

AMENDED IN SENATE SEPTEMBER 3, 2013

AMENDED IN SENATE AUGUST 14, 2013

AMENDED IN SENATE JUNE 20, 2013

AMENDED IN ASSEMBLY MAY 2, 2013

AMENDED IN ASSEMBLY APRIL 16, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 1180

Introduced by Assembly Member Pan

February 22, 2013

An act to amend Sections 1363.06, 1363.07, 1366.3, 1366.35, 1373.6, 1373.621, 1373.622, 1399.805, 1399.810, 1399.811, and 1399.815 of, and to add Section 1373.620 to, the Health and Safety Code, and to amend Sections 10116.5, 10127.14, 10127.16, 10127.18, 10785, 10901.3, 10901.8, 10901.9, 10902.3, 12672, and 12682.1 of, to add Section 12682.2 to, and to repeal Section 10902.6 of, the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1180, as amended, Pan. Health care coverage: federally eligible defined individuals: conversion or continuation of coverage.

(1) 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 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 make these provisions of law applicable only to individual grandfathered health plans, as defined, previously issued to federally eligible defined individuals, unless and until specified provisions of the federal Patient Protection and Affordable Care Act (PPACA) are amended or repealed, as specified. The bill would also require a health care service plan or an insurer, at least 60 days prior to the plan or policy renewal date, to issue prescribed notifications to a person who is enrolled in an individual health benefit plan or individual health insurance policy that is not a grandfathered health plan. The bill would also impose the notification requirement for individuals who are covered under the California Major Risk Medical Insurance Program. 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.

(2) Existing law establishes a formula establishing the upper limit for premium charges for health care plans and health insurance. Existing law authorizes the plan and insurer to adjust the premium based on family size, as specified.

This bill, after January 1, 2014, and until January 1, 2020, instead of the current formula, would limit the premium charged for coverage provided in 2014 to the rate charged in 2013 multiplied by 1.09 and would limit the rate of growth thereafter, as specified.

(3) Existing law requires a health care service plan or health insurer to offer continuation or conversion of individual or group coverage for a specified period of time and under certain circumstances.

The bill would make those provisions inoperative, unless and until specified provisions of PPACA are amended or repealed, as specified, and would make conforming changes.

(4) This bill would incorporate additional changes to Section 10785 of the Insurance Code proposed by AB 1391, that would become operative only if AB 1391 and this bill are both chaptered and become effective on or before January 1, 2014, and this bill is chaptered last.

(4)

(5) 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.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

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

1 SECTION 1. Section 1363.06 of the Health and Safety Code
2 is amended to read:

3 1363.06. (a) The Department of Managed Health Care and the
4 Department of Insurance shall compile information as required by
5 this section and Section 10127.14 of the Insurance Code into two
6 comparative benefit matrices. The first matrix shall compare benefit
7 packages offered pursuant to Section 1373.62 and Section 10127.15
8 of the Insurance Code. The second matrix shall compare benefit
9 packages offered pursuant to Sections 1366.35, 1373.6, and
10 1399.804 and Sections 10785, 10901.2, and 12682.1 of the
11 Insurance Code.

12 (b) The comparative benefit matrix shall include:

13 (1) Benefit information submitted by health care service plans
14 pursuant to subdivision (d) and by health insurers pursuant to
15 Section 10127.14 of the Insurance Code.

16 (2) The following statements in at least 12-point type at the top
17 of the matrix:

18 (A) "This benefit summary is intended to help you compare
19 coverage and benefits and is a summary only. For a more detailed
20 description of coverage, benefits, and limitations, please contact
21 the health care service plan or health insurer."

22 (B) "The comparative benefit summary is updated annually, or
23 more often if necessary to be accurate."

1 (C) “The most current version of this comparative benefit
2 summary is available on (address of the plan’s or insurer’s Internet
3 Web site).”

4 This subparagraph applies only to those plans or insurers that
5 maintain an Internet Web site.

6 (3) The telephone number or numbers that may be used by an
7 applicant to contact either the department or the Department of
8 Insurance, as appropriate, for further assistance.

9 (c) The Department of Managed Health Care and the Department
10 of Insurance shall jointly prepare two standardized templates for
11 use by health care service plans and health insurers in submitting
12 the information required pursuant to subdivision (d) and
13 subdivision (d) of Section 10127.14 of the Insurance Code. The
14 templates shall be exempt from the provisions of Chapter 3.5
15 (commencing with Section 11340) of Part 1 of Division 3 of Title
16 2 of the Government Code.

17 (d) Health care service plans, except specialized health care
18 service plans, shall submit the following to the department by
19 January 31, 2003, and annually thereafter:

20 (1) A summary explanation of the following for each product
21 described in subdivision (a).

22 (A) Eligibility requirements.

23 (B) The full premium cost of each benefit package in the service
24 area in which the individual and eligible dependents work or reside.

25 (C) When and under what circumstances benefits cease.

26 (D) The terms under which coverage may be renewed.

27 (E) Other coverage that may be available if benefits under the
28 described benefit package cease.

29 (F) The circumstances under which choice in the selection of
30 physicians and providers is permitted.

31 (G) Lifetime and annual maximums.

32 (H) Deductibles.

33 (2) A summary explanation of coverage for the following,
34 together with the corresponding copayments and limitations, for
35 each product described in subdivision (a):

36 (A) Professional services.

37 (B) Outpatient services.

38 (C) Hospitalization services.

39 (D) Emergency health coverage.

40 (E) Ambulance services.

- 1 (F) Prescription drug coverage.
- 2 (G) Durable medical equipment.
- 3 (H) Mental health services.
- 4 (I) Residential treatment.
- 5 (J) Chemical dependency services.
- 6 (K) Home health services.
- 7 (L) Custodial care and skilled nursing facilities.

8 (3) The telephone number or numbers that may be used by an
9 applicant to access a health care service plan customer service
10 representative and to request additional information about the plan
11 contract.

12 (4) Any other information specified by the department in the
13 template.

14 (e) Each health care service plan shall provide the department
15 with updates to the information required by subdivision (d) at least
16 annually, or more often if necessary to maintain the accuracy of
17 the information.

18 (f) The department and the Department of Insurance shall make
19 the comparative benefit matrices available on their respective
20 Internet Web sites and to the health care service plans and health
21 insurers for dissemination as required by Section 1373.6 and
22 Section 12682.1 of the Insurance Code, after confirming the
23 accuracy of the description of the matrices with the health care
24 service plans and health insurers.

25 (g) As used in this section and Section 1363.07, “benefit matrix”
26 shall have the same meaning as benefit summary.

27 (h) (1) This section shall be inoperative on January 1, 2014.

28 (2) If Section 5000A of the Internal Revenue Code, as added
29 by Section 1501 of PPACA, is repealed or amended to no longer
30 apply to the individual market, as defined in Section 2791 of the
31 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
32 section shall become operative on the date of that repeal or
33 amendment.

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

39 SEC. 2. Section 1363.07 of the Health and Safety Code is
40 amended to read:

1 1363.07. (a) Each health care service plan shall send copies
2 of the comparative benefit matrix prepared pursuant to Section
3 1363.06 on an annual basis, or more frequently as the matrix is
4 updated by the department and the Department of Insurance, to
5 solicitors and solicitor firms and employers with whom the plan
6 contracts.

7 (b) Each health care service plan shall require its representatives
8 and solicitors and soliciting firms with which it contracts, to
9 provide a copy of the comparative benefit matrix to individuals
10 when presenting any benefit package for examination or sale.

11 (c) Each health care service plan that maintains an Internet Web
12 site shall make a downloadable copy of the comparative benefit
13 matrix described in Section 1363.06 available through a link on
14 its site to the Internet Web sites of the department and the
15 Department of Insurance.

16 (d) (1) This section shall be inoperative on January 1, 2014.

17 (2) If Section 5000A of the Internal Revenue Code, as added
18 by Section 1501 of PPACA, is repealed or amended to no longer
19 apply to the individual market, as defined in Section 2791 of the
20 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
21 section shall become operative on the date of that repeal or
22 amendment.

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

28 SEC. 3. Section 1366.3 of the Health and Safety Code is
29 amended to read:

30 1366.3. (a) On and after January 1, 2005, a health care service
31 plan issuing individual plan contracts that ceases to offer individual
32 coverage in this state shall offer coverage to the subscribers who
33 had been covered by those contracts at the time of withdrawal
34 under the same terms and conditions as provided in paragraph (3)
35 of subdivision (a), paragraphs (2) to (4), inclusive, of subdivision
36 (b), subdivisions (c) to (e), inclusive, and subdivision (h) of Section
37 1373.6.

38 (b) A health care service plan that ceases to offer individual
39 coverage in a service area shall offer the coverage required by
40 subdivision (a) to subscribers who had been covered by those

1 contracts at the time of withdrawal, if the plan continues to offer
2 group coverage in that service area. This subdivision shall not
3 apply to coverage provided pursuant to a preferred provider
4 organization.

5 (c) The department may adopt regulations to implement this
6 section.

7 (d) This section shall not apply when a plan participating in
8 Medi-Cal, Healthy Families, Access for Infants and Mothers, or
9 any other contract between the plan and a government entity no
10 longer contracts with the government entity to provide health
11 coverage in the state, or a specified area of the state, nor shall this
12 section apply when a plan ceases entirely to market, offer, and
13 issue any and all forms of coverage in any part of this state after
14 the effective date of this section.

15 (e) (1) On and after January 1, 2014, and except as provided
16 in paragraph (2), the reference to Section 1373.6 in subdivision
17 (a) shall not apply to any health plan contracts.

18 (2) If Section 5000A of the Internal Revenue Code, as added
19 by Section 1501 of the federal Patient Protection and Affordable
20 Care Act (Public Law 111-148), as amended by the federal Health
21 Care and Education Reconciliation Act of 2010 (Public Law
22 111-152), is repealed or amended to no longer apply to the
23 individual market, as defined in Section 2791 of the federal Public
24 Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1)
25 shall become inoperative on the date of that repeal or amendment.

26 SEC. 4. Section 1366.35 of the Health and Safety Code is
27 amended to read:

28 1366.35. (a) A health care service plan providing coverage
29 for hospital, medical, or surgical benefits under an individual health
30 care service plan contract may not, with respect to a federally
31 eligible defined individual desiring to enroll in individual health
32 insurance coverage, decline to offer coverage to, or deny enrollment
33 of, the individual or impose any preexisting condition exclusion
34 with respect to the coverage.

35 (b) For purposes of this section, “federally eligible defined
36 individual” means an individual who, as of the date on which the
37 individual seeks coverage under this section, meets all of the
38 following conditions:

39 (1) Has had 18 or more months of creditable coverage, and
40 whose most recent prior creditable coverage was under a group

1 health plan, a federal governmental plan maintained for federal
2 employees, or a governmental plan or church plan as defined in
3 the federal Employee Retirement Income Security Act of 1974
4 (29 U.S.C. Sec. 1002).

5 (2) Is not eligible for coverage under a group health plan,
6 Medicare, or Medi-Cal, and does not have other health insurance
7 coverage.

8 (3) Was not terminated from his or her most recent creditable
9 coverage due to nonpayment of premiums or fraud.

10 (4) If offered continuation coverage under COBRA or
11 Cal-COBRA, has elected and exhausted that coverage.

12 (c) Every health care service plan shall comply with applicable
13 federal statutes and regulations regarding the provision of coverage
14 to federally eligible defined individuals, including any relevant
15 application periods.

16 (d) A health care service plan shall offer the following health
17 benefit plan contracts under this section that are designed for, made
18 generally available to, are actively marketed to, and enroll,
19 individuals: (1) either the two most popular products as defined
20 in Section 300gg-41(c)(2) of Title 42 of the United States Code
21 and Section 148.120(c)(2) of Title 45 of the Code of Federal
22 Regulations or (2) the two most representative products as defined
23 in Section 300gg-41(c)(3) of the United States Code and Section
24 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as
25 determined by the plan in compliance with federal law. A health
26 care service plan that offers only one health benefit plan contract
27 to individuals, excluding health benefit plans offered to Medi-Cal
28 or Medicare beneficiaries, shall be deemed to be in compliance
29 with this article if it offers that health benefit plan contract to
30 federally eligible defined individuals in a manner consistent with
31 this article.

32 (e) (1) In the case of a health care service plan that offers health
33 insurance coverage in the individual market through a network
34 plan, the plan may do both of the following:

35 (A) Limit the individuals who may be enrolled under that
36 coverage to those who live, reside, or work within the service area
37 for the network plan.

38 (B) Within the service area of the plan, deny coverage to
39 individuals if the plan has demonstrated to the director that the
40 plan will not have the capacity to deliver services adequately to

1 additional individual enrollees because of its obligations to existing
2 group contractholders and enrollees and individual enrollees, and
3 that the plan is applying this paragraph uniformly to individuals
4 without regard to any health status-related factor of the individuals
5 and without regard to whether the individuals are federally eligible
6 defined individuals.

7 (2) A health care service plan, upon denying health insurance
8 coverage in any service area in accordance with subparagraph (B)
9 of paragraph (1), may not offer coverage in the individual market
10 within that service area for a period of 180 days after the coverage
11 is denied.

12 (f) (1) A health care service plan may deny health insurance
13 coverage in the individual market to a federally eligible defined
14 individual if the plan has demonstrated to the director both of the
15 following:

16 (A) The plan does not have the financial reserves necessary to
17 underwrite additional coverage.

18 (B) The plan is applying this subdivision uniformly to all
19 individuals in the individual market and without regard to any
20 health status-related factor of the individuals and without regard
21 to whether the individuals are federally eligible defined individuals.

22 (2) A health care service plan, upon denying individual health
23 insurance coverage in any service area in accordance with
24 paragraph (1), may not offer that coverage in the individual market
25 within that service area for a period of 180 days after the date the
26 coverage is denied or until the issuer has demonstrated to the
27 director that the plan has sufficient financial reserves to underwrite
28 additional coverage, whichever is later.

29 (g) The requirement pursuant to federal law to furnish a
30 certificate of creditable coverage shall apply to health insurance
31 coverage offered by a health care service plan in the individual
32 market in the same manner as it applies to a health care service
33 plan in connection with a group health benefit plan.

34 (h) A health care service plan shall compensate a life agent or
35 fire and casualty broker-agent whose activities result in the
36 enrollment of federally eligible defined individuals in the same
37 manner and consistent with the renewal commission amounts as
38 the plan compensates life agents or fire and casualty broker-agents
39 for other enrollees who are not federally eligible defined

1 individuals and who are purchasing the same individual health
2 benefit plan contract.

3 (i) Every health care service plan shall disclose as part of its
4 COBRA or Cal-COBRA disclosure and enrollment documents,
5 an explanation of the availability of guaranteed access to coverage
6 under the Health Insurance Portability and Accountability Act of
7 1996, including the necessity to enroll in and exhaust COBRA or
8 Cal-COBRA benefits in order to become a federally eligible
9 defined individual.

10 (j) No health care service plan may request documentation as
11 to whether or not a person is a federally eligible defined individual
12 other than is permitted under applicable federal law or regulations.

13 (k) This section shall not apply to coverage defined as excepted
14 benefits pursuant to Section 300gg(c) of Title 42 of the United
15 States Code.

16 (l) This section shall apply to health care service plan contracts
17 offered, delivered, amended, or renewed on or after January 1,
18 2001.

19 (m) (1) This section shall be inoperative on January 1, 2014.

20 (2) If Section 5000A of the Internal Revenue Code, as added
21 by Section 1501 of PPACA, is repealed or amended to no longer
22 apply to the individual market, as defined in Section 2791 of the
23 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
24 this section shall become operative on the date of that repeal or
25 amendment.

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

31 SEC. 5. Section 1373.6 of the Health and Safety Code is
32 amended to read:

33 1373.6. This section does not apply to a specialized health care
34 service plan contract or to a plan contract that primarily or solely
35 supplements Medicare. The director may adopt rules consistent
36 with federal law to govern the discontinuance and replacement of
37 plan contracts that primarily or solely supplement Medicare.

38 (a) (1) Every group contract entered into, amended, or renewed
39 on or after September 1, 2003, that provides hospital, medical, or
40 surgical expense benefits for employees or members shall provide

1 that an employee or member whose coverage under the group
2 contract has been terminated by the employer shall be entitled to
3 convert to nongroup membership, without evidence of insurability,
4 subject to the terms and conditions of this section.

5 (2) If the health care service plan provides coverage under an
6 individual health care service plan contract, other than conversion
7 coverage under this section, it shall offer one of the two plans that
8 it is required to offer to a federally eligible defined individual
9 pursuant to Section 1366.35. The plan shall provide this coverage
10 at the same rate established under Section 1399.805 for a federally
11 eligible defined individual. A health care service plan that is
12 federally qualified under the federal Health Maintenance
13 Organization Act (42 U.S.C. Sec. 300e et seq.) may charge a rate
14 for the coverage that is consistent with the provisions of that act.

15 (3) If the health care service plan does not provide coverage
16 under an individual health care service plan contract, it shall offer
17 a health benefit plan contract that is the same as a health benefit
18 contract offered to a federally eligible defined individual pursuant
19 to Section 1366.35. The health care service plan may offer either
20 the most popular health maintenance organization model plan or
21 the most popular preferred provider organization plan, each of
22 which has the greatest number of enrolled individuals for its type
23 of plan as of January 1 of the prior year, as reported by plans that
24 provide coverage under an individual health care service plan
25 contract to the department or the Department of Insurance by
26 January 31, 2003, and annually thereafter. A health care service
27 plan subject to this paragraph shall provide this coverage with the
28 same cost-sharing terms and at the same premium as a health care
29 service plan providing coverage to that individual under an
30 individual health care service plan contract pursuant to Section
31 1399.805. The health care service plan shall file the health benefit
32 plan it will offer, including the premium it will charge and the
33 cost-sharing terms of the plan, with the Department of Managed
34 Health Care.

35 (b) A conversion contract shall not be required to be made
36 available to an employee or member if termination of his or her
37 coverage under the group contract occurred for any of the following
38 reasons:

39 (1) The group contract terminated or an employer's participation
40 terminated and the group contract is replaced by similar coverage

1 under another group contract within 15 days of the date of
2 termination of the group coverage or the subscriber's participation.

3 (2) The employee or member failed to pay amounts due the
4 health care service plan.

5 (3) The employee or member was terminated by the health care
6 service plan from the plan for good cause.

7 (4) The employee or member knowingly furnished incorrect
8 information or otherwise improperly obtained the benefits of the
9 plan.

10 (5) The employer's hospital, medical, or surgical expense benefit
11 program is self-insured.

12 (c) A conversion contract is not required to be issued to any
13 person if any of the following facts are present:

14 (1) The person is covered by or is eligible for benefits under
15 Title XVIII of the United States Social Security Act.

16 (2) The person is covered by or is eligible for hospital, medical,
17 or surgical benefits under any arrangement of coverage for
18 individuals in a group, whether insured or self-insured.

19 (3) The person is covered for similar benefits by an individual
20 policy or contract.

21 (4) The person has not been continuously covered during the
22 three-month period immediately preceding that person's
23 termination of coverage.

24 (d) Benefits of a conversion contract shall meet the requirements
25 for benefits under this chapter.

26 (e) Unless waived in writing by the plan, written application
27 and first premium payment for the conversion contract shall be
28 made not later than 63 days after termination from the group. A
29 conversion contract shall be issued by the plan which shall be
30 effective on the day following the termination of coverage under
31 the group contract if the written application and the first premium
32 payment for the conversion contract are made to the plan not later
33 than 63 days after the termination of coverage, unless these
34 requirements are waived in writing by the plan.

35 (f) The conversion contract shall cover the employee or member
36 and his or her dependents who were covered under the group
37 contract on the date of their termination from the group.

38 (g) A notification of the availability of the conversion coverage
39 shall be included in each evidence of coverage. However, it shall
40 be the sole responsibility of the employer to notify its employees

1 of the availability, terms, and conditions of the conversion coverage
2 which responsibility shall be satisfied by notification within 15
3 days of termination of group coverage. Group coverage shall not
4 be deemed terminated until the expiration of any continuation of
5 the group coverage. For purposes of this subdivision, the employer
6 shall not be deemed the agent of the plan for purposes of
7 notification of the availability, terms, and conditions of conversion
8 coverage.

9 (h) As used in this section, “hospital, medical, or surgical
10 benefits under state or federal law” do not include benefits under
11 Chapter 7 (commencing with Section 14000) or Chapter 8
12 (commencing with Section 14200) of Part 3 of Division 9 of the
13 Welfare and Institutions Code, or Title XIX of the United States
14 Social Security Act.

15 (i) Every group contract entered into, amended, or renewed
16 before September 1, 2003, shall be subject to the provisions of this
17 section as it read prior to its amendment by Assembly Bill 1401
18 of the 2001–02 Regular Session.

19 (j) (1) On and after January 1, 2014, and except as provided in
20 paragraph (2), this section shall apply only to individual
21 grandfathered health plan contracts previously issued pursuant to
22 this section to federally eligible defined individuals.

23 (2) If Section 5000A of the Internal Revenue Code, as added
24 by Section 1501 of PPACA, is repealed or amended to no longer
25 apply to the individual market, as defined in Section 2791 of the
26 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
27 paragraph (1) shall become inoperative on the date of that repeal
28 or amendment.

29 (3) For purposes of this subdivision, the following definitions
30 apply:

31 (A) “Grandfathered health plan” has the same meaning as that
32 term is defined in Section 1251 of PPACA.

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

38 SEC. 6. Section 1373.620 is added to the Health and Safety
39 Code, to read:

1 1373.620. (a) (1) At least 60 days prior to the plan renewal
2 date, a health care service plan that does not otherwise issue
3 individual health care service plan contracts shall issue the notice
4 described in paragraph (2) to any subscriber enrolled in an
5 individual health benefit plan contract issued pursuant to Section
6 1373.6 that is not a grandfathered health plan.

7 (2) The notice shall be in at least 12-point type and shall include
8 all of the following:

9 (A) Notice that, as of the renewal date, the individual plan
10 contract will not be renewed.

11 (B) The availability of individual health coverage through
12 Covered California, including at least all of the following:

13 (i) That, beginning on January 1, 2014, individuals seeking
14 coverage may not be denied coverage based on health status.

15 (ii) That the premium rates for coverage offered by a health care
16 service plan or a health insurer cannot be based on an individual's
17 health status.

18 (iii) That individuals obtaining coverage through Covered
19 California may, depending upon income, be eligible for premium
20 subsidies and cost-sharing subsidies.

21 (iv) That individuals seeking coverage must obtain this coverage
22 during an open or special enrollment period, and a description of
23 the open and special enrollment periods that may apply.

24 (b) (1) At least 60 days prior to the plan renewal date, a health
25 care service plan that issues individual health care service plan
26 contracts shall issue the notice described in paragraph (2) to a
27 subscriber enrolled in an individual health benefit plan contract
28 issued pursuant to Section 1366.35 or 1373.6 that is not a
29 grandfathered health plan.

30 (2) The notice shall be in at least 12-point type and shall include
31 all of the following:

32 (A) Notice that, as of the renewal date, the individual plan
33 contract will not be renewed.

34 (B) Information regarding the individual health plan contract
35 that the health plan will issue as of January 1, 2014, which the
36 health plan has reasonably concluded is the most comparable to
37 the individual's current plan. The notice shall include information
38 on premiums for the possible replacement plan and instructions
39 that the individual can continue their coverage by paying the
40 premium stated by the due date.

1 (C) Notice of the availability of other individual health coverage
2 through Covered California, including at least all of the following:

3 (i) That, beginning on January 1, 2014, individuals seeking
4 coverage may not be denied coverage based on health status.

5 (ii) That the premium rates for coverage offered by a health care
6 service plan or a health insurer cannot be based on an individual's
7 health status.

8 (iii) That individuals obtaining coverage through Covered
9 California may, depending upon income, be eligible for premium
10 subsidies and cost-sharing subsidies.

11 (iv) That individuals seeking coverage must obtain this coverage
12 during an open or special enrollment period, and a description of
13 the open and special enrollment periods that may apply.

14 (c) No later than September 1, 2013, the department, in
15 consultation with the Department of Insurance, shall adopt uniform
16 model notices that health plans shall use to comply with
17 subdivisions (a) and (b) and Sections 1366.50, 1373.622, and
18 1399.861. Use of the model notices shall not require prior approval
19 by the department. The model notices adopted by the department
20 for purposes of this section shall not be subject to the
21 Administrative Procedure Act (Chapter 3.5 (commencing with
22 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
23 Code). The director may modify the wording of these model notices
24 specifically for the purposes of clarity, readability, and accuracy.

25 (d) The notices required in this section are vital documents,
26 pursuant to clause (iii) of subparagraph (B) of paragraph (1) of
27 subdivision (b) of Section 1367.04, and shall be subject to the
28 applicable requirements of that section.

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

31 (1) "Covered California" means the California Health Benefit
32 Exchange established pursuant to Section 100500 of the
33 Government Code.

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

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

1 SEC. 7. Section 1373.621 of the Health and Safety Code is
2 amended to read:

3 1373.621. (a) Except for a specialized health care service plan,
4 every health care service plan contract that is issued, amended,
5 delivered, or renewed in this state on or after January 1, 1999, that
6 provides hospital, medical, or surgical expense coverage under an
7 employer-sponsored group plan for an employer subject to
8 COBRA, as defined in subdivision (e), or an employer group for
9 which the plan is required to offer Cal-COBRA coverage, as
10 defined in subdivision (f), including a carrier providing replacement
11 coverage under Section 1399.63, shall further offer the former
12 employee the opportunity to continue benefits as required under
13 subdivision (b), and shall further offer the former spouse of an
14 employee or former employee the opportunity to continue benefits
15 as required under subdivision (c).

16 (b) (1) In the event a former employee who worked for the
17 employer for at least five years prior to the date of termination of
18 employment and who is 60 years of age or older on the date
19 employment ends is entitled to and so elects to continue benefits
20 under COBRA or Cal-COBRA for himself or herself and for any
21 spouse, the employee or spouse may further continue benefits
22 beyond the date coverage under COBRA or Cal-COBRA ends, as
23 set forth in paragraph (2). Except as otherwise specified,
24 continuation coverage shall be under the same benefit terms and
25 conditions as if the continuation coverage under COBRA or
26 Cal-COBRA had remained in force. For the employee or spouse,
27 continuation coverage following the end of COBRA or
28 Cal-COBRA is subject to payment of premiums to the health care
29 service plan. Individuals ineligible for COBRA or Cal-COBRA,
30 or who are eligible but have not elected or exhausted continuation
31 coverage under federal COBRA or Cal-COBRA, are not entitled
32 to continuation coverage under this section. Premiums for
33 continuation coverage under this section shall be billed by, and
34 remitted to, the health care service plan in accordance with
35 subdivision (d). Failure to pay the requisite premiums may result
36 in termination of the continuation coverage in accordance with the
37 applicable provisions in the plan's group subscriber agreement
38 with the former employer.

39 (2) The employer shall notify the former employee or spouse
40 or both, or the former spouse of the employee or former employee,

1 of the availability of the continuation benefits under this section
2 in accordance with Section 2800.2 of the Labor Code. To continue
3 health care coverage pursuant to this section, the individual shall
4 elect to do so by notifying the plan in writing within 30 calendar
5 days prior to the date continuation coverage under COBRA or
6 Cal-COBRA is scheduled to end. Every health care service plan
7 and specialized health care service plan shall provide to the
8 employer replacing a health care service plan contract issued by
9 the plan, or to the employer's agent or broker representative, within
10 15 days of any written request, information in possession of the
11 plan reasonably required to administer the requirements of Section
12 2800.2 of the Labor Code.

13 (3) The continuation coverage shall end automatically on the
14 earlier of (A) the date the individual reaches age 65, (B) the date
15 the individual is covered under any group health plan not
16 maintained by the employer or any other health plan, regardless
17 of whether that coverage is less valuable, (C) the date the individual
18 becomes entitled to Medicare under Title XVIII of the Social
19 Security Act, (D) for a spouse, five years from the date on which
20 continuation coverage under COBRA or Cal-COBRA was
21 scheduled to end for the spouse, or (E) the date on which the
22 employer terminates its group subscriber agreement with the health
23 care service plan and ceases to provide coverage for any active
24 employees through that plan, in which case the health care service
25 plan shall notify the former employee or spouse or both of the right
26 to a conversion plan in accordance with Section 1373.6.

27 (c) (1) If a former spouse of an employee or former employee
28 was covered as a qualified beneficiary under COBRA or
29 Cal-COBRA, the former spouse may further continue benefits
30 beyond the date coverage under COBRA or Cal-COBRA ends, as
31 set forth in paragraph (2) of subdivision (b). Except as otherwise
32 specified in this section, continuation coverage shall be under the
33 same benefit terms and conditions as if the continuation coverage
34 under COBRA or Cal-COBRA had remained in force. Continuation
35 coverage following the end of COBRA or Cal-COBRA is subject
36 to payment of premiums to the health care service plan. Premiums
37 for continuation coverage under this section shall be billed by, and
38 remitted to, the health care service plan in accordance with
39 subdivision (d). Failure to pay the requisite premiums may result
40 in termination of the continuation coverage in accordance with the

1 applicable provisions in the plan’s group subscriber agreement
2 with the employer or former employer.

3 (2) The continuation coverage for the former spouse shall end
4 automatically on the earlier of (A) the date the individual reaches
5 65 years of age, (B) the date the individual is covered under any
6 group health plan not maintained by the employer or any other
7 health plan, regardless of whether that coverage is less valuable,
8 (C) the date the individual becomes entitled to Medicare under
9 Title XVIII of the Social Security Act, (D) five years from the date
10 on which continuation coverage under COBRA or Cal-COBRA
11 was scheduled to end for the former spouse, or (E) the date on
12 which the employer or former employer terminates its group
13 subscriber agreement with the health care service plan and ceases
14 to provide coverage for any active employees through that plan.

15 (d) (1) If the premium charged to the employer for a specific
16 employee or dependent eligible under this section is adjusted for
17 the age of the specific employee, or eligible dependent, on other
18 than a composite basis, the rate for continuation coverage under
19 this section shall not exceed 102 percent of the premium charged
20 by the plan to the employer for an employee of the same age as
21 the former employee electing continuation coverage in the case of
22 an individual who was eligible for COBRA, and 110 percent in
23 the case of an individual who was eligible for Cal-COBRA. If the
24 coverage continued is that of a former spouse, the premium charged
25 shall not exceed 102 percent of the premium charged by the plan
26 to the employer for an employee of the same age as the former
27 spouse selecting continuation coverage in the case of an individual
28 who was eligible for COBRA, and 110 percent in the case of an
29 individual who was eligible for Cal-COBRA.

30 (2) If the premium charged to the employer for a specific
31 employee or dependent eligible under this section is not adjusted
32 for age of the specific employee, or eligible dependent, then the
33 rate for continuation coverage under this section shall not exceed
34 213 percent of the applicable current group rate. For purposes of
35 this section, the “applicable current group rate” means the total
36 premiums charged by the health care service plan for coverage for
37 the group, divided by the relevant number of covered persons.

38 (3) However, in computing the premiums charged to the specific
39 employer group, the health care service plan shall not include
40 consideration of the specific medical care expenditures for

1 beneficiaries receiving continuation coverage pursuant to this
2 section.

3 (e) For purposes of this section, “COBRA” means Section
4 4980B of Title 26 of the United States Code, Section 1161 et seq.
5 of Title 29 of the United States Code, and Section 300bb of Title
6 42 of the United States Code, as added by the Consolidated
7 Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272),
8 and as amended.

9 (f) For purposes of this section, “Cal-COBRA” means the
10 continuation coverage that must be offered pursuant to Article 4.5
11 (commencing with Section 1366.20), or Article 1.7 (commencing
12 with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the
13 Insurance Code.

14 (g) For the purposes of this section, “former spouse” means
15 either an individual who is divorced from an employee or former
16 employee or an individual who was married to an employee or
17 former employee at the time of the death of the employee or former
18 employee.

19 (h) Every plan evidence of coverage that is issued, amended,
20 or renewed after July 1, 1999, shall contain a description of the
21 provisions and eligibility requirements for the continuation
22 coverage offered pursuant to this section.

23 (i) This section does not apply to any individual who is not
24 eligible for its continuation coverage prior to January 1, 2005.

25 SEC. 8. Section 1373.622 of the Health and Safety Code is
26 amended to read:

27 1373.622. (a) (1) After the termination of the pilot program
28 under Section 1373.62, a health care service plan shall continue
29 to provide coverage under the same terms and conditions specified
30 in Section 1376.62 as it existed on January 1, 2007, including the
31 terms of the standard benefit plan and the subscriber payment
32 amount, to each individual who was terminated from the program
33 pursuant to subdivision (f) of Section 12725 of the Insurance Code
34 during the term of the pilot program and who enrolled or applied
35 to enroll in a standard benefit plan within 63 days of termination.
36 The Managed Risk Medical Insurance Board shall continue to pay
37 the amount described in Section 1376.62 for each of those
38 individuals. A health care service plan shall not be required to
39 offer the coverage described in Section 1373.62 after the

1 termination of the pilot program to individuals not already enrolled
2 in the program.

3 (2) Notwithstanding paragraph (1) of this subdivision or Section
4 1373.62 as it existed on January 1, 2007, the following rules shall
5 apply:

6 (A) (i) A health care service plan shall not be obligated to
7 provide coverage to any individual pursuant to this section on or
8 after January 1, 2014.

9 (ii) The Managed Risk Medical Insurance Board shall not be
10 obligated to provide any payment to any health care service plan
11 under this section for (I) health care expenses incurred on or after
12 January 1, 2014, or (II) the standard monthly administrative fee,
13 as defined in Section 1373.62 as it existed on January 1, 2007, for
14 any month after December 2013.

15 (B) Each health care service plan providing coverage pursuant
16 to this section shall, on or before October 1, 2013, send a notice
17 to each individual enrolled in a standard benefit plan that is in at
18 least 12-point type and with, at minimum, the following
19 information:

20 (i) Notice as to whether or not the plan will terminate as of
21 January 1, 2014.

22 (ii) The availability of individual health coverage, including
23 through Covered California, including at least all of the following:

24 (I) That, beginning on January 1, 2014, individuals seeking
25 coverage may not be denied coverage based on health status.

26 (II) That the premium rates for coverage offered by a health
27 care service plan or a health insurer cannot be based on an
28 individual's health status.

29 (III) That individuals obtaining coverage through Covered
30 California may, depending upon income, be eligible for premium
31 subsidies and cost-sharing subsidies.

32 (IV) That individuals seeking coverage must obtain this coverage
33 during an open or special enrollment period, and a description of
34 the open and special enrollment periods that may apply.

35 (C) As a condition of receiving payment for a reporting period
36 pursuant to this section, a health care service plan shall provide
37 the Managed Risk Medical Insurance Board with a complete, final
38 annual reconciliation report by the earlier of December 31, 2014,
39 or an earlier date as prescribed by Section 1373.62, as it existed
40 on January 1, 2007, for that reporting period. To the extent that it

1 receives a complete, final reconciliation report for a reporting
2 period by the date required pursuant to this subparagraph, the
3 Managed Risk Medical Insurance Board shall complete
4 reconciliation with the health care service plan for that reporting
5 period within six months of receiving the report.

6 (b) If the state fails to expend, pursuant to this section, sufficient
7 funds for the state's contribution amount to any health care service
8 plan, the health care service plan may increase the monthly
9 payments that its subscribers are required to pay for any standard
10 benefit plan to the amount that the Managed Risk Medical
11 Insurance Board would charge without a state subsidy for the same
12 plan issued to the same individual within the program.

13 (c) The adoption and reoption, by the Managed Risk Medical
14 Insurance Board, of regulations implementing the amendments to
15 this section enacted by the legislation adding this subdivision shall
16 be deemed an emergency and necessary to avoid serious harm to
17 the public peace, health, safety, or general welfare for purposes of
18 Sections 11346.1 and 11349.6 of the Government Code, and the
19 Managed Risk Medical Insurance Board is hereby exempted from
20 the requirement that it describe facts showing the need for
21 immediate action and from review by the Office of Administrative
22 Law.

23 SEC. 9. Section 1399.805 of the Health and Safety Code is
24 amended to read:

25 1399.805. (a) (1) After the federally eligible defined individual
26 submits a completed application form for a plan contract, the plan
27 shall, within 30 days, notify the individual of the individual's actual
28 premium charges for that plan contract, unless the plan has
29 provided notice of the premium charge prior to the application
30 being filed. In no case shall the premium charged for any health
31 care service plan contract identified in subdivision (d) of Section
32 1366.35 exceed the following amounts:

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

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

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

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

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

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

27 (3) This subdivision shall ~~became~~ *become* inoperative on January
28 1, 2014. This subdivision shall become operative on January 1,
29 2020.

30 (b) (1) After the federally eligible defined individual submits
31 a completed application form for a plan contract, the plan shall,
32 within 30 days, notify the individual of the individual’s actual
33 premium charges for that plan contract, unless the plan has
34 provided notice of the premium charge prior to the application
35 being filed. In no case shall the premium charged for any health
36 care service plan contract identified in subdivision (d) of Section
37 1366.35 exceed the following amounts:

38 (A) With respect to the rate charged for coverage provided in
39 2014, the rate charged in 2013 for that coverage multiplied by
40 1.09.

1 (B) With respect to the rate charged for coverage provided in
2 2015 and each subsequent year, the rate charged in the prior year
3 multiplied by a factor of one plus the percentage change in the
4 statewide average premium for the second lowest cost silver plan
5 offered on the Exchange. The Exchange shall determine the
6 percentage change in the statewide average premium for the second
7 lowest cost silver plan by subtracting clause (i) from clause (ii)
8 and dividing the result by clause (i).

9 (i) The average of the premiums charged in the year prior to the
10 applicable year for the second lowest cost silver plan in all 19
11 rating regions, with the premium for each region weighted based
12 on the region's relative share of the Exchange's total individual
13 enrollment according to the latest data available to the Exchange.

14 (ii) The average of the premiums to be charged in the applicable
15 year for the second lowest cost silver plan in all 19 rating regions,
16 with the premium for each region weighted based on the region's
17 relative share of the Exchange's total individual enrollment
18 according to the latest data available to the Exchange.

19 (C) The Exchange shall determine the percentage change in the
20 statewide average premium no later than 30 days after the
21 Exchange's rates for individual coverage for the applicable year
22 have been finalized.

23 (2) For purposes of this subdivision, "Exchange" means the
24 California Health Benefit Exchange established pursuant to Section
25 100500 of the Government Code.

26 (3) This subdivision shall become operative on January 1, 2014.
27 This subdivision shall ~~became~~ *become* inoperative on January 1,
28 2020.

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

37 (d) During the first 30 days after the effective date of the plan
38 contract, the individual shall have the option of changing coverage
39 to a different plan contract offered by the same health care service
40 plan. If the individual notified the plan of the change within the

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

7 (e) (1) On and after January 1, 2014, and except as provided
8 in paragraph (2), this section shall apply only to individual
9 grandfathered health plan contracts previously issued pursuant to
10 this section to federally eligible defined individuals.

11 (2) If Section 5000A of the Internal Revenue Code, as added
12 by Section 1501 of PPACA, is repealed or amended to no longer
13 apply to the individual market, as defined in Section 2791 of the
14 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
15 paragraph (1) shall become inoperative on the date of that repeal
16 or amendment and this section shall apply to health care service
17 plan contracts issued, amended, or renewed on or after that date.

18 (3) For purposes of this subdivision, the following definitions
19 apply:

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

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

27 SEC. 10. Section 1399.810 of the Health and Safety Code is
28 amended to read:

29 1399.810. All health care service plan contracts offered to a
30 federally eligible defined individual shall be renewable with respect
31 to the individual and dependents at the option of the contractholder
32 except in cases of:

- 33 (a) Nonpayment of the required premiums.
- 34 (b) Fraud or misrepresentation by the contractholder.
- 35 (c) The plan ceases to provide or arrange for the provision of
36 health care services for individual health care service plan contracts
37 in this state, provided, however, that the following conditions are
38 satisfied:

1 (1) Notice of the decision to cease new or existing individual
2 health benefit plans in this state is provided to the director and to
3 the contractholder.

4 (2) Individual health care service plan contracts subject to this
5 chapter shall not be canceled for 180 days after the date of the
6 notice required under paragraph (1) and for that business of a plan
7 that remains in force, any plan that ceases to offer for sale new
8 individual health care service plan contracts shall continue to be
9 governed by this article with respect to business conducted under
10 this article.

11 (3) A plan that ceases to write new individual business in this
12 state after January 1, 2001, shall be prohibited from offering for
13 sale new individual health care service plan contracts in this state
14 for a period of three years from the date of the notice to the director.

15 (d) When the plan withdraws a health care service plan contract
16 from the individual market, provided that the plan makes available
17 to eligible individuals all plan contracts that it makes available to
18 new individual business, and provided that the premium for the
19 new plan contract complies with the renewal increase requirements
20 set forth in Section 1399.811.

21 (e) (1) On and after January 1, 2014, and except as provided
22 in paragraph (2), this section shall apply only to individual
23 grandfathered health plan contracts previously issued pursuant to
24 this section to federally eligible defined individuals.

25 (2) If Section 5000A of the Internal Revenue Code, as added
26 by Section 1501 of PPACA, is repealed or amended to no longer
27 apply to the individual market, as defined in Section 2791 of the
28 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
29 paragraph (1) shall become inoperative on the date of that repeal
30 or amendment and this section shall apply to health care service
31 plan contracts issued, amended, or renewed on or after that date.

32 (3) For purposes of this subdivision, the following definitions
33 apply:

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

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

1 SEC. 11. Section 1399.811 of the Health and Safety Code is
2 amended to read:

3 1399.811. (a) (1) Premiums for contracts offered, delivered,
4 amended, or renewed by plans on or after January 1, 2001, shall
5 be subject to the following requirements:

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

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

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

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

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

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

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

15 (2) This subdivision shall ~~became~~ *become* inoperative on January
16 1, 2014. This subdivision shall become operative on January 1,
17 2020.

18 (b) (1) Premiums for contracts offered, delivered, amended, or
19 renewed by plans on or after January 1, 2014, shall be subject to
20 the following requirements:

21 (A) With respect to the rate charged for coverage provided in
22 2014, the rate charged in 2013 for that coverage multiplied by
23 1.09.

24 (B) With respect to the rate charged for coverage provided in
25 2015 and each subsequent year, the rate charged in the prior year
26 multiplied by a factor of one plus the percentage change in the
27 statewide average premium for the second lowest cost silver plan
28 offered on the Exchange. The Exchange shall determine the
29 percentage change in the statewide average premium for the second
30 lowest cost silver plan by subtracting clause (i) from clause (ii)
31 and dividing the result by clause (i).

32 (i) The average of the premiums charged in the year prior to the
33 applicable year for the second lowest cost silver plan in all 19
34 rating regions, with the premium for each region weighted based
35 on the region's relative share of the Exchange's total individual
36 enrollment according to the latest data available to the Exchange.

37 (ii) The average of the premiums to be charged in the applicable
38 year for the second lowest cost silver plan in all 19 rating regions,
39 with the premium for each region weighted based on the region's

1 relative share of the Exchange’s total individual enrollment
2 according to the latest data available to the Exchange.

3 (C) The Exchange shall determine the percentage change in the
4 statewide average premium no later than 30 days after the
5 Exchange’s rates for individual coverage for the applicable year
6 have been finalized.

7 (2) For purposes of this subdivision, “Exchange” means the
8 California Health Benefit Exchange established pursuant to Section
9 100500 of the Government Code.

10 (3) This subdivision shall become operative on January 1, 2014.
11 This subdivision shall ~~became~~ *become* inoperative on January 1,
12 2020.

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

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

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

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

34 (d) (1) On and after January 1, 2014, and except as provided
35 in paragraph (2), this section shall apply only to individual
36 grandfathered health plan contracts previously issued pursuant to
37 this section to federally eligible defined individuals.

38 (2) If Section 5000A of the Internal Revenue Code, as added
39 by Section 1501 of PPACA, is repealed or amended to no longer
40 apply to the individual market, as defined in Section 2791 of the

1 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
2 paragraph (1) shall become inoperative on the date of that repeal
3 or amendment and this section shall apply to health care service
4 plan contracts issued, amended, or renewed on or after that date.

5 (3) For purposes of this subdivision, the following definitions
6 apply:

7 (A) “Grandfathered health plan” has the same meaning as that
8 term is defined in Section 1251 of PPACA.

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

14 SEC. 12. Section 1399.815 of the Health and Safety Code is
15 amended to read:

16 1399.815. (a) At least 20 business days prior to renewing or
17 amending a plan contract subject to this article, or at least 20
18 business days prior to the initial offering of a plan contract subject
19 to this article, a plan shall file a notice of an amendment with the
20 director in accordance with the provisions of Section 1352. The
21 notice of an amendment shall include a statement certifying that
22 the plan is in compliance with subdivision (a) of Section 1399.805
23 and with Section 1399.811. Any action by the director, as permitted
24 under Section 1352, to disapprove, suspend, or postpone the plan’s
25 use of a plan contract shall be in writing, specifying the reasons
26 the plan contract does not comply with the requirements of this
27 chapter.

28 (b) Prior to making any changes in the premium, the plan shall
29 file an amendment in accordance with the provisions of Section
30 1352, and shall include a statement certifying the plan is in
31 compliance with subdivision (a) of Section 1399.805 and with
32 Section 1399.811. All other changes to a plan contract previously
33 filed with the director pursuant to subdivision (a) shall be filed as
34 an amendment in accordance with the provisions of Section 1352,
35 unless the change otherwise would require the filing of a material
36 modification.

37 (c) (1) On and after January 1, 2014, and except as provided
38 in paragraph (2), this section shall apply only to individual
39 grandfathered health plan contracts previously issued pursuant to
40 this section to federally eligible defined individuals.

1 (2) If Section 5000A of the Internal Revenue Code, as added
 2 by Section 1501 of PPACA, is repealed or amended to no longer
 3 apply to the individual market, as defined in Section 2791 of the
 4 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
 5 paragraph (1) shall become inoperative on the date of that repeal
 6 or amendment and this section shall apply to plan contracts issued,
 7 amended, or renewed on or after that date.

8 (3) For purposes of this subdivision, the following definitions
 9 apply:

10 (A) “Grandfathered health plan” has the same meaning as that
 11 term is defined in Section 1251 of PPACA.

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

17 SEC. 13. Section 10116.5 of the Insurance Code is amended
 18 to read:

19 10116.5. (a) Every policy of disability insurance that is issued,
 20 amended, delivered, or renewed in this state on or after January
 21 1, 1999, that provides hospital, medical, or surgical expense
 22 coverage under an employer-sponsored group plan for an employer
 23 subject to COBRA, as defined in subdivision (e), or an employer
 24 group for which the disability insurer is required to offer
 25 Cal-COBRA coverage, as defined in subdivision (f), including a
 26 carrier providing replacement coverage under Section 10128.3,
 27 shall further offer the former employee the opportunity to continue
 28 benefits as required under subdivision (b), and shall further offer
 29 the former spouse of an employee or former employee the
 30 opportunity to continue benefits as required under subdivision (c).

31 (b) (1) If a former employee worked for the employer for at
 32 least five years prior to the date of termination of employment and
 33 is 60 years of age or older on the date employment ends is entitled
 34 to and so elects to continue benefits under COBRA or Cal-COBRA
 35 for himself or herself and for any spouse, the employee or spouse
 36 may further continue benefits beyond the date coverage under
 37 COBRA or Cal-COBRA ends, as set forth in paragraph (2). Except
 38 as otherwise specified in this section, continuation coverage shall
 39 be under the same benefit terms and conditions as if the
 40 continuation coverage under COBRA or Cal-COBRA had remained

1 in force. For the employee or spouse, continuation coverage
2 following the end of COBRA or Cal-COBRA is subject to payment
3 of premiums to the insurer. Individuals ineligible for COBRA or
4 Cal-COBRA or who are eligible but have not elected or exhausted
5 continuation coverage under federal COBRA or Cal-COBRA are
6 not entitled to continuation coverage under this section. Premiums
7 for continuation coverage under this section shall be billed by, and
8 remitted to, the insurer in accordance with subdivision (d). Failure
9 to pay the requisite premiums may result in termination of the
10 continuation coverage in accordance with the applicable provisions
11 in the insurer's group contract with the employer.

12 (2) The employer shall notify the former employee or spouse
13 or both, or the former spouse of the employee or former employee,
14 of the availability of the continuation benefits under this section
15 in accordance with Section 2800.2 of the Labor Code. To continue
16 health care coverage pursuant to this section, the individual shall
17 elect to do so by notifying the insurer in writing within 30 calendar
18 days prior to the date continuation coverage under COBRA or
19 Cal-COBRA is scheduled to end. Every disability insurer shall
20 provide to the employer replacing a group benefit plan policy
21 issued by the insurer, or to the employer's agent or broker
22 representative, within 15 days of any written request, information
23 in possession of the insurer reasonably required to administer the
24 requirements of Section 2800.2 of the Labor Code.

25 (3) The continuation coverage shall end automatically on the
26 earlier of (A) the date the individual reaches age 65, (B) the date
27 the individual is covered under any group health plan not
28 maintained by the employer or any other insurer or health care
29 service plan, regardless of whether that coverage is less valuable,
30 (C) the date the individual becomes entitled to Medicare under
31 Title XVIII of the Social Security Act, (D) for a spouse, five years
32 from the date on which continuation coverage under COBRA or
33 Cal-COBRA was scheduled to end for the spouse, or (E) the date
34 on which the employer terminates its group contract with the
35 insurer and ceases to provide coverage for any active employees
36 through that insurer, in which case the insurer shall notify the
37 former employee or spouse, or both, of the right to a conversion
38 policy.

39 (c) (1) If a former spouse of an employee or former employee
40 was covered as a qualified beneficiary under COBRA or

1 Cal-COBRA, the former spouse may further continue benefits
2 beyond the date coverage under COBRA or Cal-COBRA ends, as
3 set forth in paragraph (2) of subdivision (b). Except as otherwise
4 specified in this section, continuation coverage shall be under the
5 same benefit terms and conditions as if the continuation coverage
6 under COBRA or Cal-COBRA had remained in force. Continuation
7 coverage following the end of COBRA or Cal-COBRA is subject
8 to payment of premiums to the insurer. Premiums for continuation
9 coverage under this section shall be billed by, and remitted to, the
10 insurer in accordance with subdivision (d). Failure to pay the
11 requisite premiums may result in termination of the continuation
12 coverage in accordance with the applicable provisions in the
13 insurer's group contract with the employer or former employer.

14 (2) The continuation coverage for the former spouse shall end
15 automatically on the earlier of (A) the date the individual reaches
16 65 years of age, (B) the date the individual is covered under any
17 group health plan not maintained by the employer or any other
18 health care service plan or insurer, regardless of whether that
19 coverage is less valuable, (C) the date the individual becomes
20 entitled to Medicare under Title XVIII of the Social Security Act,
21 (D) five years from the date on which continuation coverage under
22 COBRA or Cal-COBRA was scheduled to end for the former
23 spouse, or (E) the date on which the employer or former employer
24 terminates its group contract with the insurer and ceases to provide
25 coverage for any active employees through that insurer.

26 (d) (1) If the premium charged to the employer for a specific
27 employee or dependent eligible under this section is adjusted for
28 the age of the specific employee, or eligible dependent, on other
29 than a composite basis, the rate for continuation coverage under
30 this section shall not exceed 102 percent of the premium charged
31 by the insurer to the employer for an employee of the same age as
32 the former employee electing continuation coverage in the case of
33 an individual who was eligible for COBRA, and 110 percent in
34 the case of an individual who was eligible for Cal-COBRA. If the
35 coverage continued is that of a former spouse, the premium charged
36 shall not exceed 102 percent of the premium charged by the plan
37 to the employer for an employee of the same age as the former
38 spouse selecting continuation coverage in the case of an individual
39 who was eligible for COBRA, and 110 percent in the case of an
40 individual who was eligible for Cal-COBRA.

1 (2) If the premium charged to the employer for a specific
2 employee or dependent eligible under this section is not adjusted
3 for age of the specific employee, or eligible dependent, then the
4 rate for continuation coverage under this section shall not exceed
5 213 percent of the applicable current group rate. For purposes of
6 this section, the “applicable current group rate” means the total
7 premiums charged by the insurer for coverage for the group,
8 divided by the relevant number of covered persons.

9 (3) However, in computing the premiums charged to the specific
10 employer group, the insurer shall not include consideration of the
11 specific medical care expenditures for beneficiaries receiving
12 continuation coverage pursuant to this section.

13 (e) For purposes of this section, “COBRA” means Section
14 4980B of Title 26, Section 1161 and following of Title 29, and
15 Section 300bb of Title 42 of the United States Code, as added by
16 the Consolidated Omnibus Budget Reconciliation Act of 1985
17 (Public Law 99-272), and as amended.

18 (f) For purposes of this section, “Cal-COBRA” means the
19 continuation coverage that must be offered pursuant to Article 1.7
20 (commencing with Section 10128.50), or Article 4.5 (commencing
21 with Section 1366.20) of Chapter 2.2 of Division 2 of the Health
22 and Safety Code.

23 (g) For the purposes of this section, “former spouse” means
24 either an individual who is divorced from an employee or former
25 employee or an individual who was married to an employee or
26 former employee at the time of the death of the employee or former
27 employee.

28 (h) Every group benefit plan evidence of coverage that is issued,
29 amended, or renewed after January 1, 1999, shall contain a
30 description of the provisions and eligibility requirements for the
31 continuation coverage offered pursuant to this section.

32 (i) This section does not apply to any individual who is not
33 eligible for its continuation coverage prior to January 1, 2005.

34 SEC. 14. Section 10127.14 of the Insurance Code is amended
35 to read:

36 10127.14. (a) The department and the Department of Managed
37 Health Care shall compile information required by this section and
38 Section 1363.06 of the Health and Safety Code into two
39 comparative benefit matrices. The first matrix shall compare benefit
40 packages offered pursuant to Section 1373.62 of the Health and

1 Safety Code and Section 10127.15. The second matrix shall
2 compare benefit packages offered pursuant to Sections 1366.35,
3 1373.6, and 1399.804 of the Health and Safety Code and Sections
4 10785, 10901.2, and 12682.1.

5 (b) The comparative benefit matrix shall include:

6 (1) Benefit information submitted by health care service plans
7 pursuant to Section 1363.06 of the Health and Safety Code and by
8 health insurers pursuant to subdivision (d).

9 (2) The following statements in at least 12-point type at the top
10 of the matrix:

11 (A) "This benefit summary is intended to help you compare
12 coverage and benefits and is a summary only. For a more detailed
13 description of coverage, benefits, and limitations, please contact
14 the health care service plan or health insurer."

15 (B) "The comparative benefit summary is updated annually, or
16 more often if necessary to be accurate."

17 (C) "The most current version of this comparative benefit
18 summary is available on (address of the plan's or insurer's site)."

19 This subparagraph applies only to those health insurers that
20 maintain an Internet Web site.

21 (3) The telephone number or numbers that may be used by an
22 applicant to contact either the department or the Department of
23 Managed Health Care, as appropriate, for further assistance.

24 (c) The department and the Department of Managed Health
25 Care shall jointly prepare two standardized templates for use by
26 health care service plans and health insurers in submitting the
27 information required pursuant to subdivision (d) of Section 1363.06
28 and subdivision (d). The templates shall be exempt from the
29 provisions of Chapter 3.5 (commencing with Section 11340) of
30 Part 1 of Division 3 of Title 2 of the Government Code.

31 (d) Health insurers shall submit the following to the department
32 by January 31, 2003, and annually thereafter:

33 (1) A summary explanation of the following for each product
34 described in subdivision (a):

35 (A) Eligibility requirements.

36 (B) The full premium cost of each benefit package in the service
37 area in which the individual and eligible dependents work or reside.

38 (C) When and under what circumstances benefits cease.

39 (D) The terms under which coverage may be renewed.

- 1 (E) Other coverage that may be available if benefits under the
2 described benefit package cease.
- 3 (F) The circumstances under which choice in the selection of
4 physicians and providers is permitted.
- 5 (G) Lifetime and annual maximums.
- 6 (H) Deductibles.
- 7 (2) A summary explanation of the following coverages, together
8 with the corresponding copayments and limitations, for each
9 product described in subdivision (a):
- 10 (A) Professional services.
- 11 (B) Outpatient services.
- 12 (C) Hospitalization services.
- 13 (D) Emergency health coverage.
- 14 (E) Ambulance services.
- 15 (F) Prescription drug coverage.
- 16 (G) Durable medical equipment.
- 17 (H) Mental health services.
- 18 (I) Residential treatment.
- 19 (J) Chemical dependency services.
- 20 (K) Home health services.
- 21 (L) Custodial care and skilled nursing facilities.
- 22 (3) The telephone number or numbers that may be used by an
23 applicant to access a health insurer customer service representative
24 and to request additional information about the insurance policy.
- 25 (4) Any other information specified by the department in the
26 template.
- 27 (e) Each health insurer shall provide the department with updates
28 to the information required by subdivision (d) at least annually, or
29 more often if necessary to maintain the accuracy of the information.
- 30 (f) The department and the Department of Managed Health Care
31 shall make the comparative benefit matrices available on their
32 respective Internet Web sites and to the health care service plans
33 and health insurers for dissemination as required by Section 1373.6
34 of the Health and Safety Code and Section 12682.1, after
35 confirming the accuracy of the description of the matrices with
36 the health insurers and health care service plans.
- 37 (g) As used in this section, “benefit matrix” shall have the same
38 meaning as benefit summary.
- 39 (h) This section shall not apply to accident-only, specified
40 disease, hospital indemnity, CHAMPUS supplement, long-term

1 care, Medicare supplement, dental-only, or vision-only insurance
2 policies.

3 (i) (1) This section shall be inoperative on January 1, 2014.

4 (2) If Section 5000A of the Internal Revenue Code, as added
5 by Section 1501 of PPACA, is repealed or amended to no longer
6 apply to the individual market, as defined in Section 2791 of the
7 federal Public Health Service Act (42 U.S.C. Sec. 300g-91), this
8 section shall become operative on the date of that repeal or
9 amendment.

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

15 SEC. 15. Section 10127.16 of the Insurance Code is amended
16 to read:

17 10127.16. (a) (1) After the termination of the pilot program
18 under Section 10127.15, a health insurer shall continue to provide
19 coverage under the same terms and conditions specified in Section
20 10127.15 as it existed on January 1, 2007, including the terms of
21 the standard benefit plan and the subscriber payment amount, to
22 each individual who was terminated from the program, pursuant
23 to subdivision (f) of Section 12725 of the Insurance Code during
24 the term of the pilot program and who enrolled or applied to enroll
25 in a standard benefit plan within 63 days of termination. The
26 Managed Risk Medical Insurance Board shall continue to pay the
27 amount described in Section 10127.15 for each of those individuals.
28 A health insurer shall not be required to offer the coverage
29 described in Section 10127.15 after the termination of the pilot
30 program to individuals not already enrolled in the program.

31 (2) Notwithstanding paragraph (1) of this subdivision or Section
32 10127.15 as it existed on January 1, 2007, the following rules shall
33 apply:

34 (A) (i) A health insurer shall not be obligated to provide
35 coverage to any individual pursuant to this section on or after
36 January 1, 2014.

37 (ii) The Managed Risk Medical Insurance Board shall not be
38 obligated to provide any payment to any health insurer under this
39 section for (I) health care expenses incurred on or after January 1,
40 2014, or (II) the standard monthly administrative fee, as defined

1 in Section 10127.15 as it existed on January 1, 2007, for any month
2 after December, 2013.

3 (B) Each health insurer providing coverage pursuant to this
4 section shall, on or before October 1, 2013, send a notice to each
5 individual enrolled in a standard benefit plan that is in at least
6 12-point type and with, at minimum, the following information:

7 (i) Notice as to whether or not the plan will terminate as of
8 January 1, 2014.

9 (ii) The availability of individual health coverage, including
10 through Covered California, including at least all of the following:

11 (I) That, beginning on January 1, 2014, individuals seeking
12 coverage may not be denied coverage based on health status.

13 (II) That the premium rates for coverage offered by a health
14 care service plan or a health insurer cannot be based on an
15 individual's health status.

16 (III) That individuals obtaining coverage through Covered
17 California may, depending upon income, be eligible for premium
18 subsidies and cost-sharing subsidies.

19 (IV) That individuals seeking coverage must obtain this coverage
20 during an open or special enrollment period, and a description of
21 the open and special enrollment periods that may apply.

22 (C) As a condition of receiving payment for a reporting period
23 pursuant to this section, a health insurer shall provide the Managed
24 Risk Medical Insurance Board with a complete, final annual
25 reconciliation report by the earlier of December 31, 2014, or an
26 earlier date as prescribed by Section 10127.15, as it existed on
27 January 1, 2007, for that reporting period. To the extent that it
28 receives a complete, final reconciliation report for a reporting
29 period by the date required pursuant to this subparagraph, the
30 Managed Risk Medical Insurance Board shall complete
31 reconciliation with the health insurer for that reporting period
32 within six months of receiving the report.

33 (b) If the state fails to expend, pursuant to this section, sufficient
34 funds for the state's contribution amount to any health insurer, the
35 health insurer may increase the monthly payments that its
36 subscribers are required to pay for any standard benefit plan to the
37 amount that the Managed Risk Medical Insurance Board would
38 charge without a state subsidy for the same insurance product
39 issued to the same individual within the program.

1 (c) The adoption and readoption, by the Managed Risk Medical
2 Insurance Board, of regulations implementing the amendments to
3 this section enacted by the legislation adding this subdivision shall
4 be deemed an emergency and necessary to avoid serious harm to
5 the public peace, health, safety, or general welfare for purposes of
6 Sections 11346.1 and 11349.6 of the Government Code, and the
7 Managed Risk Medical Insurance Board is hereby exempted from
8 the requirement that it describe facts showing the need for
9 immediate action and from review by the Office of Administrative
10 Law.

11 SEC. 16. Section 10127.18 of the Insurance Code is amended
12 to read:

13 10127.18. (a) On and after January 1, 2005, a health insurer
14 issuing individual policies of health insurance that ceases to offer
15 individual coverage in this state shall offer coverage to the
16 policyholders who had been covered by those policies at the time
17 of withdrawal under the same terms and conditions as provided in
18 paragraph (3) of subdivision (a), paragraphs (2) to (4), inclusive,
19 of subdivision (b), subdivisions (c) to (e), inclusive, and subdivision
20 (h) of Section 12682.1.

21 (b) The department may adopt regulations to implement this
22 section.

23 (c) This section shall not apply when a plan participating in
24 Medi-Cal, Healthy Families, Access for Infants and Mothers, or
25 any other contract between the plan and a government entity no
26 longer contracts with the government entity to provide health
27 coverage in the state, or a specified area of the state, nor shall this
28 section apply when a plan ceases entirely to market, offer, and
29 issue any and all forms of coverage in any part of this state after
30 the effective date of this section.

31 (d) (1) This section shall be inoperative on January 1, 2014.

32 (2) If Section 5000A of the Internal Revenue Code, as added
33 by Section 1501 of PPACA, is repealed or amended to no longer
34 apply to the individual market, as defined in Section 2791 of the
35 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
36 section shall become operative on the date of that repeal or
37 amendment.

38 (3) For purposes of this subdivision, "PPACA" means the federal
39 Patient Protection and Affordable Care Act (Public Law 111-148),
40 as amended by the federal Health Care and Education

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

3 SEC. 17. Section 10785 of the Insurance Code is amended to
4 read:

5 10785. (a) A disability insurer that covers hospital, medical,
6 or surgical expenses under an individual health benefit plan as
7 defined in subdivision (a) of Section 10198.6 may not, with respect
8 to a federally eligible defined individual desiring to enroll in
9 individual health insurance coverage, decline to offer coverage to,
10 or deny enrollment of, the individual or impose any preexisting
11 condition exclusion with respect to the coverage.

12 (b) For purposes of this section, “federally eligible defined
13 individual” means an individual who, as of the date on which the
14 individual seeks coverage under this section, meets all of the
15 following conditions:

16 (1) Has had 18 or more months of creditable coverage, and
17 whose most recent prior creditable coverage was under a group
18 health plan, a federal governmental plan maintained for federal
19 employees, or a governmental plan or church plan as defined in
20 the federal Employee Retirement Income Security Act of 1974
21 (29 U.S.C. Sec. 1002).

22 (2) Is not eligible for coverage under a group health plan,
23 Medicare, or Medi-Cal, and does not have other health insurance
24 coverage.

25 (3) Was not terminated from his or her most recent creditable
26 coverage due to nonpayment of premiums or fraud.

27 (4) If offered continuation coverage under COBRA or
28 Cal-COBRA, has elected and exhausted that coverage.

29 (c) Every disability insurer that covers hospital, medical, or
30 surgical expenses shall comply with applicable federal statutes
31 and regulations regarding the provision of coverage to federally
32 eligible defined individuals, including any relevant application
33 periods.

34 (d) A disability insurer shall offer the following health benefit
35 plans under this section that are designed for, made generally
36 available to, are actively marketed to, and enroll, individuals:

37 (1) either the two most popular products as defined in Section
38 300gg-41(c)(2) of Title 42 of the United States Code and Section

39 148.120(c)(2) of Title 45 of the Code of Federal Regulations or
40 (2) the two most representative products as defined in Section

1 300gg-41(c)(3) of the United States Code and Section
2 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as
3 determined by the insurer in compliance with federal law. An
4 insurer that offers only one health benefit plan to individuals,
5 excluding health benefit plans offered to Medi-Cal or Medicare
6 beneficiaries, shall be deemed to be in compliance with this chapter
7 if it offers that health benefit plan contract to federally eligible
8 defined individuals in a manner consistent with this chapter.

9 (e) (1) In the case of a disability insurer that offers health benefit
10 plans in the individual market through a network plan, the insurer
11 may do both of the following:

12 (A) Limit the individuals who may be enrolled under that
13 coverage to those who live, reside, or work within the service area
14 for the network plan.

15 (B) Within the service area covered by the health benefit plan,
16 deny coverage to individuals if the insurer has demonstrated to the
17 commissioner that the insured will not have the capacity to deliver
18 services adequately to additional individual insureds because of
19 its obligations to existing group policyholders, group
20 contractholders and insureds, and individual insureds, and that the
21 insurer is applying this paragraph uniformly to individuals without
22 regard to any health status-related factor of the individuals and
23 without regard to whether the individuals are federally eligible
24 defined individuals.

25 (2) A disability insurer, upon denying health insurance coverage
26 in any service area in accordance with subparagraph (B) of
27 paragraph (1), may not offer health benefit plans through a network
28 in the individual market within that service area for a period of
29 180 days after the coverage is denied.

30 (f) (1) A disability insurer may deny health insurance coverage
31 in the individual market to a federally eligible defined individual
32 if the insurer has demonstrated to the commissioner both of the
33 following:

34 (A) The insurer does not have the financial reserves necessary
35 to underwrite additional coverage.

36 (B) The insurer is applying this subdivision uniformly to all
37 individuals in the individual market and without regard to any
38 health status-related factor of the individuals and without regard
39 to whether the individuals are federally eligible defined individuals.

1 (2) A disability insurer, upon denying individual health
2 insurance coverage in any service area in accordance with
3 paragraph (1), may not offer that coverage in the individual market
4 within that service area for a period of 180 days after the date the
5 coverage is denied or until the insurer has demonstrated to the
6 commissioner that the insurer has sufficient financial reserves to
7 underwrite additional coverage, whichever is later.

8 (g) The requirement pursuant to federal law to furnish a
9 certificate of creditable coverage shall apply to health benefits
10 plans offered by a disability insurer in the individual market in the
11 same manner as it applies to an insurer in connection with a group
12 health benefit plan policy or group health benefit plan contract.

13 (h) A disability insurer shall compensate a life agent, property
14 broker-agent, or casualty broker-agent whose activities result in
15 the enrollment of federally eligible defined individuals in the same
16 manner and consistent with the renewal commission amounts as
17 the insurer compensates life agents, property broker-agents, or
18 casualty broker-agents for other enrollees who are not federally
19 eligible defined individuals and who are purchasing the same
20 individual health benefit plan.

21 (i) Every disability insurer shall disclose as part of its COBRA
22 or Cal-COBRA disclosure and enrollment documents, an
23 explanation of the availability of guaranteed access to coverage
24 under the Health Insurance Portability and Accountability Act of
25 1996, including the necessity to enroll in and exhaust COBRA or
26 Cal-COBRA benefits in order to become a federally eligible
27 defined individual.

28 (j) No disability insurer may request documentation as to
29 whether or not a person is a federally eligible defined individual
30 other than is permitted under applicable federal law or regulations.

31 (k) This section shall not apply to coverage defined as excepted
32 benefits pursuant to Section 300gg(c) of Title 42 of the United
33 States Code.

34 (l) This section shall apply to policies or contracts offered,
35 delivered, amended, or renewed on or after January 1, 2001.

36 (m) (1) On and after January 1, 2014, and except as provided
37 in paragraph (2), this section shall apply only to individual
38 grandfathered health plans previously issued pursuant to this
39 section to federally eligible defined individuals.

1 (2) If Section 5000A of the Internal Revenue Code, as added
 2 by Section 1501 of PPACA, is repealed or amended to no longer
 3 apply to the individual market, as defined in Section 2791 of the
 4 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
 5 paragraph (1) shall become inoperative on the date of that repeal
 6 or amendment and this section shall apply to health benefit plans
 7 issued, amended, or renewed on or after that date.

8 (3) For purposes of this subdivision, the following definitions
 9 apply:

10 (A) “Grandfathered health plan” has the same meaning as that
 11 term is defined in Section 1251 of PPACA.

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

17 *SEC. 17.5. Section 10785 of the Insurance Code is amended*
 18 *to read:*

19 10785. (a) A disability insurer that covers hospital, medical,
 20 or surgical expenses under an individual health benefit plan as
 21 defined in subdivision (a) of Section 10198.6 may not, with respect
 22 to a federally eligible defined individual desiring to enroll in
 23 individual health insurance coverage, decline to offer coverage to,
 24 or deny enrollment of, the individual or impose any preexisting
 25 condition exclusion with respect to the coverage.

26 (b) For purposes of this section, “federally eligible defined
 27 individual” means an individual who, as of the date on which the
 28 individual seeks coverage under this section, meets all of the
 29 following conditions:

30 (1) Has had 18 or more months of creditable coverage, and
 31 whose most recent prior creditable coverage was under a group
 32 health plan, a federal governmental plan maintained for federal
 33 employees, or a governmental plan or church plan as defined in
 34 the federal Employee Retirement Income Security Act of 1974
 35 (29 U.S.C. Sec. 1002).

36 (2) Is not eligible for coverage under a group health plan,
 37 Medicare, or Medi-Cal, and does not have other health insurance
 38 coverage.

39 (3) Was not terminated from his or her most recent creditable
 40 coverage due to nonpayment of premiums or fraud.

1 (4) If offered continuation coverage under COBRA or
2 Cal-COBRA, has elected and exhausted that coverage.

3 (c) Every disability insurer that covers hospital, medical, or
4 surgical expenses shall comply with applicable federal statutes
5 and regulations regarding the provision of coverage to federally
6 eligible defined individuals, including any relevant application
7 periods.

8 (d) A disability insurer shall offer the following health benefit
9 plans under this section that are designed for, made generally
10 available to, are actively marketed to, and enroll, individuals:

11 (1) either the two most popular products as defined in Section
12 300gg-41(c)(2) of Title 42 of the United States Code and Section
13 148.120(c)(2) of Title 45 of the Code of Federal Regulations or

14 (2) the two most representative products as defined in Section
15 300gg-41(c)(3) of the United States Code and Section
16 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as
17 determined by the insurer in compliance with federal law. An
18 insurer that offers only one health benefit plan to individuals,
19 excluding health benefit plans offered to Medi-Cal or Medicare
20 beneficiaries, shall be deemed to be in compliance with this chapter
21 if it offers that health benefit plan contract to federally eligible
22 defined individuals in a manner consistent with this chapter.

23 (e) (1) In the case of a disability insurer that offers health benefit
24 plans in the individual market through a network plan, the insurer
25 may do both of the following:

26 (A) Limit the individuals who may be enrolled under that
27 coverage to those who live, reside, or work within the service area
28 for the network plan.

29 (B) Within the service area covered by the health benefit plan,
30 deny coverage to individuals if the insurer has demonstrated to the
31 commissioner that the insured will not have the capacity to deliver
32 services adequately to additional individual insureds because of
33 its obligations to existing group policyholders, group
34 contractholders and insureds, and individual insureds, and that the
35 insurer is applying this paragraph uniformly to individuals without
36 regard to any health status-related factor of the individuals and
37 without regard to whether the individuals are federally eligible
38 defined individuals.

39 (2) A disability insurer, upon denying health insurance coverage
40 in any service area in accordance with subparagraph (B) of

1 paragraph (1), may not offer health benefit plans through a network
2 in the individual market within that service area for a period of
3 180 days after the coverage is denied.

4 (f) (1) A disability insurer may deny health insurance coverage
5 in the individual market to a federally eligible defined individual
6 if the insurer has demonstrated to the commissioner both of the
7 following:

8 (A) The insurer does not have the financial reserves necessary
9 to underwrite additional coverage.

10 (B) The insurer is applying this subdivision uniformly to all
11 individuals in the individual market and without regard to any
12 health status-related factor of the individuals and without regard
13 to whether the individuals are federally eligible defined individuals.

14 (2) A disability insurer, upon denying individual health
15 insurance coverage in any service area in accordance with
16 paragraph (1), may not offer that coverage in the individual market
17 within that service area for a period of 180 days after the date the
18 coverage is denied or until the insurer has demonstrated to the
19 commissioner that the insurer has sufficient financial reserves to
20 underwrite additional coverage, whichever is later.

21 (g) The requirement pursuant to federal law to furnish a
22 certificate of creditable coverage shall apply to health benefits
23 plans offered by a disability insurer in the individual market in the
24 same manner as it applies to an insurer in connection with a group
25 health benefit plan policy or group health benefit plan contract.

26 (h) A disability insurer shall compensate ~~a life agent, property~~
27 ~~broker-agent, or casualty broker-agent~~ *an accident and health*
28 *agent or a life and accident and health agent* whose activities
29 result in the enrollment of federally eligible defined individuals
30 in the same manner and consistent with the renewal commission
31 amounts as the insurer compensates ~~life agents, property~~
32 ~~broker-agents, or casualty broker-agents~~ *accident and health agents*
33 *or life and accident and health agents* for other enrollees who are
34 not federally eligible defined individuals and who are purchasing
35 the same individual health benefit plan.

36 (i) Every disability insurer shall disclose as part of its COBRA
37 or Cal-COBRA disclosure and enrollment documents, an
38 explanation of the availability of guaranteed access to coverage
39 under the *federal* Health Insurance Portability and Accountability
40 Act of 1996, including the necessity to enroll in and exhaust

1 COBRA or Cal-COBRA benefits in order to become a federally
2 eligible defined individual.

3 (j) No disability insurer may request documentation as to
4 whether or not a person is a federally eligible defined individual
5 other than is permitted under applicable federal law or regulations.

6 (k) This section shall not apply to coverage defined as excepted
7 benefits pursuant to Section 300gg(c) of Title 42 of the United
8 States Code.

9 (l) This section shall apply to policies or contracts offered,
10 delivered, amended, or renewed on or after January 1, 2001.

11 (m) (1) *On and after January 1, 2014, and except as provided*
12 *in paragraph (2), this section shall apply only to individual*
13 *grandfathered health plans previously issued pursuant to this*
14 *section to federally eligible defined individuals.*

15 (2) *If Section 5000A of the Internal Revenue Code, as added by*
16 *Section 1501 of PPACA, is repealed or amended to no longer apply*
17 *to the individual market, as defined in Section 2791 of the federal*
18 *Public Health Service Act (42 U.S.C. Sec. 300gg-91), paragraph*
19 *(1) shall become inoperative on the date of that repeal or*
20 *amendment and this section shall apply to health benefit plans*
21 *issued, amended, or renewed on or after that date.*

22 (3) *For purposes of this subdivision, the following definitions*
23 *apply:*

24 (A) *“Grandfathered health plan” has the same meaning as that*
25 *term is defined in Section 1251 of PPACA.*

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

31 SEC. 18. Section 10901.3 of the Insurance Code is amended
32 to read:

33 10901.3. (a) (1) After the federally eligible defined individual
34 submits a completed application form for a health benefit plan,
35 the carrier shall, within 30 days, notify the individual of the
36 individual’s actual premium charges for that health benefit plan
37 design. In no case shall the premium charged for any health benefit
38 plan identified in subdivision (d) of Section 10785 exceed the
39 following amounts:

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

11 (B) For health benefit plans identified in subdivision (d) of
12 Section 10785 that do not offer services through a preferred
13 provider arrangement, 170 percent of the standard premium charged
14 to an individual who is of the same age and resides in the same
15 geographic area as the federally eligible defined individual.
16 However, for a federally eligible defined individual who is between
17 the ages of 60 and 64 years, inclusive, the premium shall not exceed
18 170 percent of the standard premium charged to an individual who
19 is 59 years of age and resides in the same geographic area as the
20 federally eligible defined individual. The individual shall have 30
21 days in which to exercise the right to buy coverage at the quoted
22 premium rates.

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

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

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

35 (3) This subdivision shall ~~became~~ *become* inoperative on January
36 1, 2014. This subdivision shall become operative on January 1,
37 2020.

38 (b) (1) On and after January 1, 2014, after the federally eligible
39 defined individual submits a completed application form for a
40 health benefit plan, the carrier shall, within 30 days, notify the

1 individual of the individual’s actual premium charges for that
2 health benefit plan design. In no case shall the premium charged
3 for any health benefit plan identified in subdivision (d) of Section
4 10785 exceed the following amounts:

5 (A) With respect to the rate charged for coverage provided in
6 2014, the rate charged in 2013 for that coverage multiplied by
7 1.09.

8 (B) With respect to the rate charged for coverage provided in
9 2015 and each subsequent year, the rate charged in the prior year
10 multiplied by a factor of one plus the percentage change in the
11 statewide average premium for the second lowest cost silver plan
12 offered on the Exchange. The Exchange shall determine the
13 percentage change in the statewide average premium for the second
14 lowest cost silver plan by subtracting clause (i) from clause (ii)
15 and dividing the result by clause (i).

16 (i) The average of the premiums charged in the year prior to the
17 applicable year for the second lowest cost silver plan in all 19
18 rating regions, with the premium for each region weighted based
19 on the region’s relative share of the Exchange’s total individual
20 enrollment according to the latest data available to the Exchange.

21 (ii) The average of the premiums to be charged in the applicable
22 year for the second lowest cost silver plan in all 19 rating regions,
23 with the premium for each region weighted based on the region’s
24 relative share of the Exchange’s total individual enrollment
25 according to the latest data available to the Exchange.

26 (C) The Exchange shall determine the percentage change in the
27 statewide average premium no later than 30 days after the
28 Exchange’s rates for individual coverage for the applicable year
29 have been finalized.

30 (2) For purposes of this subdivision, “Exchange” means the
31 California Health Benefit Exchange established pursuant to Section
32 100500 of the Government Code.

33 (3) This subdivision shall become operative on January 1, 2014,
34 and shall become inoperative on January 1, 2020.

35 (c) When a federally eligible defined individual submits a
36 premium payment, based on the quoted premium charges, and that
37 payment is delivered or postmarked, whichever occurs earlier,
38 within the first 15 days of the month, coverage shall begin no later
39 than the first day of the following month. When that payment is
40 neither delivered nor postmarked until after the 15th day of a

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

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

14 (e) (1) On and after January 1, 2014, and except as provided
 15 in paragraph (2), this section shall apply only to individual
 16 grandfathered health plans previously issued pursuant to this
 17 section to federally eligible defined individuals.

18 (2) If Section 5000A of the Internal Revenue Code, as added
 19 by Section 1501 of PPACA, is repealed or amended to no longer
 20 apply to the individual market, as defined in Section 2791 of the
 21 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
 22 paragraph (1) shall become inoperative on the date of that repeal
 23 or amendment and this section shall apply to health benefit plans
 24 issued, amended, or renewed on or after that date.

25 (3) For purposes of this subdivision, the following definitions
 26 apply:

27 (A) “Grandfathered health plan” has the same meaning as that
 28 term is defined in Section 1251 of PPACA.

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

34 SEC. 19. Section 10901.8 of the Insurance Code is amended
 35 to read:

36 10901.8. All health benefit plans offered to a federally eligible
 37 defined individual shall be renewable with respect to the individual
 38 and dependents at the option of the enrolled individual except in
 39 cases of:

40 (a) Nonpayment of the required premiums.

1 (b) Fraud or misrepresentation by the enrolled individual.

2 (c) The carrier ceases to provide or arrange for the provision of
3 health care services for individual health benefit plan contracts in
4 this state, provided, however, that the following conditions are
5 satisfied:

6 (1) Notice of the decision to cease new or existing individual
7 health benefit plans in this state is provided to the commissioner
8 and to the contractholder.

9 (2) Individual health benefit plan contracts subject to this chapter
10 shall not be canceled for 180 days after the date of the notice
11 required under paragraph (1) and for that business of a carrier that
12 remains in force, any carrier that ceases to offer for sale new
13 individual health benefit plan contracts shall continue to be
14 governed by this article with respect to business conducted under
15 this chapter.

16 (3) A carrier that ceases to write new individual business in this
17 state after the effective date of this chapter shall be prohibited from
18 offering for sale new individual health benefit plan contracts in
19 this state for a period of three years from the date of the notice to
20 the commissioner.

21 (d) When a carrier withdraws a health benefit plan design from
22 the individual market, provided that a carrier makes available to
23 eligible individuals all health plan benefit designs that it makes
24 available to new individual business, and provided that premium
25 for the new health benefit plan complies with the renewal increase
26 requirements set forth in Section 10901.9.

27 (e) (1) On and after January 1, 2014, and except as provided
28 in paragraph (2), this section shall apply only to individual
29 grandfathered health plans previously issued pursuant to this
30 section to federally eligible defined individuals.

31 (2) If Section 5000A of the Internal Revenue Code, as added
32 by Section 1501 of PPACA, is repealed or amended to no longer
33 apply to the individual market, as defined in Section 2791 of the
34 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
35 paragraph (1) shall become inoperative on the date of that repeal
36 or amendment and this section shall apply to health benefit plans
37 issued, amended, or renewed on or after that date.

38 (3) For purposes of this subdivision, the following definitions
39 apply:

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

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

8 SEC. 20. Section 10901.9 of the Insurance Code is amended
9 to read:

10 10901.9. (a) Commencing January 1, 2001, premiums for
11 health benefit plans offered, delivered, amended, or renewed by
12 carriers shall be subject to the following requirements:

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

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

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

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

38 (A) For health benefit plans identified in subdivision (d) of
39 Section 10785 that offer services through a preferred provider
40 arrangement, the average premium paid by a subscriber of the

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

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

21 (3) This subdivision shall ~~became~~ *become* inoperative January
22 1, 2014. This subdivision shall become operative on January 1,
23 2020.

24 (b) (1) Commencing January 1, 2014, premiums for health
25 benefit plans offered, delivered, amended, or renewed by carriers
26 shall be subject to the following requirements:

27 (A) With respect to the rate charged for coverage provided in
28 2014, the rate charged in 2013 for that coverage multiplied by
29 1.09.

30 (B) With respect to the rate charged for coverage provided in
31 2015 and each subsequent year, the rate charged in the prior year
32 multiplied by a factor of one plus the percentage change in the
33 statewide average premium for the second lowest cost silver plan
34 offered on the Exchange. The Exchange shall determine the
35 percentage change in the statewide average premium for the second
36 lowest cost silver plan by subtracting clause (i) from clause (ii)
37 and dividing the result by clause (i).

38 (i) The average of the premiums charged in the year prior to the
39 applicable year for the second lowest cost silver plan in all 19
40 rating regions, with the premium for each region weighted based

1 on the region's relative share of the Exchange's total individual
2 enrollment according to the latest data available to the Exchange.

3 (ii) The average of the premiums to be charged in the applicable
4 year for the second lowest cost silver plan in all 19 rating regions,
5 with the premium for each region weighted based on the region's
6 relative share of the Exchange's total individual enrollment
7 according to the latest data available to the Exchange.

8 (C) The Exchange shall determine the percentage change in the
9 statewide average premium no later than 30 days after the
10 Exchange's rates for individual coverage for the applicable year
11 have been finalized.

12 (2) For purposes of this subdivision, "Exchange" means the
13 California Health Benefit Exchange established pursuant to Section
14 100500 of the Government Code.

15 (3) This subdivision shall become operative on January 1, 2014,
16 and shall become inoperative on January 1, 2020.

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

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

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

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

37 (d) (1) On and after January 1, 2014, and except as provided
38 in paragraph (2), this section shall apply only to individual
39 grandfathered health plans previously issued pursuant to this
40 section to federally eligible defined individuals.

1 (2) If Section 5000A of the Internal Revenue Code, as added
2 by Section 1501 of PPACA, is repealed or amended to no longer
3 apply to the individual market, as defined in Section 2791 of the
4 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
5 paragraph (1) shall become inoperative on the date of that repeal
6 or amendment and this section shall apply to health benefit plans
7 issued, amended, or renewed or amended on or after that date.

8 (3) For purposes of this subdivision, the following definitions
9 apply:

10 (A) “Grandfathered health plan” has the same meaning as that
11 term is defined in Section 1251 of PPACA.

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

17 SEC. 21. Section 10902.3 of the Insurance Code is amended
18 to read:

19 10902.3. (a) At least 20 business days prior to renewing or
20 amending a health benefit plan contract subject to this chapter, or
21 at least 20 business days prior to the initial offering of a health
22 benefit plan subject to this chapter, a carrier shall file a statement
23 with the commissioner in the same manner as required for small
24 employers as outlined in Section 10717. The statement shall include
25 a statement certifying that the carrier is in compliance with
26 subdivision (a) of Section 10901.3 and with Section 10901.9. Any
27 action by the commissioner, as permitted under Section 10717, to
28 disapprove, suspend, or postpone the plan’s use of a carrier’s health
29 benefit plan design shall be in writing, specifying the reasons the
30 health benefit plan does not comply with the requirements of this
31 chapter.

32 (b) Prior to making any changes in the premium, the carrier
33 shall file an amendment in the same manner as required for small
34 employers as outlined in Section 10717, and shall include a
35 statement certifying the carrier is in compliance with subdivision
36 (a) of Section 10901.3 and with Section 10901.9. All other changes
37 to a health benefit plan previously filed with the commissioner
38 pursuant to subdivision (a) shall be filed as an amendment in the
39 same manner as required for small employers as outlined in Section
40 10717.

1 (c) (1) On and after January 1, 2014, and except as provided
2 in paragraph (2), this section shall apply only to individual
3 grandfathered health plans previously issued pursuant to this
4 section to federally eligible defined individuals.

5 (2) If Section 5000A of the Internal Revenue Code, as added
6 by Section 1501 of PPACA, is repealed or amended to no longer
7 apply to the individual market, as defined in Section 2791 of the
8 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
9 paragraph (1) shall become inoperative on the date of that repeal
10 or amendment and this section shall apply to health benefit plans
11 issued, amended, or renewed on or after that date.

12 (3) For purposes of this subdivision, the following definitions
13 apply:

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

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

21 SEC. 22. Section 10902.6 of the Insurance Code is repealed.

22 SEC. 23. Section 12672 of the Insurance Code is amended to
23 read:

24 12672. (a) Any group policy issued, amended, or renewed in
25 this state on or after January 1, 1983, which provides insurance
26 for employees or members on an expense-incurred or service basis,
27 other than for a specific disease or for accidental injuries only,
28 shall contain a provision that an employee or member whose
29 coverage under the group policy has been terminated for any reason
30 except as provided in this part, shall be entitled to have a converted
31 policy issued to him or her by the insurer under whose group policy
32 he or she was covered, without evidence of insurability, subject
33 to the terms and conditions of this part.

34 (b) (1) This section shall be inoperative on January 1, 2014.

35 (2) If Section 5000A of the Internal Revenue Code, as added
36 by Section 1501 of PPACA, is repealed or amended to no longer
37 apply to the individual market, as defined in Section 2791 of the
38 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
39 section shall become operative on the date of that repeal or
40 amendment.

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

6 SEC. 24. Section 12682.1 of the Insurance Code is amended
7 to read:

8 12682.1. This section does not apply to a policy that primarily
9 or solely supplements Medicare. The commissioner may adopt
10 rules consistent with federal law to govern the discontinuance and
11 replacement of plan policies that primarily or solely supplement
12 Medicare.

13 (a) (1) Every group policy entered into, amended, or renewed
14 on or after September 1, 2003, that provides hospital, medical, or
15 surgical expense benefits for employees or members shall provide
16 that an employee or member whose coverage under the group
17 policy has been terminated by the employer shall be entitled to
18 convert to nongroup membership, without evidence of insurability,
19 subject to the terms and conditions of this section.

20 (2) If the health insurer provides coverage under an individual
21 health insurance policy, other than conversion coverage under this
22 part, it shall offer one of the two health insurance policies that the
23 insurer is required to offer to a federally eligible defined individual
24 pursuant to Section 10785. The health insurer shall provide this
25 coverage at the same rate established under Section 10901.3 for a
26 federally eligible defined individual.

27 (3) If the health insurer does not provide coverage under an
28 individual health insurance policy, it shall offer a health benefit
29 plan contract that is the same as a health benefit contract offered
30 to a federally eligible defined individual pursuant to Section
31 1366.35. The health insurer shall offer the most popular preferred
32 provider organization plan that has the greatest number of enrolled
33 individuals for its type of plan as of January 1 of the prior year, as
34 reported by plans by January 31, 2003, and annually thereafter,
35 that provide coverage under an individual health care service plan
36 contract to the department or the Department of Managed Health
37 Care. A health insurer subject to this paragraph shall provide this
38 coverage with the same cost-sharing terms and at the same
39 premium as a health care service plan providing coverage to that
40 individual under an individual health care service plan contract

1 pursuant to Section 1399.805. The health insurer shall file the
2 health benefit plan contract it will offer, including the premium it
3 will charge and the cost-sharing terms of the contract, with the
4 Department of Insurance.

5 (b) A conversion policy shall not be required to be made
6 available to an employee or insured if termination of his or her
7 coverage under the group policy occurred for any of the following
8 reasons:

9 (1) The group policy terminated or an employer’s participation
10 terminated and the insurance is replaced by similar coverage under
11 another group policy within 15 days of the date of termination of
12 the group coverage or the employer’s participation.

13 (2) The employee or insured failed to pay amounts due the health
14 insurer.

15 (3) The employee or insured was terminated by the health insurer
16 from the policy for good cause.

17 (4) The employee or insured knowingly furnished incorrect
18 information or otherwise improperly obtained the benefits of the
19 policy.

20 (5) The employer’s hospital, medical, or surgical expense benefit
21 program is self-insured.

22 (c) A conversion policy is not required to be issued to any person
23 if any of the following facts are present:

24 (1) The person is covered by or is eligible for benefits under
25 Title XVIII of the United States Social Security Act.

26 (2) The person is covered by or is eligible for hospital, medical,
27 or surgical benefits under any arrangement of coverage for
28 individuals in a group, whether insured or self-insured.

29 (3) The person is covered for similar benefits by an individual
30 policy or contract.

31 (4) The person has not been continuously covered during the
32 three-month period immediately preceding that person’s
33 termination of coverage.

34 (d) Benefits of a conversion policy shall meet the requirements
35 for benefits under this chapter.

36 (e) Unless waived in writing by the insurer, written application
37 and first premium payment for the conversion policy shall be made
38 not later than 63 days after termination from the group. A
39 conversion policy shall be issued by the insurer which shall be
40 effective on the day following the termination of coverage under

1 the group contract if the written application and the first premium
2 payment for the conversion contract are made to the insurer not
3 later than 63 days after the termination of coverage, unless these
4 requirements are waived in writing by the insurer.

5 (f) The conversion policy shall cover the employee or insured
6 and his or her dependents who were covered under the group policy
7 on the date of their termination from the group.

8 (g) A notification of the availability of the conversion coverage
9 shall be included in each evidence of coverage or other legally
10 required document explaining coverage. However, it shall be the
11 sole responsibility of the employer to notify its employees of the
12 availability, terms, and conditions of the conversion coverage
13 which responsibility shall be satisfied by notification within 15
14 days of termination of group coverage. Group coverage shall not
15 be deemed terminated until the expiration of any continuation of
16 the group coverage. For purposes of this subdivision, the employer
17 shall not be deemed the agent of the insurer for purposes of
18 notification of the availability, terms, and conditions of conversion
19 coverage.

20 (h) As used in this section, “hospital, medical, or surgical
21 benefits under state or federal law” do not include benefits under
22 Chapter 7 (commencing with Section 14000) or Chapter 8
23 (commencing with Section 14200) of Part 3 of Division 9 of the
24 Welfare and Institutions Code, or Title XIX of the United States
25 Social Security Act.

26 (i) (1) On and after January 1, 2014, and except as provided in
27 paragraph (2), this section shall not apply to any health insurance
28 policies.

29 (2) If Section 5000A of the Internal Revenue Code, as added
30 by Section 1501 of PPACA, is repealed or amended to no longer
31 apply to the individual market, as defined in Section 2791 of the
32 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
33 paragraph (1) shall become inoperative on the date of that repeal
34 or amendment and this section shall apply to health insurance
35 policies issued, renewed, or amended on or after that date.

36 (3) For purposes of this subdivision, “PPACA” means the federal
37 Patient Protection and Affordable Care Act (Public Law 111-148),
38 as amended by the federal Health Care and Education
39 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
40 regulations, or guidance issued pursuant to that law.

1 SEC. 25. Section 12682.2 is added to the Insurance Code, to
2 read:

3 12682.2. (a) (1) At least 60 days prior to the policy renewal
4 date, an insurer that does not otherwise issue individual health
5 insurance policies shall issue the notice described in paragraph (2)
6 to any policyholder of an individual health insurance policy issued
7 pursuant to Section 12682.1 that is not a grandfathered health plan.

8 (2) The notice shall be in at least 12-point type and shall include
9 all of the following information:

10 (A) Notice that, as of the renewal date, the individual policy
11 will not be renewed.

12 (B) The availability of individual health coverage through
13 Covered California, including at least all of the following:

14 (i) That, beginning on January 1, 2014, individuals seeking
15 coverage may not be denied coverage based on health status.

16 (ii) That the premium rates for coverage offered by a health care
17 service plan or a health insurer cannot be based on an individual's
18 health status.

19 (iii) That individuals obtaining coverage through Covered
20 California may, depending upon income, be eligible for premium
21 subsidies and cost-sharing subsidies.

22 (iv) That individuals seeking coverage must obtain this coverage
23 during an open or special enrollment period, and describe the open
24 and special enrollment periods that may apply.

25 (b) (1) At least 60 days prior to the policy renewal date, an
26 insurer that issues individual health insurance policies shall issue
27 the notice described in paragraph (2) to a policyholder of an
28 individual health insurance policy issued pursuant to Section 10785
29 or 12682.1 that is not a grandfathered health plan.

30 (2) The notice shall be in at least 12-point type and shall include
31 all of the following:

32 (A) Notice that, as of the renewal date, the individual policy
33 shall not be renewed.

34 (B) Information regarding the individual health insurance policy
35 that the insurer will issue as of January 1, 2014, which the insurer
36 has reasonably concluded is the most comparable to the
37 individual's current policy. The notice shall include information
38 on premiums for the possible replacement policy and instructions
39 that the individual can continue their coverage by paying the
40 premium stated by the due date.

1 (C) Notice of the availability of other individual health coverage
2 through Covered California, including at least all of the following:

3 (i) That, beginning on January 1, 2014, individuals seeking
4 coverage may not be denied coverage based on health status.

5 (ii) That the premium rates for coverage offered by a health care
6 service plan or a health insurer cannot be based on an individual's
7 health status.

8 (iii) That individuals obtaining coverage through Covered
9 California may, depending upon income, be eligible for premium
10 subsidies and cost-sharing subsidies.

11 (iv) That individuals seeking coverage must obtain this coverage
12 during an open or special enrollment period, and describe the open
13 and special enrollment periods that may apply.

14 (c) No later than September 1, 2013, the commissioner, in
15 consultation with the Department of Managed Health Care, shall
16 adopt uniform model notices that health-plans insurers shall use
17 to comply with subdivisions (a) and (b) and Sections 10127.16,
18 10786, and 10965.13. Use of the model notices shall not require
19 prior approval by the department. The model notices adopted for
20 purposes of this section shall not be subject to the Administrative
21 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
22 Part 1 of Division 3 of Title 2 of the Government Code). The
23 ~~director~~-commissioner may modify the wording of these model
24 notices specifically for purposes of clarity, readability, and
25 accuracy.

26 (d) The notices required under this section are vital documents,
27 pursuant to clause (iii) of subparagraph (B) of paragraph (1) of
28 subdivision (b) of Section 10133.8, and shall be subject to the
29 requirements of that section.

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

32 (1) "Covered California" means the California Health Benefit
33 Exchange established pursuant to Section 100500 of the
34 Government Code.

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

37 (3) "PPACA" means the federal Patient Protection and
38 Affordable Care Act (Public Law 111-148), as amended by the
39 federal Health Care and Education Reconciliation Act of 2010

1 (Public Law 111-152), and any rules, regulations, or guidance
 2 issued pursuant to that law.

3 *SEC. 26. Section 17.5 of this bill incorporates amendments to*
 4 *Section 10785 of the Insurance Code proposed by both this bill*
 5 *and Assembly Bill 1391. It shall only become operative if (1) both*
 6 *bills are enacted and become effective on or before January 1,*
 7 *2014, but this bill becomes operative first, (2) each bill amends*
 8 *Section 10785 of the Insurance Code, and (3) this bill is enacted*
 9 *after Assembly Bill 1391, in which case Section 10785 of the*
 10 *Insurance Code, as amended by Section 17 of this bill, shall remain*
 11 *operative only until the operative date of Assembly Bill 1391, at*
 12 *which time Section 17.5 of this bill shall become operative.*

13 ~~SEC. 26.~~

14 *SEC. 27. No reimbursement is required by this act pursuant to*
 15 *Section 6 of Article XIII B of the California Constitution because*
 16 *the only costs that may be incurred by a local agency or school*
 17 *district will be incurred because this act creates a new crime or*
 18 *infraction, eliminates a crime or infraction, or changes the penalty*
 19 *for a crime or infraction, within the meaning of Section 17556 of*
 20 *the Government Code, or changes the definition of a crime within*
 21 *the meaning of Section 6 of Article XIII B of the California*
 22 *Constitution.*

23 ~~SEC. 27.~~

24 *SEC. 28. This act is an urgency statute necessary for the*
 25 *immediate preservation of the public peace, health, or safety within*
 26 *the meaning of Article IV of the Constitution and shall go into*
 27 *immediate effect. The facts constituting the necessity are:*

28 *In order for the public to be informed in a timely manner of*
 29 *critical changes to health care coverage, it is necessary that this*
 30 *bill take effect immediately.*