *later of the following dates:*

(1) The 181st day after the date that coverage is denied pursuant to this section.

(2) The date on which the carrier ~~has ceased~~ *ceases* to be financially impaired, *as determined by the commissioner*.

(d) Subdivision (c) shall not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage as described in Sections 10273.4, 10273.6, and 10753.13.

(e) Coverage offered within a service area after the period specified in subdivision (c) shall be subject to the requirements of this section.

SEC. 34. Section 10753.14 of the Insurance Code is amended to read:

10753.14. (a) The premium rate for a health benefit plan issued, amended, or renewed on or after January 1, 2014, shall vary with respect to the particular coverage involved only by the following:

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services *and the age rating curve established by the Centers for Medicare and Medicaid Services* pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined ~~based on the individual's birthday~~ *using the individual's age as of the date of the plan issuance or renewal, as applicable,* and shall not vary by more than three to one for ~~adults~~ *like individuals of different age who are 21 years of age or older as described in federal regulations adopted pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3))*.

(2) (A) Geographic region. ~~The~~ *Except as provided in subparagraph (B), the* geographic regions for purposes of rating shall be the following:

(i) Region 1 shall consist of the Counties of Alpine, *Amador, Butte, Calaveras, Colusa,* Del Norte, *El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra,* Siskiyou, ~~Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter,~~ *Sutter, Tehama, Trinity, Tulare, Tuolomne, Yolo, and* Yuba ~~, Colusa, Amador, Calaveras, and Tuolumne~~.

(ii) Region 2 shall consist of the Counties of *Fresno, Imperial, Kern, Madera, Mariposa, Merced,* Napa, *Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano,* Sonoma, ~~Solano, and Marin~~ *and Stanislaus*.

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

~~(iv)~~

(iii) Region ~~4~~ *3* shall consist of the ~~County~~ *Counties* of *Alameda, Contra Costa, Marin,* San Francisco*, San Mateo, and Santa Clara.*

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

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

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

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

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

~~(x) Region 10 shall consist of the Counties of San Joaquin, Stanislaus, Merced, Mariposa, and Tulare.~~

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

~~(xii)~~

(iv) Region ~~12~~ *4* shall consist of the Counties of ~~San Luis Obispo,~~ *Orange,* Santa Barbara, and Ventura.

~~(xiii) Region 13 shall consist of the Counties of Mono, Inyo, and Imperial.~~

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

~~(xv)~~

(v) Region ~~15~~ *5* shall consist of the ~~ZIP Codes in~~ *County of* Los Angeles ~~County starting with 906 to 912, inclusive, 915, 917, 918, and 935~~.

~~(xvi) Region 16 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (xv).~~

~~(xvii) Region 17 shall consist of the Counties of San Bernardino and Riverside.~~

~~(xviii) Region 18 shall consist of the County of Orange.~~

~~(xix)~~

(vi) Region ~~19~~ *6* shall consist of the ~~County~~ *Counties* of *Riverside, San Bernardino, and* San Diego.

(B) For the 2015 plan year and plan years thereafter, the geographic regions for purposes of rating shall be the following, subject to federal approval if required pursuant to Section 2701

of the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and obtained by the department and the Department of Managed Health Care by July 1, 2014:

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

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

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

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

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

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

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

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

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

(x) Region 10 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (ix).

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

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

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

~~(B)~~

(C) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Health Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and make a report to the appropriate policy committees of the Legislature.

(3) Whether the health benefit plan covers an individual or family, as described in PPACA.

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

(c) The total premium charged to a small employer pursuant to this section shall be determined by summing the premiums of covered employees and dependents in accordance with Section 147.102(c)(1) of Title 45 of the Code of Federal Regulations.

~~(c)~~

(d) The rating period for rates subject to this section shall be no less than 12 months from the date of issuance or renewal of the health benefit plan.

~~(d)~~

~~This section shall become inoperative if Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added by Section 1201 of PPACA, is repealed, in which case rates for health benefit plans subject to this section shall instead be subject to Section 10714, to the extent permitted by federal law, and all references to this section shall be deemed to be references to Section 10714.~~

SEC. 35. Section 10901.3 of the Insurance Code is amended to read:

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

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

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

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

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

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

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

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

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

(d) This section shall remain in effect only until January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later, and as of

that date is repealed, unless a later enacted statute, that becomes operative on or before that date, deletes or extends the date on which it is repealed.

SEC. 36. Section 10901.3 is added to the Insurance Code, to read:

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

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

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

(d) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 37. Section 10901.9 of the Insurance Code is amended to read:

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

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

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

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

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

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

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

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

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

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

~~(2)~~

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

(d) This section shall remain in effect only until January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later, and as of that date is repealed, unless a later enacted statute, that becomes operative on or before that date, deletes or extends the date on which it is repealed.

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

10901.9. (a) Commencing on the date on which the act adding this section becomes operative, premiums for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

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

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

(b) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 39. Section 10902.4 of the Insurance Code is repealed.

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

SEC. 40. The heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of the Insurance Code is amended to read:

CHAPTER 9.7. ~~INDIVIDUAL~~ *CHILD* ACCESS TO HEALTH INSURANCE

SEC. 41. Section 10954 of the Insurance Code is amended to read:

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

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

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

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

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

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

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

"Please consider your options carefully before failing to maintain or ~~renew~~ *renewing* coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for

that child, the premium for the same coverage may be higher than the premium you pay now."

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

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

~~(f)~~

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

(f) (1) On and after the operative date of the act adding this subdivision, and until January 1, 2014, a carrier shall provide a notice to all applicants for coverage under this chapter and to all insureds, or the responsible party for an insured, renewing coverage under this chapter that contains the following information:

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

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

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

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

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

(3) The department may adopt a model notice to be used by carriers in order to comply with this subdivision, and shall consult with the Department of Managed Health Care in adopting that model notice. Use of the model notice shall not require prior approval of the department. Any model notice designated by the department for purposes of this section shall not be subject to the

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

SEC. 42. Section 10960.5 is added to the Insurance Code, to read:

10960.5. This chapter shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

SEC. 43. Chapter 9.9 (commencing with Section 10965) is added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 9.9. Individual Access to Health Insurance

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

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

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

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

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

(e) "Health benefit plan" means any individual or group policy of health insurance, as defined in Section 106. The term does not include a health insurance policy that provides excepted benefits, as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91), subject to Section 10965.01, a health insurance conversion policy offered pursuant to Section 12682.1, a health insurance policy provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2, or a health insurance policy offered to a federally eligible defined individual under Chapter

8.5 (commencing with Section 10785), to the extent consistent with PPACA.

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

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

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

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

(j) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

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

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

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

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

"This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

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

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

(b) As used in this section, "policies or certificates of specified disease" and "policies or certificates of hospital confinement indemnity" mean policies or certificates of insurance sold to an insured to supplement other health insurance coverage as specified in this section.

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

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

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

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

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

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

(d) (1) Subject to paragraph (2), commencing January 1, 2014, a health insurer shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

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

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

(ii) "Loss of minimum essential coverage" includes, but is not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code. "Loss of minimum essential coverage" also includes loss of that coverage for a reason that is not due to the fault of the individual.

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 10119.2 and 10384.17.

(B) He or she gains a dependent or becomes a dependent.

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

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

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

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

(G) He or she was receiving services from a contracting provider under another health benefit plan, as defined in Section 10965 or Section 1399.845 of the Health and Safety Code for one of the

conditions described in subdivision (a) of Section 10133.56 and that provider is no longer participating in the health benefit plan.

(H) He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.

(I) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 63 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 63 days from the date of a triggering event identified in paragraph (1) to select a plan offered through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the following provisions shall apply:

(1) The effective date of coverage selected pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(2) Notwithstanding paragraph (1), in the case where an individual acquires a dependent or becomes a dependent by entering into a registered domestic partnership pursuant to Section 297 of the Family Code and applies for coverage of that domestic partner consistent with subdivision (d), the coverage effective date shall be the first day of the month following the date he or she selects a plan through the Exchange, unless an earlier date is agreed to under Section 155.420(b)(3) of Title 45 of the Code of Federal Regulations.

(f) With respect to an individual health benefit plan offered outside the Exchange, the following provisions shall apply:

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

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

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

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

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or

postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the insurer receives the request for special enrollment.

(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

(h) (1) A health insurer shall consider the claims experience of all insureds in all individual health benefit plans offered in the

state that are subject to subdivision (a), including those insureds who do not enroll in the plans through the Exchange, to be members of a single risk pool.

(2) Each policy year, a health insurer shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the health insurer's health benefit plans in the individual market shall use the applicable index rate, as adjusted for total expected market-wide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A health insurer may vary premiums rates for a particular health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(i) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

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

10965.5. (a) No health insurer or agent or broker shall, directly or indirectly, engage in the following activities:

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

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

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

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

(c) This section shall only apply with respect to individual health benefit plans for policy years on or after January 1, 2014.

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

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

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

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

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services and the age rating curve established by the federal Centers for Medicare and Medicaid Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined using the individual's age as of the date of the plan issuance or renewal, as applicable, and shall not vary by more than three to one for like individuals of different age who are age 21 or older as described in federal regulations adopted pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).

(2) (A) Geographic region. Except as provided in subparagraph (B), the geographic regions for purposes of rating shall be the following:

(i) Region 1 shall consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolomne, Yolo, and Yuba.

(ii) Region 2 shall consist of the Counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(iii) Region 3 shall consist of the Counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(iv) Region 4 shall consist of the Counties of Orange, Santa Barbara, and Ventura.

(v) Region 5 shall consist of the County of Los Angeles.

(vi) Region 6 shall consist of the Counties of Riverside, San Bernardino, and San Diego.

(B) For the 2015 plan year and plan years thereafter, the geographic regions for purposes of rating shall be the following, subject to federal approval if required pursuant to Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg) and

obtained by the department and the Department of Managed Health Care by July 1, 2014:

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

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

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

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

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

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

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

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

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

(x) Region 10 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (ix).

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

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

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

(C) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Heath Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and make a report to the appropriate policy committees of the Legislature.

(3) Whether the plan covers an individual or family, as described in PPACA.

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

(c) With respect to family coverage under an individual health benefit plan, the rating variation permitted under paragraph (1) of

subdivision (a) shall be applied based on the portion of the premium attributable to each family member covered under the plan. The total premium for family coverage shall be determined by summing the premiums for each individual family member. In determining the total premium for family members, premiums for no more than the three oldest family members who are under age 21 shall be taken into account.

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

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

(f) The requirement for submitting a report imposed under subparagraph (B) of paragraph (2) of subdivision (a) is inoperative on June 1, 2021, pursuant to Section 10231.5 of the Government Code.

10965.11. (a) A health insurer shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to Section 10965.3 in the case of any of the following:

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

(2) (A) Within a specific service area or portion of a service area, if the insurer reasonably anticipates and demonstrates to the satisfaction of the commissioner both of the following:

(i) It will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual because of its obligations to existing insureds.

(ii) It is applying this subparagraph uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(B) A health insurer that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area pursuant to subparagraph (A) shall not offer an individual health benefit plan in that area until the later of the following dates:

(i) The 181st day after the date coverage is denied pursuant to this paragraph.

(ii) The date the insurer notifies the commissioner that it has the ability to deliver services to individuals, and certifies to the commissioner that from the date of the notice it will enroll all individuals requesting coverage in that area from the insurer.

(C) Subparagraph (B) shall not limit the insurer's ability to renew coverage already in force or relieve the insurer of the responsibility to renew that coverage as described in Section 10273.6.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to this section.

(b) (1) A health insurer may decline to offer an individual health benefit plan to an individual if the insurer demonstrates to the satisfaction of the commissioner both of the following:

(A) It does not have the financial reserves necessary to underwrite additional coverage. In determining whether this subparagraph has been satisfied, the commissioner shall consider, but not be limited to, the insurer's compliance with the requirements of this part and the rules adopted under those provisions.

(B) It is applying this subdivision uniformly to all individuals without regard to the claims experience of those individuals or any health status-related factor relating to those individuals.

(2) A health insurer that denies coverage to an individual under paragraph (1) shall not offer coverage in the individual market before the later of the following dates:

(A) The 181st day after the date coverage is denied pursuant to this subdivision.

(B) The date the insurer demonstrates to the satisfaction of the commissioner that the insurer has sufficient financial reserves necessary to underwrite additional coverage.

(3) Paragraph (2) shall not limit the insurer's ability to renew coverage already in force or relieve the insurer of the responsibility to renew that coverage as described in Section 10273.6.

(C) Coverage offered within a service area after the period specified in paragraph (2) shall be subject to this section.

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

10965.13. (a) A health insurer that receives an application for an individual health benefit plan outside the Exchange during the initial open enrollment period, an annual enrollment period, or a special enrollment period described in Section 10965.3 shall inform

the applicant that he or she may be eligible for lower cost coverage through the Exchange and shall inform the applicant of the applicable enrollment period provided through the Exchange described in Section 10965.3.

(b) On or before October 1, 2013, and annually thereafter, a health insurer shall issue a notice to a policyholder enrolled in an individual health benefit plan offered outside the Exchange. The notice shall inform the policyholder that he or she may be eligible for lower cost coverage through the Exchange and shall inform the policyholder of the applicable open enrollment period provided through the Exchange described in Section 10965.3.

(c) This section shall not apply where the individual health benefit plan described in subdivision (a) or (b) is a grandfathered health plan.

10965.15. (a) On or before October 1, 2013, and annually thereafter, a health insurer shall issue the following notice to all policyholders enrolled in an individual health benefit plan that is a grandfathered health plan:

New improved health insurance options are available in California. You currently have health insurance that is exempt from many of the new requirements. For instance, your policy may not include certain consumer protections that apply to other policies, such as the requirement for the provision of preventive health services without any cost sharing and the prohibition against increasing your rates based on your health status. You have the option to remain in your current policy or switch to a new policy. Under the new rules, a health insurance company cannot deny your application based on any health conditions you may have. For more information about your options, please contact the California Health Benefit Exchange, the Office of Patient Advocate, your policy representative, an insurance broker, or a health care navigator.

(b) Commencing October 1, 2013, a health insurer shall include the notice described in subdivision (a) in any renewal material of the individual grandfathered health plan and in any application for dependent coverage under the individual grandfathered health plan.

(c) A health insurer shall not advertise or market an individual health benefit plan that is a grandfathered health plan for purposes of enrolling a dependent of a policyholder into the plan for policy years on or after January 1, 2014. Nothing in this subdivision shall be construed to prohibit an individual enrolled in an individual grandfathered health plan from adding a dependent to that plan to the extent permitted by PPACA.

10965.16. Except as otherwise provided in this chapter, this chapter shall be implemented to the extent that it meets or exceeds the requirements set forth in PPACA.

SEC. 44. Part 6.25 (commencing with Section 12694.50) is added to Division 2 of the Insurance Code, to read:

PART 6.25. CHIP CONTINUATION COVERAGE

12694.50. For purposes of this part, the following definitions shall apply:

(a) "Board" means the Managed Risk Medical Insurance Board.

(b) "Department" means the State Department of Health Care Services.

(c) "Participating dental plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal dental services under insurance policies or health care service plan contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that, on or after January 1, 2012, has or had a contract with the board or the department to provide coverage to program subscribers:

(1) A dental insurer holding a valid outstanding certificate of authority from the commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(d) "Participating health plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or health care service plan contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that, on or after January 1, 2012, has or had a contract with

the board or the department to provide coverage to program subscribers:

(1) A private health insurer holding a valid outstanding certificate of authority from the commissioner.

(2) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, including a plan operating as a geographic managed care plan pursuant to a contract entered into under Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(3) A county organized health system.

(e) "Participating vision care plan" means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal vision services under insurance policies or health care service plan contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that, on or after January 1, 2012, has or had a contract with the board or the department to provide coverage to program subscribers:

(1) A vision insurer holding a valid outstanding certificate of authority from the commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(f) "Program" means the federal Children's Health Insurance Program established in the state pursuant to Title XXI of the federal Social Security Act and includes the program established under Part 6.2 (commencing with Section 12693) and the transition of the enrollees in that program pursuant to Section 14005.26 of the Welfare and Institutions Code.

(g) "Qualified beneficiary" means an individual who meets all of the following requirements:

(1) On or after January 1, 2012, received or receives coverage under a participating dental, health, or vision plan under the program.

(2) Was disenrolled or will be disenrolled from the program due to loss of eligibility because of his or her age.

(3) Is not eligible for full scope benefits under the Medi-Cal program.

(h) "Subscriber" means an individual who is eligible for and enrolled in the program.

12694.52. (a) Until January 1, 2014, or the date that is six months following the operative date of this part, whichever date is later, every participating health, dental, and vision plan shall offer coverage to a qualified beneficiary. The plan shall offer the qualified beneficiary the same coverage that the beneficiary had immediately prior to disenrollment from the program or coverage with benefits that are most equivalent to the coverage that the beneficiary had immediately prior to disenrollment from the program.

(b) Except as otherwise provided in this part, coverage provided pursuant to this part shall be provided under the same terms and conditions that apply to similarly situated subscribers in the program under the applicable participating plan.

(c) (1) For a qualified beneficiary who was disenrolled from the program prior to the operative date of this part, the participating health, dental, or vision plan shall provide written notification of eligibility for coverage pursuant to this section to the qualified beneficiary within 30 days of the operative date of this part.

(2) For a qualified beneficiary who is disenrolled from the program on or after the operative date of this part, the participating health, dental, or vision plan shall provide written notification of eligibility for coverage pursuant to this section to the qualified beneficiary no less than 30 days prior to disenrollment from the program.

(3) The notice required under this subdivision shall state that the qualified beneficiary must elect the coverage in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the participating plan within 60 days of the mailing of the notice. The notice shall also state that a qualified beneficiary electing coverage pursuant to this part shall pay to the participating plan the amount of the required premium payment, as set forth in Section 12694.54.

(d) A qualified beneficiary shall have 60 days from the mailing of the notice required under subdivision (c) to elect coverage pursuant to this section. The election shall be in writing and shall be delivered by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the participating plan.

(e) A qualified beneficiary receiving coverage pursuant to this part shall continue to receive that coverage until the coverage is terminated at his or her election or pursuant to Section 12694.56, whichever occurs first.

(f) A qualified beneficiary receiving coverage pursuant to this part shall be considered part of the participating plan and treated as similarly situated subscribers for contract purposes, unless otherwise specified in this part.

12694.54. (a) A qualified beneficiary who elects coverage pursuant to this part shall make the following premium payments to the participating health, dental, or vision plan, as applicable:

(1) To the participating health plan: not more than 110 percent of the average per subscriber payment made by the board or the department to all participating health plans for coverage provided under the program to subscribers who are one year of age or older.

(2) To the participating dental plan: not more than 110 percent of the average per subscriber payment made by the board or the department to all participating dental plans for coverage provided under the program to subscribers who are one year of age or older.

(3) To the participating vision plan: not more than 110 percent of the average per subscriber payment made by the board or the department to all participating vision plans for coverage provided under the program to subscribers who are one year of age or older.

(b) The premium payments required by this section shall be made before the due date of each payment but not more frequently than on a monthly basis.

12694.56. The continuation coverage provided pursuant to this part shall terminate at the first to occur of the following:

(a) The date 18 months after the effective date of coverage elected pursuant to this part.

(b) The end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with Section 12694.54 and the terms and conditions of the policy or contract. In the case of nonpayment of premiums, reinstatement shall be governed by the terms and conditions of the policy or contract.

(c) The qualified beneficiary moves out of the plan's service area or the qualified beneficiary, or applicant acting on his or her behalf, commits fraud or deception in the use of plan services.

SEC. 45. The Insurance Commissioner may adopt regulations to implement the changes made to the Insurance Code by this act pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The commissioner shall consult with the Director of the Department of Managed Health Care prior to adopting any regulations pursuant to this section for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to entities regulated by the commissioner and those regulated by the Director of the Department of Managed Health Care.

SEC. 46. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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