

AMENDED IN SENATE MARCH 17, 2014

SENATE BILL

No. 959

Introduced by Senator Hernandez

February 6, 2014

An act to amend *Section 100503 of the Government Code, to amend Sections 1357.503, 1366.6, 1367.005, 1367.006, 1374.21, 1385.03, 1385.06, 1385.07, 1385.11, 1389.25, and 1399.849 of the Health and Safety Code, and to amend Sections 10112.27, 10112.28, 10112.3, 10113.9, 10181.3, 10181.6, 10181.7, 10181.11, 10199.1, 10753.05, and 10965.3 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

SB 959, as amended, Hernandez. ~~Health care coverage: small group and individual markets: single risk pool: index rate: coverage.~~

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA requires a health insurance issuer to consider all enrollees in its individual market plans to be part of a single risk pool and to consider all enrollees in its small group market plans to be part of a single risk pool. PPACA also requires an issuer to establish an index rate for each of those markets based on the total combined claim costs for providing essential health benefits within the single risk pool for that market and authorizes the issuer to vary premium rates from the index rate based only on specified factors. PPACA requires that the index rate be adjusted based on

Exchange user fees and expected payments and charges under certain risk adjustment and reinsurance programs.

Existing law establishes the California Health Benefit Exchange within state government for the purpose of facilitating the purchase of qualified health plans through the Exchange by qualified individuals and small employers. 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 Department of Insurance. Existing law requires a health care service plan and a health insurer to consider as a single risk pool the claims experience of all enrollees and insureds in its nongrandfathered small employer plans, *whether offered as health care service plan contracts or health insurance policies*, and to also consider as a single risk pool the claims experience of all enrollees and insureds in its nongrandfathered individual market plans, *whether offered as health care service plan contracts or health insurance policies*. Existing law requires a plan or insurer to establish an index rate for those markets, as specified, and authorizes the plan or insurer to vary premium rates from the index rate based only on specified factors. Existing law requires that the index rate be adjusted based on expected payments and charges under the risk adjustment and reinsurance programs specified under PPACA.

This bill would *require that both the enrollees of nongrandfathered individual health benefit plans issued by a health care service plan and the insureds of nongrandfathered individual health benefit plans issued by a health insurer that is a corporate affiliate, subsidiary, or parent of the plan be part of a single risk pool and would make parallel changes with respect to the small group market. The bill would require that the index rate also be adjusted based on Exchange user fees, as specified under PPACA. ~~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.~~*

PPACA requires a health insurance issuer offering coverage in the individual or small group market to ensure that the coverage includes the essential health benefits package and defines this package to mean coverage that, among other requirements, provides the platinum, gold, silver, or bronze level of coverage or, in the individual market, provides catastrophic coverage to specified individuals. Existing law requires health care service plans and health insurers participating in the

Exchange to fairly and affirmatively offer, market, and sell in the Exchange at least one product in each of these 5 levels of coverage. Existing law requires a health care service plan or health insurer that does not participate in the Exchange to offer at least one standardized product designated by the Exchange in each of the platinum, gold, silver, and bronzed levels of coverage.

This bill would specify that health care service plans and health insurers participating in the small group market of the Exchange are only required to fairly and affirmatively offer, market, and sell in that market the platinum, gold, silver, and bronze levels of coverage. The bill would also specify that the requirement for plans or insurers not participating in the Exchange to offer at least one standardized product designated by the Exchange in each of those levels of coverage only applies to the individual and small group markets.

Existing law prohibits a health care service plan or a health insurer offering coverage in the individual market from changing the premium rate or coverage without providing specified notice to the subscriber or policyholder at least 60 days prior to the contract or policy renewal date.

The bill would require that the notice be sent on the earlier of 60 days prior to the renewal date or 15 days prior to the start of the annual enrollment period applicable to the contract or policy.

Existing law requires a plan or insurer that declines to offer coverage or denies enrollment for an individual or his or her dependents applying for individual coverage or that offers individual or small group coverage at a rate that is higher than the standard rate to provide the applicant with the reason for the decision in writing.

This bill would delete those requirements.

Existing law requires a health care service plan or health insurer in the individual or small group market to file rate information with the Department of Managed Health Care or the Department of Insurance, as applicable, at least 60 days prior to implementing a rate change and requires the filing to be concurrent with the notice sent to subscribers prior to increasing premium rates. Existing law requires that the rate filing include specified information regarding the proposed rate increase and the plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category. Existing law authorizes the plan to provide aggregated additional data that demonstrates year-to-year cost increases in specific benefit categories

in major geographic regions of the state to be defined by the department to include no more than 9 regions.

This bill would eliminate the requirement that the rate filing be concurrent with the notice sent to subscribers prior to increasing premium rates. The bill would also require that a rate filing include specified information regarding a plan or insurer’s proposed rate change, rather than rate increase, and would require that the geographic regions correspond with those regions used by the plan to establish premium rates.

The bill would make other related, conforming, and technical changes.

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

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

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

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

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

1 SECTION 1. Section 100503 of the Government Code, as
2 amended by Section 4 of Chapter 5 of the First Extraordinary
3 Session of the Statutes of 2013, is amended to read:

4 100503. In addition to meeting the minimum requirements of
5 Section 1311 of the federal act, the board shall do all of the
6 following:

7 (a) Determine the criteria and process for eligibility, enrollment,
8 and disenrollment of enrollees and potential enrollees in the
9 Exchange and coordinate that process with the state and local
10 government entities administering other health care coverage
11 programs, including the State Department of Health Care Services,
12 the Managed Risk Medical Insurance Board, and California
13 counties, in order to ensure consistent eligibility and enrollment
14 processes and seamless transitions between coverage.

15 (b) Develop processes to coordinate with the county entities
16 that administer eligibility for the Medi-Cal program and the entity
17 that determines eligibility for the Healthy Families Program,

1 including, but not limited to, processes for case transfer, referral,
2 and enrollment in the Exchange of individuals applying for
3 assistance to those entities, if allowed or required by federal law.

4 (c) Determine the minimum requirements a carrier must meet
5 to be considered for participation in the Exchange, and the
6 standards and criteria for selecting qualified health plans to be
7 offered through the Exchange that are in the best interests of
8 qualified individuals and qualified small employers. The board
9 shall consistently and uniformly apply these requirements,
10 standards, and criteria to all carriers. In the course of selectively
11 contracting for health care coverage offered to qualified individuals
12 and qualified small employers through the Exchange, the board
13 shall seek to contract with carriers so as to provide health care
14 coverage choices that offer the optimal combination of choice,
15 value, quality, and service.

16 (d) Provide, in each region of the state, a choice of qualified
17 health plans at each of the five levels of coverage contained in
18 subsections (d) and (e) of Section 1302 of the federal act, *subject*
19 *to subdivision (e) of this section, paragraph (2) of subdivision (d)*
20 *of Section 1366.6 of the Health and Safety Code, and paragraph*
21 *(2) of subdivision (d) of Section 10112.3 of the Insurance Code.*

22 (e) Require, as a condition of participation in the *individual*
23 *market of the Exchange*, carriers to fairly and affirmatively offer,
24 market, and sell in the *individual market of the Exchange* at least
25 one product within each of the five levels of coverage contained
26 in subsections (d) and (e) of Section 1302 of the federal act *and*
27 *require, as a condition of participation in the SHOP Program,*
28 *carriers to fairly and affirmatively offer, market, and sell in the*
29 *SHOP Program at least one product within each of the four levels*
30 *of coverage contained in subsection (d) of Section 1302 of the*
31 *federal act.* The board may require carriers to offer additional
32 products within each of those ~~five~~ levels of coverage. This
33 subdivision shall not apply to a carrier that solely offers
34 supplemental coverage in the Exchange under paragraph (10) of
35 subdivision (a) of Section 100504.

36 (f) (1) Except as otherwise provided in this section and Section
37 100504.5, require, as a condition of participation in the Exchange,
38 carriers that sell any products outside the Exchange to do both of
39 the following:

1 (A) Fairly and affirmatively offer, market, and sell all products
2 made available to individuals in the Exchange to individuals
3 purchasing coverage outside the Exchange.

4 (B) Fairly and affirmatively offer, market, and sell all products
5 made available to small employers in the Exchange to small
6 employers purchasing coverage outside the Exchange.

7 (2) For purposes of this subdivision, “product” does not include
8 contracts entered into pursuant to Part 6.2 (commencing with
9 Section 12693) of Division 2 of the Insurance Code between the
10 Managed Risk Medical Insurance Board and carriers for enrolled
11 Healthy Families beneficiaries or contracts entered into pursuant
12 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
13 (commencing with Section 14200) of, Part 3 of Division 9 of the
14 Welfare and Institutions Code between the State Department of
15 Health Care Services and carriers for enrolled Medi-Cal
16 beneficiaries. “Product” also does not include a bridge plan product
17 offered pursuant to Section 100504.5.

18 (3) Except as required by Section 1301(a)(1)(C)(ii) of the federal
19 act, a carrier offering a bridge plan product in the Exchange may
20 limit the products it offers in the Exchange solely to a bridge plan
21 product contract.

22 (g) Determine when an enrollee’s coverage commences and the
23 extent and scope of coverage.

24 (h) Provide for the processing of applications and the enrollment
25 and disenrollment of enrollees.

26 (i) Determine and approve cost-sharing provisions for qualified
27 health plans.

28 (j) Establish uniform billing and payment policies for qualified
29 health plans offered in the Exchange to ensure consistent
30 enrollment and disenrollment activities for individuals enrolled in
31 the Exchange.

32 (k) Undertake activities necessary to market and publicize the
33 availability of health care coverage and federal subsidies through
34 the Exchange. The board shall also undertake outreach and
35 enrollment activities that seek to assist enrollees and potential
36 enrollees with enrolling and reenrolling in the Exchange in the
37 least burdensome manner, including populations that may
38 experience barriers to enrollment, such as the disabled and those
39 with limited English language proficiency.

1 (l) Select and set performance standards and compensation for
2 navigators selected under subdivision (l) of Section 100502.

3 (m) Employ necessary staff.

4 (1) The board shall hire a chief fiscal officer, a chief operations
5 officer, a director for the SHOP Exchange, a director of Health
6 Plan Contracting, a chief technology and information officer, a
7 general counsel, and other key executive positions, as determined
8 by the board, who shall be exempt from civil service.

9 (2) (A) The board shall set the salaries for the exempt positions
10 described in paragraph (1) and subdivision (i) of Section 100500
11 in amounts that are reasonably necessary to attract and retain
12 individuals of superior qualifications. The salaries shall be
13 published by the board in the board's annual budget. The board's
14 annual budget shall be posted on the Internet Web site of the
15 Exchange. To determine the compensation for these positions, the
16 board shall cause to be conducted, through the use of independent
17 outside advisors, salary surveys of both of the following:

18 (i) Other state and federal health insurance exchanges that are
19 most comparable to the Exchange.

20 (ii) Other relevant labor pools.

21 (B) The salaries established by the board under subparagraph
22 (A) shall not exceed the highest comparable salary for a position
23 of that type, as determined by the surveys conducted pursuant to
24 subparagraph (A).

25 (C) The Department of Human Resources shall review the
26 methodology used in the surveys conducted pursuant to
27 subparagraph (A).

28 (3) The positions described in paragraph (1) and subdivision (i)
29 of Section 100500 shall not be subject to otherwise applicable
30 provisions of the Government Code or the Public Contract Code
31 and, for those purposes, the Exchange shall not be considered a
32 state agency or public entity.

33 (n) Assess a charge on the qualified health plans offered by
34 carriers that is reasonable and necessary to support the
35 development, operations, and prudent cash management of the
36 Exchange. This charge shall not affect the requirement under
37 Section 1301 of the federal act that carriers charge the same
38 premium rate for each qualified health plan whether offered inside
39 or outside the Exchange.

1 (o) Authorize expenditures, as necessary, from the California
2 Health Trust Fund to pay program expenses to administer the
3 Exchange.

4 (p) Keep an accurate accounting of all activities, receipts, and
5 expenditures, and annually submit to the United States Secretary
6 of Health and Human Services a report concerning that accounting.
7 Commencing January 1, 2016, the board shall conduct an annual
8 audit.

9 (q) (1) Annually prepare a written report on the implementation
10 and performance of the Exchange functions during the preceding
11 fiscal year, including, at a minimum, the manner in which funds
12 were expended and the progress toward, and the achievement of,
13 the requirements of this title. The report shall also include data
14 provided by health care service plans and health insurers offering
15 bridge plan products regarding the extent of health care provider
16 and health facility overlap in their Medi-Cal networks as compared
17 to the health care provider and health facility networks contracting
18 with the plan or insurer in their bridge plan contracts. This report
19 shall be transmitted to the Legislature and the Governor and shall
20 be made available to the public on the Internet Web site of the
21 Exchange. A report made to the Legislature pursuant to this
22 subdivision shall be submitted pursuant to Section 9795.

23 (2) The Exchange shall prepare, or contract for the preparation
24 of, an evaluation of the bridge plan program using the first three
25 years of experience with the program. The evaluation shall be
26 provided to the health policy and fiscal committees of the
27 Legislature in the fourth year following federal approval of the
28 bridge plan option. The evaluation shall include, but not be limited
29 to, all of the following:

30 (A) The number of individuals eligible to participate in the
31 bridge plan program each year by category of eligibility.

32 (B) The number of eligible individuals who elect a bridge plan
33 option each year by category of eligibility.

34 (C) The average length of time, by region and statewide, that
35 individuals remain in the bridge plan option each year by category
36 of eligibility.

37 (D) The regions of the state with a bridge plan option, and the
38 carriers in each region that offer a bridge plan, by year.

1 (E) The premium difference each year, by region, between the
2 bridge plan and the first and second lowest cost plan for individuals
3 in the Exchange who are not eligible for the bridge plan.

4 (F) The effect of the bridge plan on the premium subsidy amount
5 for bridge plan eligible individuals each year by each region.

6 (G) Based on a survey of individuals enrolled in the bridge plan:

7 (i) Whether individuals enrolling in the bridge plan product are
8 able to keep their existing health care providers.

9 (ii) Whether individuals would want to retain their bridge plan
10 product, buy a different Exchange product, or decline to purchase
11 health insurance if there was no bridge plan product available. The
12 Exchange may include questions designed to elicit the information
13 in this subparagraph as part of an existing survey of individuals
14 receiving coverage in the Exchange.

15 (3) In addition to the evaluation required by paragraph (2), the
16 Exchange shall post the items in subparagraphs (A) to (F),
17 inclusive, on its Internet Web site each year.

18 (4) In addition to the report described in paragraph (1), the board
19 shall be responsive to requests for additional information from the
20 Legislature, including providing testimony and commenting on
21 proposed state legislation or policy issues. The Legislature finds
22 and declares that activities including, but not limited to, responding
23 to legislative or executive inquiries, tracking and commenting on
24 legislation and regulatory activities, and preparing reports on the
25 implementation of this title and the performance of the Exchange,
26 are necessary state requirements and are distinct from the
27 promotion of legislative or regulatory modifications referred to in
28 subdivision (d) of Section 100520.

29 (r) Maintain enrollment and expenditures to ensure that
30 expenditures do not exceed the amount of revenue in the fund, and
31 if sufficient revenue is not available to pay estimated expenditures,
32 institute appropriate measures to ensure fiscal solvency.

33 (s) Exercise all powers reasonably necessary to carry out and
34 comply with the duties, responsibilities, and requirements of this
35 act and the federal act.

36 (t) Consult with stakeholders relevant to carrying out the
37 activities under this title, including, but not limited to, all of the
38 following:

39 (1) Health care consumers who are enrolled in health plans.

- 1 (2) Individuals and entities with experience in facilitating
2 enrollment in health plans.
- 3 (3) Representatives of small businesses and self-employed
4 individuals.
- 5 (4) The State Medi-Cal Director.
- 6 (5) Advocates for enrolling hard-to-reach populations.
- 7 (u) Facilitate the purchase of qualified health plans in the
8 Exchange by qualified individuals and qualified small employers
9 no later than January 1, 2014.
- 10 (v) Report, or contract with an independent entity to report, to
11 the Legislature by December 1, 2018, on whether to adopt the
12 option in Section 1312(c)(3) of the federal act to merge the
13 individual and small employer markets. In its report, the board
14 shall provide information, based on at least two years of data from
15 the Exchange, on the potential impact on rates paid by individuals
16 and by small employers in a merged individual and small employer
17 market, as compared to the rates paid by individuals and small
18 employers if a separate individual and small employer market is
19 maintained. A report made pursuant to this subdivision shall be
20 submitted pursuant to Section 9795.
- 21 (w) With respect to the SHOP Program, collect premiums and
22 administer all other necessary and related tasks, including, but not
23 limited to, enrollment and plan payment, in order to make the
24 offering of employee plan choice as simple as possible for qualified
25 small employers.
- 26 (x) Require carriers participating in the Exchange to immediately
27 notify the Exchange, under the terms and conditions established
28 by the board when an individual is or will be enrolled in or
29 disenrolled from any qualified health plan offered by the carrier.
- 30 (y) Ensure that the Exchange provides oral interpretation
31 services in any language for individuals seeking coverage through
32 the Exchange and makes available a toll-free telephone number
33 for the hearing and speech impaired. The board shall ensure that
34 written information made available by the Exchange is presented
35 in a plainly worded, easily understandable format and made
36 available in prevalent languages.
- 37 (z) This section shall become inoperative on the October 1 that
38 is five years after the date that federal approval of the bridge plan
39 option occurs, and, as of the second January 1 thereafter, is
40 repealed, unless a later enacted statute that is enacted before that

1 date deletes or extends the dates on which it becomes inoperative
2 and is repealed.

3 *SEC. 2. Section 100503 of the Government Code, as added by*
4 *Section 5 of Chapter 5 of the First Extraordinary Session of the*
5 *Statutes of 2013, is amended to read:*

6 100503. In addition to meeting the minimum requirements of
7 Section 1311 of the federal act, the board shall do all of the
8 following:

9 (a) Determine the criteria and process for eligibility, enrollment,
10 and disenrollment of enrollees and potential enrollees in the
11 Exchange and coordinate that process with the state and local
12 government entities administering other health care coverage
13 programs, including the State Department of Health Care Services,
14 the Managed Risk Medical Insurance Board, and California
15 counties, in order to ensure consistent eligibility and enrollment
16 processes and seamless transitions between coverage.

17 (b) Develop processes to coordinate with the county entities
18 that administer eligibility for the Medi-Cal program and the entity
19 that determines eligibility for the Healthy Families Program,
20 including, but not limited to, processes for case transfer, referral,
21 and enrollment in the Exchange of individuals applying for
22 assistance to those entities, if allowed or required by federal law.

23 (c) Determine the minimum requirements a carrier must meet
24 to be considered for participation in the Exchange, and the
25 standards and criteria for selecting qualified health plans to be
26 offered through the Exchange that are in the best interests of
27 qualified individuals and qualified small employers. The board
28 shall consistently and uniformly apply these requirements,
29 standards, and criteria to all carriers. In the course of selectively
30 contracting for health care coverage offered to qualified individuals
31 and qualified small employers through the Exchange, the board
32 shall seek to contract with carriers so as to provide health care
33 coverage choices that offer the optimal combination of choice,
34 value, quality, and service.

35 (d) Provide, in each region of the state, a choice of qualified
36 health plans at each of the five levels of coverage contained in
37 subsections (d) and (e) of Section 1302 of the federal act, *subject*
38 *to subdivision (e) of this section, paragraph (2) of subdivision (d)*
39 *of Section 1366.6 of the Health and Safety Code and paragraph*
40 *(2) of subdivision (d) of Section 10112.3 of the Insurance Code.*

1 (e) Require, as a condition of participation in the Exchange,
2 carriers to fairly and affirmatively offer, market, and sell in the
3 Exchange at least one product within each of the five levels of
4 coverage contained in subsections (d) and (e) of Section 1302 of
5 the federal act *and require, as a condition of participation in the*
6 *SHOP Program, carriers to fairly and affirmatively offer, market,*
7 *and sell in the SHOP Program at least one product within each*
8 *of the four levels of coverage contained in subsection (d) of Section*
9 *1302 of the federal act.* The board may require carriers to offer
10 additional products within each of those ~~five~~ levels of coverage.
11 This subdivision shall not apply to a carrier that solely offers
12 supplemental coverage in the Exchange under paragraph (10) of
13 subdivision (a) of Section 100504.

14 (f) (1) Require, as a condition of participation in the Exchange,
15 carriers that sell any products outside the Exchange to do both of
16 the following:

17 (A) Fairly and affirmatively offer, market, and sell all products
18 made available to individuals in the Exchange to individuals
19 purchasing coverage outside the Exchange.

20 (B) Fairly and affirmatively offer, market, and sell all products
21 made available to small employers in the Exchange to small
22 employers purchasing coverage outside the Exchange.

23 (2) For purposes of this subdivision, “product” does not include
24 contracts entered into pursuant to Part 6.2 (commencing with
25 Section 12693) of Division 2 of the Insurance Code between the
26 Managed Risk Medical Insurance Board and carriers for enrolled
27 Healthy Families beneficiaries or contracts entered into pursuant
28 to Chapter 7 (commencing with Section 14000) of, or Chapter 8
29 (commencing with Section 14200) of, Part 3 of Division 9 of the
30 Welfare and Institutions Code between the State Department of
31 Health Care Services and carriers for enrolled Medi-Cal
32 beneficiaries.

33 (g) Determine when an enrollee’s coverage commences and the
34 extent and scope of coverage.

35 (h) Provide for the processing of applications and the enrollment
36 and disenrollment of enrollees.

37 (i) Determine and approve cost-sharing provisions for qualified
38 health plans.

39 (j) Establish uniform billing and payment policies for qualified
40 health plans offered in the Exchange to ensure consistent

1 enrollment and disenrollment activities for individuals enrolled in
2 the Exchange.

3 (k) Undertake activities necessary to market and publicize the
4 availability of health care coverage and federal subsidies through
5 the Exchange. The board shall also undertake outreach and
6 enrollment activities that seek to assist enrollees and potential
7 enrollees with enrolling and reenrolling in the Exchange in the
8 least burdensome manner, including populations that may
9 experience barriers to enrollment, such as the disabled and those
10 with limited English language proficiency.

11 (l) Select and set performance standards and compensation for
12 navigators selected under subdivision (l) of Section 100502.

13 (m) Employ necessary staff.

14 (1) The board shall hire a chief fiscal officer, a chief operations
15 officer, a director for the SHOP Exchange, a director of Health
16 Plan Contracting, a chief technology and information officer, a
17 general counsel, and other key executive positions, as determined
18 by the board, who shall be exempt from civil service.

19 (2) (A) The board shall set the salaries for the exempt positions
20 described in paragraph (1) and subdivision (i) of Section 100500
21 in amounts that are reasonably necessary to attract and retain
22 individuals of superior qualifications. The salaries shall be
23 published by the board in the board's annual budget. The board's
24 annual budget shall be posted on the Internet Web site of the
25 Exchange. To determine the compensation for these positions, the
26 board shall cause to be conducted, through the use of independent
27 outside advisors, salary surveys of both of the following:

28 (i) Other state and federal health insurance exchanges that are
29 most comparable to the Exchange.

30 (ii) Other relevant labor pools.

31 (B) The salaries established by the board under subparagraph
32 (A) shall not exceed the highest comparable salary for a position
33 of that type, as determined by the surveys conducted pursuant to
34 subparagraph (A).

35 (C) The Department of Human Resources shall review the
36 methodology used in the surveys conducted pursuant to
37 subparagraph (A).

38 (3) The positions described in paragraph (1) and subdivision (i)
39 of Section 100500 shall not be subject to otherwise applicable
40 provisions of the Government Code or the Public Contract Code

1 and, for those purposes, the Exchange shall not be considered a
2 state agency or public entity.

3 (n) Assess a charge on the qualified health plans offered by
4 carriers that is reasonable and necessary to support the
5 development, operations, and prudent cash management of the
6 Exchange. This charge shall not affect the requirement under
7 Section 1301 of the federal act that carriers charge the same
8 premium rate for each qualified health plan whether offered inside
9 or outside the Exchange.

10 (o) Authorize expenditures, as necessary, from the California
11 Health Trust Fund to pay program expenses to administer the
12 Exchange.

13 (p) Keep an accurate accounting of all activities, receipts, and
14 expenditures, and annually submit to the United States Secretary
15 of Health and Human Services a report concerning that accounting.
16 Commencing January 1, 2016, the board shall conduct an annual
17 audit.

18 (q) (1) Annually prepare a written report on the implementation
19 and performance of the Exchange functions during the preceding
20 fiscal year, including, at a minimum, the manner in which funds
21 were expended and the progress toward, and the achievement of,
22 the requirements of this title. This report shall be transmitted to
23 the Legislature and the Governor and shall be made available to
24 the public on the Internet Web site of the Exchange. A report made
25 to the Legislature pursuant to this subdivision shall be submitted
26 pursuant to Section 9795.

27 (2) In addition to the report described in paragraph (1), the board
28 shall be responsive to requests for additional information from the
29 Legislature, including providing testimony and commenting on
30 proposed state legislation or policy issues. The Legislature finds
31 and declares that activities including, but not limited to, responding
32 to legislative or executive inquiries, tracking and commenting on
33 legislation and regulatory activities, and preparing reports on the
34 implementation of this title and the performance of the Exchange,
35 are necessary state requirements and are distinct from the
36 promotion of legislative or regulatory modifications referred to in
37 subdivision (d) of Section 100520.

38 (r) Maintain enrollment and expenditures to ensure that
39 expenditures do not exceed the amount of revenue in the fund, and

1 if sufficient revenue is not available to pay estimated expenditures,
2 institute appropriate measures to ensure fiscal solvency.

3 (s) Exercise all powers reasonably necessary to carry out and
4 comply with the duties, responsibilities, and requirements of this
5 act and the federal act.

6 (t) Consult with stakeholders relevant to carrying out the
7 activities under this title, including, but not limited to, all of the
8 following:

9 (1) Health care consumers who are enrolled in health plans.

10 (2) Individuals and entities with experience in facilitating
11 enrollment in health plans.

12 (3) Representatives of small businesses and self-employed
13 individuals.

14 (4) The State Medi-Cal Director.

15 (5) Advocates for enrolling hard-to-reach populations.

16 (u) Facilitate the purchase of qualified health plans in the
17 Exchange by qualified individuals and qualified small employers
18 no later than January 1, 2014.

19 (v) Report, or contract with an independent entity to report, to
20 the Legislature by December 1, 2018, on whether to adopt the
21 option in Section 1312(c)(3) of the federal act to merge the
22 individual and small employer markets. In its report, the board
23 shall provide information, based on at least two years of data from
24 the Exchange, on the potential impact on rates paid by individuals
25 and by small employers in a merged individual and small employer
26 market, as compared to the rates paid by individuals and small
27 employers if a separate individual and small employer market is
28 maintained. A report made pursuant to this subdivision shall be
29 submitted pursuant to Section 9795.

30 (w) With respect to the SHOP Program, collect premiums and
31 administer all other necessary and related tasks, including, but not
32 limited to, enrollment and plan payment, in order to make the
33 offering of employee plan choice as simple as possible for qualified
34 small employers.

35 (x) Require carriers participating in the Exchange to immediately
36 notify the Exchange, under the terms and conditions established
37 by the board when an individual is or will be enrolled in or
38 disenrolled from any qualified health plan offered by the carrier.

39 (y) Ensure that the Exchange provides oral interpretation
40 services in any language for individuals seeking coverage through

1 the Exchange and makes available a toll-free telephone number
2 for the hearing and speech impaired. The board shall ensure that
3 written information made available by the Exchange is presented
4 in a plainly worded, easily understandable format and made
5 available in prevalent languages.

6 (z) This section shall become operative only if Section 4 of the
7 act that added this section becomes inoperative pursuant to
8 subdivision (z) of that Section 4.

9 ~~SECTION 4.~~

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

12 1357.503. (a) (1) On and after October 1, 2013, a plan shall
13 fairly and affirmatively offer, market, and sell all of the plan’s
14 small employer health care service plan contracts for plan years
15 on or after January 1, 2014, to all small employers in each service
16 area in which the plan provides or arranges for the provision of
17 health care services.

18 (2) On and after October 1, 2013, a plan shall make available
19 to each small employer all small employer health care service plan
20 contracts that the plan offers and sells to small employers or to
21 associations that include small employers in this state for plan
22 years on or after January 1, 2014. Health coverage through an
23 association that is not related to employment shall be considered
24 individual coverage pursuant to Section 144.102(c) of Title 45 of
25 the Code of Federal Regulations.

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

31 (b) A plan shall provide enrollment periods consistent with
32 PPACA and described in Section 155.725 of Title 45 of the Code
33 of Federal Regulations. Commencing January 1, 2014, a plan shall
34 provide special enrollment periods consistent with the special
35 enrollment periods described in Section 1399.849, to the extent
36 permitted by PPACA, except for the triggering events identified
37 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
38 the Code of Federal Regulations with respect to plan contracts
39 offered through the Exchange.

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

6 (d) Every plan shall file with the director the reasonable
7 employee participation requirements and employer contribution
8 requirements that will be applied in offering its plan contracts.
9 Participation requirements shall be applied uniformly among all
10 small employer groups, except that a plan may vary application
11 of minimum employee participation requirements by the size of
12 the small employer group and whether the employer contributes
13 100 percent of the eligible employee's premium. Employer
14 contribution requirements shall not vary by employer size. A health
15 care service plan shall not establish a participation requirement
16 that (1) requires a person who meets the definition of a dependent
17 in Section 1357.500 to enroll as a dependent if he or she is
18 otherwise eligible for coverage and wishes to enroll as an eligible
19 employee and (2) allows a plan to reject an otherwise eligible small
20 employer because of the number of persons that waive coverage
21 due to coverage through another employer. Members of an
22 association eligible for health coverage under subdivision (m) of
23 Section 1357.500, but not electing any health coverage through
24 the association, shall not be counted as eligible employees for
25 purposes of determining whether the guaranteed association meets
26 a plan's reasonable participation standards.

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

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

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

36 (3) The small employer agrees to inform the small employer's
37 employees of the availability of coverage and the provision that
38 those not electing coverage must wait until the next open
39 enrollment or a special enrollment period to obtain coverage

1 through the group if they later decide they would like to have
2 coverage.

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

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

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

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

18 (3) Employ marketing practices or benefit designs that will have
19 the effect of discouraging the enrollment of individuals with
20 significant health needs or discriminate based on an individual's
21 race, color, national origin, present or predicted disability, age,
22 sex, gender identity, sexual orientation, expected length of life,
23 degree of medical dependency, quality of life, or other health
24 conditions.

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

36 (h) (1) A policy or contract that covers a small employer, as
37 defined in Section 1304(b) of PPACA and in Section 1357.500,
38 shall not establish rules for eligibility, including continued
39 eligibility, of an individual, or dependent of an individual, to enroll

1 under the terms of the policy or contract based on any of the
2 following health status-related factors:

- 3 (A) Health status.
- 4 (B) Medical condition, including physical and mental illnesses.
- 5 (C) Claims experience.
- 6 (D) Receipt of health care.
- 7 (E) Medical history.
- 8 (F) Genetic information.
- 9 (G) Evidence of insurability, including conditions arising out
10 of acts of domestic violence.
- 11 (H) Disability.
- 12 (I) Any other health status-related factor as determined by any
13 federal regulations, rules, or guidance issued pursuant to Section
14 2705 of the federal Public Health Service Act.

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

23 (i) (1) A health care service plan shall consider as a single risk
24 pool for rating purposes in the small employer market the claims
25 experience of all enrollees in all nongrandfathered small employer
26 ~~health benefit plans~~ *care service plan contracts* offered by the
27 health care service plan in this state, ~~whether offered as health care~~
28 ~~service plan contracts or health insurance policies, and all insureds~~
29 *in all nongrandfathered health benefit plans subject to Chapter*
30 *8.01 (commencing with Section 10753) of Part 2 of Division 2 of*
31 *the Insurance Code offered by a health insurer that is a corporate*
32 *affiliate, subsidiary, or parent of the plan*, including those insureds
33 and enrollees who enroll in coverage through the Exchange and
34 insureds and enrollees ~~covered by the health care service plan~~ *who*
35 *enroll in coverage* outside of the Exchange.

36 (2) At least each calendar year, and no more frequently than
37 each calendar quarter, a health care service plan shall establish an
38 index rate for the small employer market in the state based on the
39 total combined claims costs for providing essential health benefits,
40 as defined pursuant to Section 1302 of PPACA and Section

1 1367.005, within the single risk pool required under paragraph
2 (1). The index rate shall be adjusted on a marketwide basis based
3 on the total expected marketwide payments and charges under the
4 risk adjustment and reinsurance programs established for the state
5 pursuant to Sections 1343 and 1341 of PPACA and Exchange user
6 fees, as described in subdivision (d) of Section 156.80 of Title 45
7 of the Code of Federal Regulations. The premium rate for all of
8 ~~the health care service plan's~~ nongrandfathered small employer
9 health care service plan contracts *and nongrandfathered health*
10 *benefit plans within the single risk pool required under paragraph*
11 *(1)* shall use the applicable index rate, as adjusted for total expected
12 marketwide payments and charges under the risk adjustment and
13 reinsurance programs established for the state pursuant to Sections
14 1343 and 1341 of PPACA, subject only to the adjustments
15 permitted under paragraph (3).

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

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

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

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

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

34 (E) Administrative costs, excluding any user fees required by
35 the Exchange.

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

37 (k) (1) Except as provided in paragraph (2), if Section 2702 of
38 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1),
39 as added by Section 1201 of PPACA, is repealed, this section shall
40 become inoperative 12 months after the repeal date, in which case

1 health care service plans subject to this section shall instead be
2 governed by Section 1357.03 to the extent permitted by federal
3 law, and all references in this article to this section shall instead
4 refer to Section 1357.03 except for purposes of paragraph (2).

5 (2) Subdivision (b) shall remain operative with respect to health
6 care service plan contracts offered through the Exchange.

7 *SEC. 4. Section 1366.6 of the Health and Safety Code, as*
8 *amended by Section 8 of Chapter 5 of the First Extraordinary*
9 *Session of the Statutes of 2013, is amended to read:*

10 1366.6. (a) For purposes of this section, the following
11 definitions shall apply:

12 (1) “Exchange” means the California Health Benefit Exchange
13 established in Title 22 (commencing with Section 100500) of the
14 Government Code.

15 (2) “Federal act” means the federal Patient Protection and
16 Affordable Care Act (Public Law 111-148), as amended by the
17 federal Health Care and Education Reconciliation Act of 2010
18 (Public Law 111-152), and any amendments to, or regulations or
19 guidance issued under, those acts.

20 (3) “Qualified health plan” has the same meaning as that term
21 is defined in Section 1301 of the federal act.

22 (4) “Small employer” has the same meaning as that term is
23 defined in ~~Section 1357~~ 1357.500.

24 (b) (1) Health care service plans participating in the *individual*
25 *market of the* Exchange shall fairly and affirmatively offer, market,
26 and sell in the *individual market of the* Exchange at least one
27 product within each of the five levels of coverage contained in
28 subsections (d) and (e) of Section 1302 of the federal act. *Health*
29 *care service plans participating in the Small Business Health*
30 *Options Program (SHOP Program) of the Exchange, established*
31 *pursuant to subdivision (m) of Section 100504 of the Government*
32 *Code, shall fairly and affirmatively offer, market, and sell in the*
33 *SHOP Program at least one product within each of the four levels*
34 *of coverage contained in subsection (d) of Section 1302 of the*
35 *federal act.*

36 (2) The board established under Section 100500 of the
37 Government Code may require plans to sell additional products
38 within each of ~~those~~ *the* levels of coverage *identified in paragraph*
39 *(1).*

1 (3) This subdivision shall not apply to a plan that solely offers
2 supplemental coverage in the Exchange under paragraph (10) of
3 subdivision (a) of Section 100504 of the Government Code.

4 (4) This subdivision shall not apply to a bridge plan product
5 that meets the requirements of Section 100504.5 of the Government
6 Code to the extent approved by the appropriate federal agency.

7 (c) (1) Health care service plans participating in the Exchange
8 that sell any products outside the Exchange shall do both of the
9 following:

10 (A) Fairly and affirmatively offer, market, and sell all products
11 made available to individuals in the Exchange to individuals
12 purchasing coverage outside the Exchange.

13 (B) Fairly and affirmatively offer, market, and sell all products
14 made available to small employers in the Exchange to small
15 employers purchasing coverage outside the Exchange.

16 (2) For purposes of this subdivision, “product” does not include
17 contracts entered into pursuant to Part 6.2 (commencing with
18 Section 12693) of Division 2 of the Insurance Code between the
19 Managed Risk Medical Insurance Board and health care service
20 plans for enrolled Healthy Families beneficiaries or to contracts
21 entered into pursuant to Chapter 7 (commencing with Section
22 14000) of, or Chapter 8 (commencing with Section 14200) of, Part
23 3 of Division 9 of the Welfare and Institutions Code between the
24 State Department of Health Care Services and health care service
25 plans for enrolled Medi-Cal beneficiaries, or for contracts with
26 bridge plan products that meet the requirements of Section
27 100504.5 of the Government Code.

28 (d) (1) Commencing January 1, 2014, a health care service plan
29 shall, with respect to *individual* plan contracts that cover hospital,
30 medical, or surgical benefits, only sell the five levels of coverage
31 contained in subsections (d) and (e) of Section 1302 of the federal
32 act, except that a health care service plan that does not participate
33 in the Exchange shall, with respect to *individual* plan contracts
34 that cover hospital, medical, or surgical benefits, only sell the four
35 levels of coverage contained in *subsection (d) of Section 1302* (~~of~~)
36 *1302* of the federal act.

37 (2) *Commencing January 1, 2014, a health care service plan*
38 *shall, with respect to small employer plan contracts that cover*
39 *hospital, medical, or surgical expenses, only sell the four levels*

1 *of coverage contained in subsection (d) of Section 1302 of the*
2 *federal act.*

3 (e) Commencing January 1, 2014, a health care service plan
4 that does not participate in the Exchange shall, with respect to
5 *individual or small employer* plan contracts that cover hospital,
6 medical, or surgical benefits, offer at least one standardized product
7 that has been designated by the Exchange in each of the four levels
8 of coverage contained in ~~subsection (d) of Section 1302(d)~~ *1302*
9 of the federal act. This subdivision shall only apply if the board
10 of the Exchange exercises its authority under subdivision (c) of
11 Section 100504 of the Government Code. Nothing in this
12 subdivision shall require a plan that does not participate in the
13 Exchange to offer standardized products in the small employer
14 market if the plan only sells products in the individual market.
15 Nothing in this subdivision shall require a plan that does not
16 participate in the Exchange to offer standardized products in the
17 individual market if the plan only sells products in the small
18 employer market. This subdivision shall not be construed to
19 prohibit the plan from offering other products provided that it
20 complies with subdivision (d).

21 (f) For purposes of this section, a bridge plan product shall mean
22 an individual health benefit plan, as defined in subdivision (f) of
23 Section 1399.845, that is offered by a health care service plan
24 licensed under this chapter that contracts with the Exchange
25 pursuant to Title 22 (commencing with Section 100500) of the
26 Government Code.

27 (g) This section shall become inoperative on the October 1 that
28 is five years after the date that federal approval of the bridge plan
29 option occurs, and, as of the second January 1 thereafter, is
30 repealed, unless a later enacted statute that is enacted before that
31 date deletes or extends the dates on which it becomes inoperative
32 and is repealed.

33 *SEC. 5. Section 1366.6 of the Health and Safety Code, as added*
34 *by Section 9 of Chapter 5 of the 1st Extraordinary Session of the*
35 *Statutes of 2013, is amended to read:*

36 1366.6. (a) For purposes of this section, the following
37 definitions shall apply:

38 (1) “Exchange” means the California Health Benefit Exchange
39 established in Title 22 (commencing with Section 100500) of the
40 Government Code.

1 (2) “Federal act” means the federal Patient Protection and
2 Affordable Care Act (Public Law 111-148), as amended by the
3 federal Health Care and Education Reconciliation Act of 2010
4 (Public Law 111-152), and any amendments to, or regulations or
5 guidance issued under, those acts.

6 (3) “Qualified health plan” has the same meaning as that term
7 is defined in Section 1301 of the federal act.

8 (4) “Small employer” has the same meaning as that term is
9 defined in Section ~~1357~~ 1357.500.

10 (b) (1) Health care service plans participating in the *individual*
11 *market of the Exchange* shall fairly and affirmatively offer, market,
12 and sell in the *individual market of the Exchange* at least one
13 product within each of the five levels of coverage contained in
14 subsections (d) and (e) of Section 1302 of the federal act. ~~The~~
15 *Health care service plans participating in the Small Business*
16 *Health Options Program (SHOP Program) of the Exchange,*
17 *established pursuant to subdivision (m) of Section 100504 of the*
18 *Government Code, shall fairly and affirmatively offer, market, and*
19 *sell in the SHOP Program at least one product within each of the*
20 *four levels of coverage contained in subsection (d) of Section 1302*
21 *of the federal act.*

22 (2) ~~The~~ board established under Section 100500 of the
23 Government Code may require plans to sell additional products
24 within each of ~~those~~ *the* levels of coverage *identified in paragraph*
25 *(1).* ~~This~~

26 (3) *This* subdivision shall not apply to a plan that solely offers
27 supplemental coverage in the Exchange under paragraph (10) of
28 subdivision (a) of Section 100504 of the Government Code.

29 (c) (1) Health care service plans participating in the Exchange
30 that sell any products outside the Exchange shall do both of the
31 following:

32 (A) Fairly and affirmatively offer, market, and sell all products
33 made available to individuals in the Exchange to individuals
34 purchasing coverage outside the Exchange.

35 (B) Fairly and affirmatively offer, market, and sell all products
36 made available to small employers in the Exchange to small
37 employers purchasing coverage outside the Exchange.

38 (2) For purposes of this subdivision, “product” does not include
39 contracts entered into pursuant to Part 6.2 (commencing with
40 Section 12693) of Division 2 of the Insurance Code between the

1 Managed Risk Medical Insurance Board and health care service
2 plans for enrolled Healthy Families beneficiaries or to contracts
3 entered into pursuant to Chapter 7 (commencing with Section
4 14000) of, or Chapter 8 (commencing with Section 14200) of, Part
5 3 of Division 9 of the Welfare and Institutions Code between the
6 State Department of Health Care Services and health care service
7 plans for enrolled Medi-Cal beneficiaries.

8 (d) (1) Commencing January 1, 2014, a health care service plan
9 shall, with respect to *individual* plan contracts that cover hospital,
10 medical, or surgical benefits, only sell the five levels of coverage
11 contained in subsections (d) and (e) of Section 1302 of the federal
12 act, except that a health care service plan that does not participate
13 in the Exchange shall, with respect to *individual* plan contracts
14 that cover hospital, medical, or surgical benefits, only sell the four
15 levels of coverage contained in *subsection (d) of Section 1302(d)*
16 *1302* of the federal act.

17 (2) *Commencing January 1, 2014, a health care service plan*
18 *shall, with respect to small employer plan contracts that cover*
19 *hospital, medical, or surgical expenses, only sell the four levels*
20 *of coverage contained in subsection (d) of Section 1302 of the*
21 *federal act.*

22 (e) Commencing January 1, 2014, a health care service plan
23 that does not participate in the Exchange shall, with respect to
24 *individual or small employer* plan contracts that cover hospital,
25 medical, or surgical benefits, offer at least one standardized product
26 that has been designated by the Exchange in each of the four levels
27 of coverage contained in *subdivision (d) of Section 1302(d)* *1302*
28 of the federal act. This subdivision shall only apply if the board
29 of the Exchange exercises its authority under subdivision (c) of
30 Section 100504 of the Government Code. Nothing in this
31 subdivision shall require a plan that does not participate in the
32 Exchange to offer standardized products in the small employer
33 market if the plan only sells products in the individual market.
34 Nothing in this subdivision shall require a plan that does not
35 participate in the Exchange to offer standardized products in the
36 individual market if the plan only sells products in the small
37 employer market. This subdivision shall not be construed to
38 prohibit the plan from offering other products provided that it
39 complies with subdivision (d).

1 (f) This section shall become operative only if Section 8 of the
2 act that added this section becomes inoperative pursuant to
3 subdivision (g) of that Section 8.

4 *SEC. 6. Section 1367.005 of the Health and Safety Code is*
5 *amended to read:*

6 1367.005. (a) An individual or small group health care service
7 plan contract issued, amended, or renewed on or after January 1,
8 2014, shall, at a minimum, include coverage for essential health
9 benefits pursuant to PPACA and as outlined in this section. For
10 purposes of this section, “essential health benefits” means all of
11 the following:

12 (1) Health benefits within the categories identified in Section
13 1302(b) of PPACA: ambulatory patient services, emergency
14 services, hospitalization, maternity and newborn care, mental health
15 and substance use disorder services, including behavioral health
16 treatment, prescription drugs, rehabilitative and habilitative services
17 and devices, laboratory services, preventive and wellness services
18 and chronic disease management, and pediatric services, including
19 oral and vision care.

20 (2) (A) The health benefits covered by the Kaiser Foundation
21 Health Plan Small Group HMO 30 plan (federal health product
22 identification number 40513CA035) as this plan was offered during
23 the first quarter of 2012, as follows, regardless of whether the
24 benefits are specifically referenced in the evidence of coverage or
25 plan contract for that plan:

26 (i) Medically necessary basic health care services, as defined
27 in subdivision (b) of Section 1345 and in Section 1300.67 of Title
28 28 of the California Code of Regulations.

29 (ii) The health benefits mandated to be covered by the plan
30 pursuant to statutes enacted before December 31, 2011, as
31 described in the following sections: Sections 1367.002, 1367.06,
32 and 1367.35 (preventive services for children); Section 1367.25
33 (prescription drug coverage for contraceptives); Section 1367.45
34 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51
35 (diabetes); Section 1367.54 (alpha feto protein testing); Section
36 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for
37 laryngectomy); Section 1367.62 (maternity hospital stay); Section
38 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies);
39 Section 1367.64 (prostate cancer); Section 1367.65
40 (mammography); Section 1367.66 (cervical cancer); Section

1 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis);
2 Section 1367.68 (surgical procedures for jaw bones); Section
3 1367.71 (anesthesia for dental); Section 1367.9 (conditions
4 attributable to diethylstilbestrol); Section 1368.2 (hospice care);
5 Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency
6 response ambulance or ambulance transport services); subdivision
7 (b) of Section 1373 (sterilization operations or procedures); Section
8 1373.4 (inpatient hospital and ambulatory maternity); Section
9 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for
10 HIV); Section 1374.72 (mental health parity); and Section 1374.73
11 (autism/behavioral health treatment).

12 (iii) Any other benefits mandated to be covered by the plan
13 pursuant to statutes enacted before December 31, 2011, as
14 described in those statutes.

15 (iv) The health benefits covered by the plan that are not
16 otherwise required to be covered under this chapter, to the extent
17 required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22,
18 1367.24, and 1367.25, and Section 1300.67.24 of Title 28 of the
19 California Code of Regulations.

20 (v) Any other health benefits covered by the plan that are not
21 otherwise required to be covered under this chapter.

22 (B) Where there are any conflicts or omissions in the plan
23 identified in subparagraph (A) as compared with the requirements
24 for health benefits under this chapter that were enacted prior to
25 December 31, 2011, the requirements of this chapter shall be
26 controlling, except as otherwise specified in this section.

27 (C) Notwithstanding subparagraph (B) or any other provision
28 of this section, the home health services benefits covered under
29 the plan identified in subparagraph (A) shall be deemed to not be
30 in conflict with this chapter.

31 (D) For purposes of this section, the Paul Wellstone and Pete
32 Domenici Mental Health Parity and Addiction Equity Act of 2008
33 (Public Law 110-343) shall apply to a contract subject to this
34 section. Coverage of mental health and substance use disorder
35 services pursuant to this paragraph, along with any scope and
36 duration limits imposed on the benefits, shall be in compliance
37 with the Paul Wellstone and Pete Domenici Mental Health Parity
38 and Addiction Equity Act of 2008 (Public Law 110-343), and all
39 rules, regulations, or guidance issued pursuant to Section 2726 of
40 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

1 (3) With respect to habilitative services, in addition to any
2 habilitative services identified in paragraph (2), coverage shall
3 also be provided as required by federal rules, regulations, and
4 guidance issued pursuant to Section 1302(b) of PPACA.
5 Habilitative services shall be covered under the same terms and
6 conditions applied to rehabilitative services under the plan contract.

7 (4) With respect to pediatric vision care, the same health benefits
8 for pediatric vision care covered under the Federal Employees
9 Dental and Vision Insurance Program vision plan with the largest
10 national enrollment as of the first quarter of 2012. The pediatric
11 vision care benefits covered pursuant to this paragraph shall be in
12 addition to, and shall not replace, any vision services covered under
13 the plan identified in paragraph (2).

14 (5) With respect to pediatric oral care, the same health benefits
15 for pediatric oral care covered under the dental plan available to
16 subscribers of the Healthy Families Program in 2011–12, including
17 the provision of medically necessary orthodontic care provided
18 pursuant to the federal Children’s Health Insurance Program
19 Reauthorization Act of 2009. The pediatric oral care benefits
20 covered pursuant to this paragraph shall be in addition to, and shall
21 not replace, any dental or orthodontic services covered under the
22 plan identified in paragraph (2).

23 (b) Treatment limitations imposed on health benefits described
24 in this section shall be no greater than the treatment limitations
25 imposed by the corresponding plans identified in subdivision (a),
26 subject to the requirements set forth in paragraph (2) of subdivision
27 (a).

28 (c) Except as provided in subdivision (d), nothing in this section
29 shall be construed to permit a health care service plan to make
30 substitutions for the benefits required to be covered under this
31 section, regardless of whether those substitutions are actuarially
32 equivalent.

33 (d) To the extent permitted under Section 1302 of PPACA and
34 any rules, regulations, or guidance issued pursuant to that section,
35 and to the extent that substitution would not create an obligation
36 for the state to defray costs for any individual, a plan may substitute
37 its prescription drug formulary for the formulary provided under
38 the plan identified in subdivision (a) as long as the coverage for
39 prescription drugs complies with the sections referenced in clauses

1 (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision
2 (a) that apply to prescription drugs.

3 (e) No health care service plan, or its agent, solicitor, or
4 representative, shall issue, deliver, renew, offer, market, represent,
5 or sell any product, contract, or discount arrangement as compliant
6 with the essential health benefits requirement in federal law, unless
7 it meets all of the requirements of this section.

8 (f) This section shall apply regardless of whether the plan
9 contract is offered inside or outside the California Health Benefit
10 Exchange created by Section 100500 of the Government Code.

11 (g) Nothing in this section shall be construed to exempt a plan
12 or a plan contract from meeting other applicable requirements of
13 law.

14 (h) This section shall not be construed to prohibit a plan contract
15 from covering additional benefits, including, but not limited to,
16 spiritual care services that are tax deductible under Section 213 of
17 the Internal Revenue Code.

18 (i) Subdivision (a) shall not apply to any of the following:

19 (1) A specialized health care service plan contract.

20 (2) A Medicare supplement plan.

21 (3) A plan contract that qualifies as a grandfathered health plan
22 under Section 1251 of PPACA or any rules, regulations, or
23 guidance issued pursuant to that section.

24 (j) Nothing in this section shall be implemented in a manner
25 that conflicts with a requirement of PPACA.

26 (k) This section shall be implemented only to the extent essential
27 health benefits are required pursuant to PPACA.

28 (l) An essential health benefit is required to be provided under
29 this section only to the extent that federal law does not require the
30 state to defray the costs of the benefit.

31 (m) Nothing in this section shall obligate the state to incur costs
32 for the coverage of benefits that are not essential health benefits
33 as defined in this section.

34 (n) A plan is not required to cover, under this section, changes
35 to health benefits that are the result of statutes enacted on or after
36 December 31, 2011.

37 (o) (1) The department may adopt emergency regulations
38 implementing this section. The department may, on a one-time
39 basis, readopt any emergency regulation authorized by this section

1 that is the same as, or substantially equivalent to, an emergency
2 regulation previously adopted under this section.

3 (2) The initial adoption of emergency regulations implementing
4 this section and the readoption of emergency regulations authorized
5 by this subdivision shall be deemed an emergency and necessary
6 for the immediate preservation of the public peace, health, safety,
7 or general welfare. The initial emergency regulations and the
8 readoption of emergency regulations authorized by this section
9 shall be submitted to the Office of Administrative Law for filing
10 with the Secretary of State and each shall remain in effect for no
11 more than 180 days, by which time final regulations may be
12 adopted.

13 (3) The director shall consult with the Insurance Commissioner
14 to ensure consistency and uniformity in the development of
15 regulations under this subdivision.

16 (4) This subdivision shall become inoperative on March 1, 2016.

17 (p) For purposes of this section, the following definitions shall
18 apply:

19 (1) “Habilitative services” means medically necessary health
20 care services and health care devices that assist an individual in
21 partially or fully acquiring or improving skills and functioning and
22 that are necessary to address a health condition, to the maximum
23 extent practical. These services address the skills and abilities
24 needed for functioning in interaction with an individual’s
25 environment. Examples of health care services that are not
26 habilitative services include, but are not limited to, respite care,
27 day care, recreational care, residential treatment, social services,
28 custodial care, or education services of any kind, including, but
29 not limited to, vocational training. Habilitative services shall be
30 covered under the same terms and conditions applied to
31 rehabilitative services under the plan contract.

32 (2) (A) “Health benefits,” unless otherwise required to be
33 defined pursuant to federal rules, regulations, or guidance issued
34 pursuant to Section 1302(b) of PPACA, means health care items
35 or services for the diagnosis, cure, mitigation, treatment, or
36 prevention of illness, injury, disease, or a health condition,
37 including a behavioral health condition.

38 (B) “Health benefits” does not mean any cost-sharing
39 requirements such as copayments, coinsurance, or deductibles.

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

6 (4) “Small group health care service plan contract” means a
7 group health care service plan contract issued to a small employer,
8 as defined in Section ~~1357~~ 1357.500.

9 *SEC. 7. Section 1367.006 of the Health and Safety Code is*
10 *amended to read:*

11 1367.006. (a) This section shall apply to nongrandfathered
12 individual and group health care service plan contracts that provide
13 coverage for essential health benefits, as defined in Section
14 1367.005, and that are issued, amended, or renewed on or after
15 January 1, 2015.

16 (b) (1) For nongrandfathered health care service plan contracts
17 in the individual or small group markets, a health care service plan
18 contract, except a specialized health care service plan contract,
19 that is issued, amended, or renewed on or after January 1, 2015,
20 shall provide for a limit on annual out-of-pocket expenses for all
21 covered benefits that meet the definition of essential health benefits
22 in Section 1367.005, including out-of-network emergency care
23 consistent with Section ~~1317.4~~ 1371.4.

24 (2) For nongrandfathered health care service plan contracts in
25 the large group market, a health care service plan contract, except
26 a specialized health care service plan contract, that is issued,
27 amended, or renewed on or after January 1, 2015, shall provide
28 for a limit on annual out-of-pocket expenses for covered benefits,
29 including out-of-network emergency care consistent with Section
30 1371.4. This limit shall only apply to essential health benefits, as
31 defined in Section 1367.005, that are covered under the plan to
32 the extent that this provision does not conflict with federal law or
33 guidance on out-of-pocket maximums for nongrandfathered health
34 care service plan contracts in the large group market.

35 (c) (1) The limit described in subdivision (b) shall not exceed
36 the limit described in Section 1302(c) of PPACA, and any
37 subsequent rules, regulations, or guidance issued under that section.

38 (2) The limit described in subdivision (b) shall result in a total
39 maximum out-of-pocket limit for all *covered* essential health
40 benefits equal to the dollar amounts in effect under Section

1 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the
2 dollar amounts adjusted as specified in Section 1302(c)(1)(B) of
3 PPACA.

4 (d) Nothing in this section shall be construed to affect the
5 reduction in cost sharing for eligible enrollees described in Section
6 1402 of PPACA, and any subsequent rules, regulations, or guidance
7 issued under that section.

8 (e) If an essential health benefit is offered or provided by a
9 specialized health care service plan, the total annual out-of-pocket
10 maximum for all covered essential benefits shall not exceed the
11 limit in subdivision (b). This section shall not apply to a specialized
12 health care service plan that does not offer an essential health
13 benefit as defined in Section 1367.005.

14 (f) The maximum out-of-pocket limit shall apply to any
15 copayment, coinsurance, deductible, and any other form of cost
16 sharing for all covered benefits that meet the definition of essential
17 health benefits in Section 1367.005.

18 (g) For nongrandfathered health plan contracts in the group
19 market, “plan year” has the meaning set forth in Section 144.103
20 of Title 45 of the Code of Federal Regulations. For
21 nongrandfathered health plan contracts sold in the individual
22 market, “plan year” means the calendar year.

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

28 *SEC. 8. Section 1374.21 of the Health and Safety Code is*
29 *amended to read:*

30 1374.21. (a) No change in premium rates or changes in
31 coverage stated in a group health care service plan contract shall
32 become effective unless the plan has delivered in writing a notice
33 indicating the change or changes at least 60 days prior to the
34 contract renewal effective date.

35 (b) A health care service plan that declines to offer coverage to
36 or denies enrollment for a large group applying for coverage ~~or~~
37 ~~that offers small group coverage at a rate that is higher than the~~
38 ~~standard employee risk rate~~, shall, at the time of the denial ~~or offer~~
39 of coverage, provide the applicant with the specific reason or

1 reasons for the decision in writing, in clear, easily understandable
2 language.

3 *SEC. 9. Section 1385.03 of the Health and Safety Code is*
4 *amended to read:*

5 1385.03. (a) ~~(1)~~—All health care service plans shall file with
6 the department all required rate information for individual and
7 small group health care service plan contracts at least 60 days prior
8 to implementing any rate change.

9 ~~(2) For individual health care service plan contracts, the filing~~
10 ~~shall be concurrent with the notice required under Section 1389.25.~~

11 ~~(3) For small group health care service plan contracts, the filing~~
12 ~~shall be concurrent with the notice required under subdivision (a)~~
13 ~~of Section 1374.21.~~

14 (b) A plan shall disclose to the department all of the following
15 for each individual and small group rate filing:

- 16 (1) Company name and contact information.
- 17 (2) Number of plan contract forms covered by the filing.
- 18 (3) Plan contract form numbers covered by the filing.
- 19 (4) Product type, such as a preferred provider organization or
20 health maintenance organization.
- 21 (5) Segment type.
- 22 (6) Type of plan involved, such as for profit or not for profit.
- 23 (7) Whether the products are opened or closed.
- 24 (8) Enrollment in each plan contract and rating form.
- 25 (9) Enrollee months in each plan contract form.
- 26 (10) Annual rate.
- 27 (11) Total earned premiums in each plan contract form.
- 28 (12) Total incurred claims in each plan contract form.
- 29 (13) Average rate ~~increase~~ *change* initially requested.
- 30 (14) Review category: initial filing for new product, filing for
31 existing product, or resubmission.
- 32 (15) Average rate of ~~increase~~ *change*.
- 33 (16) Effective date of rate ~~increase~~ *change*.
- 34 (17) Number of subscribers or enrollees affected by each plan
35 contract form.
- 36 (18) The plan's overall annual medical trend factor assumptions
37 in each rate filing for all benefits and by aggregate benefit category,
38 including hospital inpatient, hospital outpatient, physician services,
39 prescription drugs and other ancillary services, laboratory, and
40 radiology. A plan may provide aggregated additional data that

1 demonstrates or reasonably estimates year-to-year cost-increases
2 changes in specific benefit categories in major geographic regions
3 of the state. For purposes of this paragraph, “major geographic
4 region” shall be defined by the department and shall include no
5 more than nine regions *the geographic regions listed in Sections*
6 *1357.512 and 1399.855*. A health plan that exclusively contracts
7 with no more than two medical groups in the state to provide or
8 arrange for professional medical services for the enrollees of the
9 plan shall instead disclose the amount of its actual trend experience
10 for the prior contract year by aggregate benefit category, using
11 benefit categories that are, to the maximum extent possible, the
12 same or similar to those used by other plans.

13 (19) The amount of the projected trend attributable to the use
14 of services, price inflation, or fees and risk for annual plan contract
15 trends by aggregate benefit category, such as hospital inpatient,
16 hospital outpatient, physician services, prescription drugs and other
17 ancillary services, laboratory, and radiology. A health plan that
18 exclusively contracts with no more than two medical groups in the
19 state to provide or arrange for professional medical services for
20 the enrollees of the plan shall instead disclose the amount of its
21 actual trend experience for the prior contract year by aggregate
22 benefit category, using benefit categories that are, to the maximum
23 extent possible, the same or similar to those used by other plans.

24 (20) A comparison of claims cost and rate of changes over time.

25 (21) Any changes in enrollee cost-sharing over the prior year
26 associated with the submitted rate filing.

27 (22) Any changes in enrollee benefits over the prior year
28 associated with the submitted rate filing.

29 (23) The certification described in subdivision (b) of Section
30 1385.06.

31 (24) Any changes in administrative costs.

32 (25) Any other information required for rate review under
33 PPACA.

34 (c) A health care service plan subject to subdivision (a) shall
35 also disclose the following aggregate data for all rate filings
36 submitted under this section in the individual and small group
37 health plan markets:

38 (1) Number and percentage of rate filings reviewed by the
39 following:

40 (A) Plan year.

- 1 (B) Segment type.
2 (C) Product type.
3 (D) Number of subscribers.
4 (E) Number of covered lives affected.
5 (2) The plan's average rate ~~increase~~ *change* by the following
6 categories:
7 (A) Plan year.
8 (B) Segment type.
9 (C) Product type.
10 (3) Any cost containment and quality improvement efforts since
11 the plan's last rate filing for the same category of health benefit
12 plan. To the extent possible, the plan shall describe any significant
13 new health care cost containment and quality improvement efforts
14 and provide an estimate of potential savings together with an
15 estimated cost or savings for the projection period.
16 (d) The department may require all health care service plans to
17 submit all rate filings to the National Association of Insurance
18 Commissioners' System for Electronic Rate and Form Filing
19 (SERFF). Submission of the required rate filings to SERFF shall
20 be deemed to be filing with the department for purposes of
21 compliance with this section.
22 (e) A plan shall submit any other information required under
23 PPACA. A plan shall also submit any other information required
24 pursuant to any regulation adopted by the department to comply
25 with this article.
26 *SEC. 10. Section 1385.06 of the Health and Safety Code is*
27 *amended to read:*
28 1385.06. (a) A filing submitted under this article shall be
29 actuarially sound.
30 (b) (1) The plan shall contract with an independent actuary or
31 actuaries consistent with this section.
32 (2) A filing submitted under this article shall include a
33 certification by an independent actuary or actuarial firm that the
34 rate ~~increase~~ *change* is reasonable or unreasonable and, if
35 unreasonable, that the justification for the ~~increase~~ *change* is based
36 on accurate and sound actuarial assumptions and methodologies.
37 Unless PPACA requires a certification of actuarial soundness for
38 each large group contract, a filing submitted under Section 1385.04
39 shall include a certification by an independent actuary, as described

1 in this section, that the aggregate or average rate increase is based
2 on accurate and sound actuarial assumptions and methodologies.

3 (3) The actuary or actuarial firm acting under paragraph (2)
4 shall not be an affiliate or a subsidiary of, nor in any way owned
5 or controlled by, a health care service plan or a trade association
6 of health care service plans. A board member, director, officer, or
7 employee of the actuary or actuarial firm shall not serve as a board
8 member, director, or employee of a health care service plan. A
9 board member, director, or officer of a health care service plan or
10 a trade association of health care service plans shall not serve as
11 a board member, director, officer, or employee of the actuary or
12 actuarial firm.

13 (c) Nothing in this article shall be construed to permit the
14 director to establish the rates charged subscribers and enrollees
15 for covered health care services.

16 *SEC. 11. Section 1385.07 of the Health and Safety Code is*
17 *amended to read:*

18 1385.07. (a) Notwithstanding Chapter 3.5 (commencing with
19 Section 6250) of Division 7 of Title 1 of the Government Code,
20 all information submitted under this article shall be made publicly
21 available by the department except as provided in subdivision (b).

22 (b) The contracted rates between a health care service plan and
23 a provider shall be deemed confidential information that shall not
24 be made public by the department and are exempt from disclosure
25 under the California Public Records Act (Chapter 3.5 (commencing
26 with Section 6250) of Division 7 of Title 1 of the Government
27 Code). The contracted rates between a health care service plan and
28 a large group shall be deemed confidential information that shall
29 not be made public by the department and are exempt from
30 disclosure under the California Public Records Act (Chapter 3.5
31 (commencing with Section 6250) of Division 7 of Title 1 of the
32 Government Code).

33 (c) All information submitted to the department under this article
34 shall be submitted electronically in order to facilitate review by
35 the department and the public.

36 (d) In addition, the department and the health care service plan
37 shall, at a minimum, make the following information readily
38 available to the public on their Internet Web sites, in plain language
39 and in a manner and format specified by the department, except
40 as provided in subdivision (b). The information shall be made

1 public for 60 days prior to the implementation of the rate-increase
2 *change*. The information shall include:

3 (1) Justifications for any unreasonable rate-increases *changes*,
4 including all information and supporting documentation as to why
5 the rate-increase *change* is justified.

6 (2) A plan's overall annual medical trend factor assumptions in
7 each rate filing for all benefits.

8 (3) A health plan's actual costs, by aggregate benefit category
9 to include hospital inpatient, hospital outpatient, physician services,
10 prescription drugs and other ancillary services, laboratory, and
11 radiology.

12 (4) The amount of the projected trend attributable to the use of
13 services, price inflation, or fees and risk for annual plan contract
14 trends by aggregate benefit category, such as hospital inpatient,
15 hospital outpatient, physician services, prescription drugs and other
16 ancillary services, laboratory, and radiology. A health plan that
17 exclusively contracts with no more than two medical groups in the
18 state to provide or arrange for professional medical services for
19 the enrollees of the plan shall instead disclose the amount of its
20 actual trend experience for the prior contract year by aggregate
21 benefit category, using benefit categories that are, to the maximum
22 extent possible, the same or similar to those used by other plans.

23 *SEC. 12. Section 1385.11 of the Health and Safety Code is*
24 *amended to read:*

25 1385.11. (a) Whenever it appears to the department that any
26 person has engaged, or is about to engage, in any act or practice
27 constituting a violation of this article, including the filing of
28 inaccurate or unjustified rates or inaccurate or unjustified rate
29 information, the department may review the rate filing to ensure
30 compliance with the law.

31 (b) The department may review other filings.

32 (c) The department shall accept and post to its Internet Web site
33 any public comment on a rate-increase *change* submitted to the
34 department during the 60-day period described in subdivision (d)
35 of Section 1385.07.

36 (d) The department shall report to the Legislature at least
37 quarterly on all unreasonable rate filings.

38 (e) The department shall post on its Internet Web site any
39 *changes modifications* submitted by the plan to the proposed rate

1 ~~increase change~~, including any documentation submitted by the
 2 plan supporting those ~~changes~~ *modifications*.

3 (f) If the ~~department finds~~ *director makes a decision* that an
 4 unreasonable rate ~~increase change~~ is not justified or that a rate
 5 filing contains inaccurate information, the department shall post
 6 ~~its finding that decision~~ on its Internet Web site.

7 (g) Nothing in this article shall be construed to impair or impede
 8 the department's authority to administer or enforce any other
 9 provision of this chapter.

10 *SEC. 13. Section 1389.25 of the Health and Safety Code is*
 11 *amended to read:*

12 1389.25. (a) (1) This section shall apply only to a full service
 13 health care service plan offering health coverage in the individual
 14 market in California and shall not apply to a specialized health
 15 care service plan, a health care service plan contract in the
 16 Medi-Cal program (Chapter 7 (commencing with Section 14000)
 17 of Part 3 of Division 9 of the Welfare and Institutions Code), a
 18 health care service plan conversion contract offered pursuant to
 19 Section 1373.6, a health care service plan contract in the Healthy
 20 Families Program (Part 6.2 (commencing with Section 12693) of
 21 Division 2 of the Insurance Code), or a health care service plan
 22 contract offered to a federally eligible defined individual under
 23 Article 4.6 (commencing with Section 1366.35).

24 (2) A local initiative, as defined in subdivision (v) of Section
 25 53810 of Title 22 of the California Code of Regulations, that is
 26 awarded a contract by the State Department of Health Care Services
 27 pursuant to subdivision (b) of Section 53800 of Title 22 of the
 28 California Code of Regulations, shall not be subject to this section
 29 unless the plan offers coverage in the individual market to persons
 30 not covered by Medi-Cal or the Healthy Families Program.

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

38 (2)

39 (b) (1) No change in the premium rate or coverage for an
 40 individual plan contract shall become effective unless the plan has

1 delivered a written notice of the change at least *15 days prior to*
2 *the start of the annual enrollment period applicable to the contract*
3 *or 60 days prior to the effective date of the contract renewal or the*
4 *date on which the rate or coverage changes. A notice of an increase*
5 *in the premium rate shall include the reasons for the rate increase.*
6 *renewal, whichever occurs earlier in the calendar year.*

7 ~~(3)~~

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

21 ~~(4) If a plan rejects an applicant or the dependents of an~~
22 ~~applicant for coverage or offers individual coverage at a rate that~~
23 ~~is higher than the standard rate, the plan shall inform the applicant~~
24 ~~about the state's high-risk health insurance pool, the California~~
25 ~~Major Risk Medical Insurance Program (MRMIP) (Part 6.5~~
26 ~~(commencing with Section 12700) of Division 2 of the Insurance~~
27 ~~Code), and the federal temporary high risk pool established~~
28 ~~pursuant to Part 6.6 (commencing with Section 12739.5) of~~
29 ~~Division 2 of the Insurance Code. The information provided to the~~
30 ~~applicant by the plan shall be in accordance with standards~~
31 ~~developed by the department, in consultation with the Managed~~
32 ~~Risk Medical Insurance Board, and shall specifically include the~~
33 ~~toll-free telephone number and Internet Web site address for~~
34 ~~MRMIP and the federal temporary high risk pool. The requirement~~
35 ~~to notify applicants of the availability of MRMIP and the federal~~
36 ~~temporary high risk pool shall not apply when a health plan rejects~~
37 ~~an applicant for Medicare supplement coverage.~~

38 (c) A notice provided pursuant to this section is a private and
39 confidential communication and, at the time of application, the
40 plan shall give the individual applicant the opportunity to designate

1 the address for receipt of the written notice in order to protect the
2 confidentiality of any personal or privileged information.

3 ~~SEC. 2.~~

4 *SEC. 14.* Section 1399.849 of the Health and Safety Code is
5 amended to read:

6 1399.849. (a) (1) On and after October 1, 2013, a plan shall
7 fairly and affirmatively offer, market, and sell all of the plan's
8 health benefit plans that are sold in the individual market for policy
9 years on or after January 1, 2014, to all individuals and dependents
10 in each service area in which the plan provides or arranges for the
11 provision of health care services. A plan shall limit enrollment in
12 individual health benefit plans to open enrollment periods and
13 special enrollment periods as provided in subdivisions (c) and (d).

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

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

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

27 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code
28 of Federal Regulations, for individuals enrolled in noncalendar
29 year individual health plan contracts, a plan shall provide a limited
30 open enrollment period beginning on the date that is 30 calendar
31 days prior to the date the policy year ends in 2014.

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

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

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

- 1 (ii) “Loss of minimum essential coverage” includes, but is not
2 limited to, loss of that coverage due to the circumstances described
3 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
4 Code of Federal Regulations and the circumstances described in
5 Section 1163 of Title 29 of the United States Code. “Loss of
6 minimum essential coverage” also includes loss of that coverage
7 for a reason that is not due to the fault of the individual.
- 8 (iii) “Loss of minimum essential coverage” does not include
9 loss of that coverage due to the individual’s failure to pay
10 premiums on a timely basis or situations allowing for a rescission,
11 subject to clause (ii) and Sections 1389.7 and 1389.21.
- 12 (B) He or she gains a dependent or becomes a dependent.
13 (C) He or she is mandated to be covered as a dependent pursuant
14 to a valid state or federal court order.
15 (D) He or she has been released from incarceration.
16 (E) His or her health coverage issuer substantially violated a
17 material provision of the health coverage contract.
18 (F) He or she gains access to new health benefit plans as a result
19 of a permanent move.
20 (G) He or she was receiving services from a contracting provider
21 under another health benefit plan, as defined in Section 1399.845
22 *of this code* or Section 10965 of the Insurance Code, for one of
23 the conditions described in subdivision (c) of Section 1373.96 and
24 that provider is no longer participating in the health benefit plan.
25 (H) He or she demonstrates to the Exchange, with respect to
26 health benefit plans offered through the Exchange, or to the
27 department, with respect to health benefit plans offered outside
28 the Exchange, that he or she did not enroll in a health benefit plan
29 during the immediately preceding enrollment period available to
30 the individual because he or she was misinformed that he or she
31 was covered under minimum essential coverage.
32 (I) He or she is a member of the reserve forces of the United
33 States military returning from active duty or a member of the
34 California National Guard returning from active duty service under
35 Title 32 of the United States Code.
36 (J) With respect to individual health benefit plans offered
37 through the Exchange, in addition to the triggering events listed
38 in this paragraph, any other events listed in Section 155.420(d) of
39 Title 45 of the Code of Federal Regulations.

1 (2) With respect to individual health benefit plans offered
2 outside the Exchange, an individual shall have 60 days from the
3 date of a triggering event identified in paragraph (1) to apply for
4 coverage from a health care service plan subject to this section.
5 With respect to individual health benefit plans offered through the
6 Exchange, an individual shall have 60 days from the date of a
7 triggering event identified in paragraph (1) to select a plan offered
8 through the Exchange, unless a longer period is provided in Part
9 155 (commencing with Section 155.10) of Subchapter B of Subtitle
10 A of Title 45 of the Code of Federal Regulations.

11 (e) With respect to individual health benefit plans offered
12 through the Exchange, the effective date of coverage required
13 pursuant to this section shall be consistent with the dates specified
14 in Section 155.410 or 155.420 of Title 45 of the Code of Federal
15 Regulations, as applicable. A dependent who is a registered
16 domestic partner pursuant to Section 297 of the Family Code shall
17 have the same effective date of coverage as a spouse.

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

20 (1) After an individual submits a completed application form
21 for a plan contract, the health care service plan shall, within 30
22 days, notify the individual of the individual's actual premium
23 charges for that plan established in accordance with Section
24 1399.855. The individual shall have 30 days in which to exercise
25 the right to buy coverage at the quoted premium charges.

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

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

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

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

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

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

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

39 (A) Health status.

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

- 1 (C) Claims experience.
- 2 (D) Receipt of health care.
- 3 (E) Medical history.
- 4 (F) Genetic information.
- 5 (G) Evidence of insurability, including conditions arising out
- 6 of acts of domestic violence.
- 7 (H) Disability.
- 8 (I) Any other health status-related factor as determined by any
- 9 federal regulations, rules, or guidance issued pursuant to Section
- 10 2705 of the federal Public Health Service Act.

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

18 (h) (1) A health care service plan shall consider as a single risk
19 pool for rating purposes in the individual market the claims
20 experience of all ~~insureds and~~ enrollees in all nongrandfathered
21 individual health benefit plans offered by that health care service
22 plan in this state, ~~whether offered as health care service plan~~
23 ~~contracts or individual health insurance policies, and all insureds~~
24 ~~in all nongrandfathered individual health benefit plans, as defined~~
25 ~~in Section 10965 of the Insurance Code, offered in this state by a~~
26 ~~health insurer that is a corporate affiliate, subsidiary, or parent~~
27 ~~of the plan, including those insureds and enrollees who enroll in~~
28 individual coverage through the Exchange and insureds and
29 enrollees who enroll in individual coverage outside of the
30 Exchange. Student health insurance coverage, as that coverage is
31 defined in Section 147.145(a) of Title 45 of the Code of Federal
32 Regulations, shall not be included in a health care service plan's
33 single risk pool for individual coverage.

34 (2) Each calendar year, a health care service plan shall establish
35 an index rate for the individual market in the state based on the
36 total combined claims costs for providing essential health benefits,
37 as defined pursuant to Section 1302 of PPACA, within the single
38 risk pool required under paragraph (1). The index rate shall be
39 adjusted on a marketwide basis based on the total expected
40 marketwide payments and charges under the risk adjustment and

1 reinsurance programs established for the state pursuant to Sections
2 1343 and 1341 of PPACA and Exchange user fees, as described
3 in subdivision (d) of Section 156.80 of Title 45 of the Code of
4 Federal Regulations. The premium rate for all of the ~~health care~~
5 ~~service plan's~~ health benefit plans in the individual market *within*
6 *the single risk pool required under paragraph (1)* shall use the
7 applicable index rate, as adjusted for total expected marketwide
8 payments and charges under the risk adjustment and reinsurance
9 programs established for the state pursuant to Sections 1343 and
10 1341 of PPACA, subject only to the adjustments permitted under
11 paragraph (3).

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

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

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

19 (C) The benefits provided under the health benefit plan that are
20 in addition to the essential health benefits, as defined pursuant to
21 Section 1302 of PPACA and Section 1367.005. These additional
22 benefits shall be pooled with similar benefits within the single risk
23 pool required under paragraph (1) and the claims experience from
24 those benefits shall be utilized to determine rate variations for
25 plans that offer those benefits in addition to essential health
26 benefits.

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

30 (E) Administrative costs, excluding user fees required by the
31 Exchange.

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

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

36 (k) If Section 5000A of the Internal Revenue Code, as added
37 by Section 1501 of PPACA, is repealed or amended to no longer
38 apply to the individual market, as defined in Section 2791 of the
39 federal Public Health Service Act (42 U.S.C. Sec. ~~300gg-4~~),

1 300gg-91), subdivisions (a), (b), and (g) shall become inoperative
2 12 months after that repeal or amendment.

3 *SEC. 15. Section 10112.27 of the Insurance Code is amended*
4 *to read:*

5 10112.27. (a) An individual or small group health insurance
6 policy issued, amended, or renewed on or after January 1, 2014,
7 shall, at a minimum, include coverage for essential health benefits
8 pursuant to PPACA and as outlined in this section. This section
9 shall exclusively govern what benefits a health insurer must cover
10 as essential health benefits. For purposes of this section, “essential
11 health benefits” means all of the following:

12 (1) Health benefits within the categories identified in Section
13 1302(b) of PPACA: ambulatory patient services, emergency
14 services, hospitalization, maternity and newborn care, mental health
15 and substance use disorder services, including behavioral health
16 treatment, prescription drugs, rehabilitative and habilitative services
17 and devices, laboratory services, preventive and wellness services
18 and chronic disease management, and pediatric services, including
19 oral and vision care.

20 (2) (A) The health benefits covered by the Kaiser Foundation
21 Health Plan Small Group HMO 30 plan (federal health product
22 identification number 40513CA035) as this plan was offered during
23 the first quarter of 2012, as follows, regardless of whether the
24 benefits are specifically referenced in the plan contract or evidence
25 of coverage for that plan:

26 (i) Medically necessary basic health care services, as defined
27 in subdivision (b) of Section 1345 of the Health and Safety Code
28 and in Section 1300.67 of Title 28 of the California Code of
29 Regulations.

30 (ii) The health benefits mandated to be covered by the plan
31 pursuant to statutes enacted before December 31, 2011, as
32 described in the following sections of the Health and Safety Code:
33 Sections 1367.002, 1367.06, and 1367.35 (preventive services for
34 children); Section 1367.25 (prescription drug coverage for
35 contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46
36 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha
37 fetoprotein testing); Section 1367.6 (breast cancer screening);
38 Section 1367.61 (prosthetics for laryngectomy); Section 1367.62
39 (maternity hospital stay); Section 1367.63 (reconstructive surgery);
40 Section 1367.635 (mastectomies); Section 1367.64 (prostate

1 cancer); Section 1367.65 (mammography); Section 1367.66
2 (cervical cancer); Section 1367.665 (cancer screening tests);
3 Section 1367.67 (osteoporosis); Section 1367.68 (surgical
4 procedures for jaw bones); Section 1367.71 (anesthesia for dental);
5 Section 1367.9 (conditions attributable to diethylstilbestrol);
6 Section 1368.2 (hospice care); Section 1370.6 (cancer clinical
7 trials); Section 1371.5 (emergency response ambulance or
8 ambulance transport services); subdivision (b) of Section 1373
9 (sterilization operations or procedures); Section 1373.4 (inpatient
10 hospital and ambulatory maternity); Section 1374.56
11 (phenylketonuria); Section 1374.17 (organ transplants for HIV);
12 Section 1374.72 (mental health parity); and Section 1374.73
13 (autism/behavioral health treatment).

14 (iii) Any other benefits mandated to be covered by the plan
15 pursuant to statutes enacted before December 31, 2011, as
16 described in those statutes.

17 (iv) The health benefits covered by the plan that are not
18 otherwise required to be covered under Chapter 2.2 (commencing
19 with Section 1340) of Division 2 of the Health and Safety Code,
20 to the extent otherwise required pursuant to Sections 1367.18,
21 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health
22 and Safety Code, and Section 1300.67.24 of Title 28 of the
23 California Code of Regulations.

24 (v) Any other health benefits covered by the plan that are not
25 otherwise required to be covered under Chapter 2.2 (commencing
26 with Section 1340) of Division 2 of the Health and Safety Code.

27 (B) Where there are any conflicts or omissions in the plan
28 identified in subparagraph (A) as compared with the requirements
29 for health benefits under Chapter 2.2 (commencing with Section
30 1340) of Division 2 of the Health and Safety Code that were
31 enacted prior to December 31, 2011, the requirements of Chapter
32 2.2 (commencing with Section 1340) of Division 2 of the Health
33 and Safety Code shall be controlling, except as otherwise specified
34 in this section.

35 (C) Notwithstanding subparagraph (B) or any other provision
36 of this section, the home health services benefits covered under
37 the plan identified in subparagraph (A) shall be deemed to not be
38 in conflict with Chapter 2.2 (commencing with Section 1340) of
39 Division 2 of the Health and Safety Code.

1 (D) For purposes of this section, the Paul Wellstone and Pete
2 Domenici Mental Health Parity and Addiction Equity Act of 2008
3 (Public Law 110-343) shall apply to a policy subject to this section.
4 Coverage of mental health and substance use disorder services
5 pursuant to this paragraph, along with any scope and duration
6 limits imposed on the benefits, shall be in compliance with the
7 Paul Wellstone and Pete Domenici Mental Health Parity and
8 Addiction Equity Act of 2008 (Public Law 110-343), and all rules,
9 regulations, and guidance issued pursuant to Section 2726 of the
10 federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

11 (3) With respect to habilitative services, in addition to any
12 habilitative services identified in paragraph (2), coverage shall
13 also be provided as required by federal rules, regulations, or
14 guidance issued pursuant to Section 1302(b) of PPACA.
15 Habilitative services shall be covered under the same terms and
16 conditions applied to rehabilitative services under the policy.

17 (4) With respect to pediatric vision care, the same health benefits
18 for pediatric vision care covered under the Federal Employees
19 Dental and Vision Insurance Program vision plan with the largest
20 national enrollment as of the first quarter of 2012. The pediatric
21 vision care services covered pursuant to this paragraph shall be in
22 addition to, and shall not replace, any vision services covered under
23 the plan identified in paragraph (2).

24 (5) With respect to pediatric oral care, the same health benefits
25 for pediatric oral care covered under the dental plan available to
26 subscribers of the Healthy Families Program in 2011–12, including
27 the provision of medically necessary orthodontic care provided
28 pursuant to the federal Children’s Health Insurance Program
29 Reauthorization Act of 2009. The pediatric oral care benefits
30 covered pursuant to this paragraph shall be in addition to, and shall
31 not replace, any dental or orthodontic services covered under the
32 plan identified in paragraph (2).

33 (b) Treatment limitations imposed on health benefits described
34 in this section shall be no greater than the treatment limitations
35 imposed by the corresponding plans identified in subdivision (a),
36 subject to the requirements set forth in paragraph (2) of subdivision
37 (a).

38 (c) Except as provided in subdivision (d), nothing in this section
39 shall be construed to permit a health insurer to make substitutions

1 for the benefits required to be covered under this section, regardless
2 of whether those substitutions are actuarially equivalent.

3 (d) To the extent permitted under Section 1302 of PPACA and
4 any rules, regulations, or guidance issued pursuant to that section,
5 and to the extent that substitution would not create an obligation
6 for the state to defray costs for any individual, an insurer may
7 substitute its prescription drug formulary for the formulary
8 provided under the plan identified in subdivision (a) as long as the
9 coverage for prescription drugs complies with the sections
10 referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph
11 (2) of subdivision (a) that apply to prescription drugs.

12 (e) No health insurer, or its agent, producer, or representative,
13 shall issue, deliver, renew, offer, market, represent, or sell any
14 product, policy, or discount arrangement as compliant with the
15 essential health benefits requirement in federal law, unless it meets
16 all of the requirements of this section. This subdivision shall be
17 enforced in the same manner as Section 790.03, including through
18 the means specified in Sections 790.035 and 790.05.

19 (f) This section shall apply regardless of whether the policy is
20 offered inside or outside the California Health Benefit Exchange
21 created by Section 100500 of the Government Code.

22 (g) Nothing in this section shall be construed to exempt a health
23 insurer or a health insurance policy from meeting other applicable
24 requirements of law.

25 (h) This section shall not be construed to prohibit a policy from
26 covering additional benefits, including, but not limited to, spiritual
27 care services that are tax deductible under Section 213 of the
28 Internal Revenue Code.

29 (i) Subdivision (a) shall not apply to any of the following:

30 (1) A policy that provides excepted benefits as described in
31 Sections 2722 and 2791 of the federal Public Health Service Act
32 (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

33 (2) A policy that qualifies as a grandfathered health plan under
34 Section 1251 of PPACA or any binding rules, regulation, or
35 guidance issued pursuant to that section.

36 (j) Nothing in this section shall be implemented in a manner
37 that conflicts with a requirement of PPACA.

38 (k) This section shall be implemented only to the extent essential
39 health benefits are required pursuant to PPACA.

1 (l) An essential health benefit is required to be provided under
2 this section only to the extent that federal law does not require the
3 state to defray the costs of the benefit.

4 (m) Nothing in this section shall obligate the state to incur costs
5 for the coverage of benefits that are not essential health benefits
6 as defined in this section.

7 (n) An insurer is not required to cover, under this section,
8 changes to health benefits that are the result of statutes enacted on
9 or after December 31, 2011.

10 (o) (1) The commissioner may adopt emergency regulations
11 implementing this section. The commissioner may, on a one-time
12 basis, readopt any emergency regulation authorized by this section
13 that is the same as, or substantially equivalent to, an emergency
14 regulation previously adopted under this section.

15 (2) The initial adoption of emergency regulations implementing
16 this section and the readoption of emergency regulations authorized
17 by this subdivision shall be deemed an emergency and necessary
18 for the immediate preservation of the public peace, health, safety,
19 or general welfare. The initial emergency regulations and the
20 readoption of emergency regulations authorized by this section
21 shall be submitted to the Office of Administrative Law for filing
22 with the Secretary of State and each shall remain in effect for no
23 more than 180 days, by which time final regulations may be
24 adopted.

25 (3) The commissioner shall consult with the Director of the
26 Department of Managed Health Care to ensure consistency and
27 uniformity in the development of regulations under this
28 subdivision.

29 (4) This subdivision shall become inoperative on March 1, 2016.

30 (p) Nothing in this section shall impose on health insurance
31 policies the cost sharing or network limitations of the plans
32 identified in subdivision (a) except to the extent otherwise required
33 to comply with provisions of this code, including this section, and
34 as otherwise applicable to all health insurance policies offered to
35 individuals and small groups.

36 (q) For purposes of this section, the following definitions shall
37 apply:

38 (1) “Habilitative services” means medically necessary health
39 care services and health care devices that assist an individual in
40 partially or fully acquiring or improving skills and functioning and

1 that are necessary to address a health condition, to the maximum
2 extent practical. These services address the skills and abilities
3 needed for functioning in interaction with an individual’s
4 environment. Examples of health care services that are not
5 habilitative services include, but are not limited to, respite care,
6 day care, recreational care, residential treatment, social services,
7 custodial care, or education services of any kind, including, but
8 not limited to, vocational training. Habilitative services shall be
9 covered under the same terms and conditions applied to
10 rehabilitative services under the policy.

11 (2) (A) “Health benefits,” unless otherwise required to be
12 defined pursuant to federal rules, regulations, or guidance issued
13 pursuant to Section 1302(b) of PPACA, means health care items
14 or services for the diagnosis, cure, mitigation, treatment, or
15 prevention of illness, injury, disease, or a health condition,
16 including a behavioral health condition.

17 (B) “Health benefits” does not mean any cost-sharing
18 requirements such as copayments, coinsurance, or deductibles.

19 (3) “PPACA” means the federal Patient Protection and
20 Affordable Care Act (Public Law 111-148), as amended by the
21 federal Health Care and Education Reconciliation Act of 2010
22 (Public Law 111-152), and any rules, regulations, or guidance
23 issued thereunder.

24 (4) “Small group health insurance policy” means a group health
25 ~~care service~~ insurance policy issued to a small employer, as defined
26 in Section ~~10700~~ 10753.

27 *SEC. 16. Section 10112.28 of the Insurance Code is amended*
28 *to read:*

29 10112.28. (a) This section shall apply to nongrandfathered
30 individual and group health insurance policies that provide
31 coverage for essential health benefits, as defined in Section
32 10112.27, and that are issued, amended, or renewed on or after
33 January 1, 2015.

34 (b) (1) For nongrandfathered health insurance policies in the
35 individual or small group markets, a health insurance policy, except
36 a specialized health insurance policy, that is issued, amended, or
37 renewed on or after January 1, 2015, shall provide for a limit on
38 annual out-of-pocket expenses for all covered benefits that meet
39 the definition of essential health benefits in Section 10112.27,
40 including out-of-network emergency care.

1 (2) For nongrandfathered health insurance policies in the large
2 group market, a health insurance policy, except a specialized health
3 insurance policy, that is issued, amended, or renewed on or after
4 January 1, 2015, shall provide for a limit on annual out-of-pocket
5 expenses for covered benefits, including out-of-network emergency
6 care. This limit shall apply only to essential health benefits, as
7 defined in Section 10112.27, that are covered under the policy to
8 the extent that this provision does not conflict with federal law or
9 guidance on out-of-pocket maximums for nongrandfathered health
10 insurance policies in the large group market.

11 (c) (1) The limit described in subdivision (b) shall not exceed
12 the limit described in Section 1302(c) of PPACA and any
13 subsequent rules, regulations, or guidance issued under that section.

14 (2) The limit described in subdivision (b) shall result in a total
15 maximum out-of-pocket limit for all covered essential health
16 benefits that shall equal the dollar amounts in effect under Section
17 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the
18 dollar amounts adjusted as specified in Section 1302(c)(1)(B) of
19 PPACA.

20 (d) Nothing in this section shall be construed to affect the
21 reduction in cost sharing for eligible insureds described in Section
22 1402 of PPACA and any subsequent rules, regulations, or guidance
23 issued under that section.

24 (e) If an essential health benefit is offered or provided by a
25 specialized health insurance policy, the total annual out-of-pocket
26 maximum for all covered essential benefits shall not exceed the
27 limit in subdivision (b). This section shall not apply to a specialized
28 health insurance policy that does not offer an essential health
29 benefit as defined in Section ~~10112.28~~. *10112.27*.

30 (f) The maximum out-of-pocket limit shall apply to any
31 copayment, coinsurance, deductible, and any other form of cost
32 sharing for all covered benefits that meet the definition of essential
33 health benefits, as defined in Section ~~10112.28~~. *10112.27*.

34 (g) For nongrandfathered health insurance policies in the group
35 market, “policy year” has the meaning set forth in Section 144.103
36 of Title 45 of the Code of Federal Regulations. For
37 nongrandfathered health insurance policies sold in the individual
38 market, “policy year” means the calendar year.

39 (h) “PPACA” means the federal Patient Protection and
40 Affordable Care Act (Public Law 111-148), as amended by the

1 federal Health Care and Education Reconciliation Act of 2010
2 (Public Law 111-152), and any rules, regulations, or guidance
3 issued thereunder.

4 *SEC. 17. Section 10112.3 of the Insurance Code, as amended*
5 *by Section 11 of Chapter 5 of the First Extraordinary Session of*
6 *the Statutes of 2013, is amended to read:*

7 10112.3. (a) For purposes of this section, the following
8 definitions shall apply:

9 (1) “Exchange” means the California Health Benefit Exchange
10 established in Title 22 (commencing with Section 100500) of the
11 Government Code.

12 (2) “Federal act” 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 amendments to, or regulations or
16 guidance issued under, those acts.

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

19 (4) “Small employer” has the same meaning as that term is
20 defined in Section ~~10700~~ 10753.

21 (b) (1) Health insurers participating in the *individual market*
22 *of the Exchange* shall fairly and affirmatively offer, market, and
23 sell in the *individual market of the Exchange* at least one product
24 within each of the five levels of coverage contained in subsections
25 (d) and (e) of Section 1302 of the federal act. ~~The Health insurers~~
26 ~~participating in the Small Business Health Options Program~~
27 ~~(SHOP Program) of the Exchange, established pursuant to~~
28 ~~subdivision (m) of Section 100504 of the Government Code, shall~~
29 ~~fairly and affirmatively offer, market, and sell in the SHOP~~
30 ~~Program at least one product within each of the four levels of~~
31 ~~coverage contained in subsection (d) of Section 1302 of the federal~~
32 ~~act.~~

33 (2) ~~The board established under Section 100500 of the~~
34 ~~Government Code may require insurers to sell additional products~~
35 ~~within each of those the levels of coverage identified in paragraph~~
36 ~~(1). This~~

37 (3) ~~This subdivision shall not apply to an insurer that solely~~
38 ~~offers supplemental coverage in the Exchange under paragraph~~
39 ~~(10) of subdivision (a) of Section 100504 of the Government Code.~~
40 ~~This subdivision shall not apply to a bridge plan product of a~~

1 Medi-Cal managed care plan that contracts with the State
2 Department of Health Care Services pursuant to Section 14005.70
3 of the Welfare and Institutions Code and that meets the
4 requirements of Section 100504.5 of the Government Code, to the
5 extent approved by the appropriate federal agency.

6 (c) (1) Health insurers participating in the Exchange that sell
7 any products outside the Exchange shall do both of the following:

8 (A) Fairly and affirmatively offer, market, and sell all products
9 made available to individuals in the Exchange to individuals
10 purchasing coverage outside the Exchange.

11 (B) Fairly and affirmatively offer, market, and sell all products
12 made available to small employers in the Exchange to small
13 employers purchasing coverage outside the Exchange.

14 (2) For purposes of this subdivision, “product” does not include
15 contracts entered into pursuant to Part 6.2 (commencing with
16 Section 12693) of Division 2 between the Managed Risk Medical
17 Insurance Board and health insurers for enrolled Healthy Families
18 beneficiaries or to contracts entered into pursuant to Chapter 7
19 (commencing with Section 14000) of, or Chapter 8 (commencing
20 with Section 14200) of, Part 3 of Division 9 of the Welfare and
21 Institutions Code between the State Department of Health Care
22 Services and health insurers for enrolled Medi-Cal beneficiaries
23 or for contracts with bridge plan products that meet the
24 requirements of Section 100504.5 of the Government Code.

25 (d) (1) Commencing January 1, 2014, a health insurer *shall*,
26 with respect to *individual* policies that cover hospital, medical, or
27 surgical benefits, ~~may~~ only sell the five levels of coverage
28 contained in subsections (d) and (e) of Section 1302 of the federal
29 act, except that a health insurer that does not participate in the
30 Exchange ~~may~~ *shall*, with respect to *individual* policies that cover
31 hospital, medical, or surgical benefits, only sell the four levels of
32 coverage contained in *subsection (d) of Section 1302* ~~(d) 1302~~ of
33 the federal act.

34 (2) *Commencing January 1, 2014, a health insurer shall, with*
35 *respect to small employer policies that cover hospital, medical,*
36 *or surgical expenses, only sell the four levels of coverage contained*
37 *in subsection (d) of Section 1302 of the federal act.*

38 (e) Commencing January 1, 2014, a health insurer that does not
39 participate in the Exchange shall, with respect to *individual or*
40 *small employer* policies that cover hospital, medical, or surgical

1 expenses, offer at least one standardized product that has been
2 designated by the Exchange in each of the four levels of coverage
3 contained in *subsection (d) of Section ~~1302(d)~~ 1302* of the federal
4 act. This subdivision shall only apply if the board of the Exchange
5 exercises its authority under subdivision (c) of Section 100504 of
6 the Government Code. Nothing in this subdivision shall require
7 an insurer that does not participate in the Exchange to offer
8 standardized products in the small employer market if the insurer
9 only sells products in the individual market. Nothing in this
10 subdivision shall require an insurer that does not participate in the
11 Exchange to offer standardized products in the individual market
12 if the insurer only sells products in the small employer market.
13 This subdivision shall not be construed to prohibit the insurer from
14 offering other products provided that it complies with subdivision
15 (d).

16 (f) For purposes of this section, a bridge plan product shall mean
17 an individual health benefit plan, as defined in subdivision (a) of
18 Section 10198.6 that is offered by a health insurer that contracts
19 with the Exchange pursuant to Section 100504.5 of the Government
20 Code.

21 (g) This section shall become inoperative on the October 1 that
22 is five years after the date that federal approval of the bridge plan
23 option occurs, and, as of the second January 1 thereafter, is
24 repealed, unless a later enacted statute that is enacted before that
25 date deletes or extends the dates on which it becomes inoperative
26 and is repealed.

27 *SEC. 18. Section 10112.3 of the Insurance Code, as added by*
28 *Section 12 of Chapter 5 of the First Extraordinary Session of the*
29 *Statutes of 2013, is amended to read:*

30 10112.3. (a) For purposes of this section, the following
31 definitions shall apply:

32 (1) "Exchange" means the California Health Benefit Exchange
33 established in Title 22 (commencing with Section 100500) of the
34 Government Code.

35 (2) "Federal act" means the federal Patient Protection and
36 Affordable Care Act (Public Law 111-148), as amended by the
37 federal Health Care and Education Reconciliation Act of 2010
38 (Public Law 111-152), and any amendments to, or regulations or
39 guidance issued under, those acts.

1 (3) “Qualified health plan” has the same meaning as that term
2 is defined in Section 1301 of the federal act.

3 (4) “Small employer” has the same meaning as that term is
4 defined in Section ~~10700~~ 10753.

5 (b) (1) Health insurers participating in the *individual market*
6 *of the Exchange* shall fairly and affirmatively offer, market, and
7 sell in the *individual market of the Exchange* at least one product
8 within each of the five levels of coverage contained in subsections
9 (d) and (e) of Section 1302 of the federal act. ~~The Health insurers~~
10 ~~participating in the Small Business Health Options Program~~
11 ~~(SHOP Program) of the Exchange, established pursuant to~~
12 ~~subdivision (m) of Section 100504 of the Government Code, shall~~
13 ~~fairly and affirmatively offer, market, and sell in the SHOP~~
14 ~~Program at least one product within each of the four levels of~~
15 ~~coverage contained in subsection (d) of Section 1302 of the federal~~
16 ~~act.~~

17 (2) The board established under Section 100500 of the
18 Government Code may require insurers to sell additional products
19 within each of ~~those~~ *the* levels of coverage *identified in paragraph*
20 *(1)*. ~~This~~

21 (3) *This* subdivision shall not apply to an insurer that solely
22 offers supplemental coverage in the Exchange under paragraph
23 (10) of subdivision (a) of Section 100504 of the Government Code.

24 (c) (1) Health insurers participating in the Exchange that sell
25 any products outside the Exchange shall do both of the following:

26 (A) Fairly and affirmatively offer, market, and sell all products
27 made available to individuals in the Exchange to individuals
28 purchasing coverage outside the Exchange.

29 (B) Fairly and affirmatively offer, market, and sell all products
30 made available to small employers in the Exchange to small
31 employers purchasing coverage outside the Exchange.

32 (2) For purposes of this subdivision, “product” does not include
33 contracts entered into pursuant to Part 6.2 (commencing with
34 Section 12693) of Division 2 between the Managed Risk Medical
35 Insurance Board and health insurers for enrolled Healthy Families
36 beneficiaries or to contracts entered into pursuant to Chapter 7
37 (commencing with Section 14000) of, or Chapter 8 (commencing
38 with Section 14200) of, Part 3 of Division 9 of the Welfare and
39 Institutions Code between the State Department of Health Care
40 Services and health insurers for enrolled Medi-Cal beneficiaries.

1 (d) (1) Commencing January 1, 2014, a health insurer shall,
2 with respect to *individual* policies that cover hospital, medical, or
3 surgical benefits, ~~may~~ only sell the five levels of coverage
4 contained in subsections (d) and (e) of Section 1302 of the federal
5 act, except that a health insurer that does not participate in the
6 Exchange ~~may~~ shall, with respect to *individual* policies that cover
7 hospital, medical, or surgical benefits, only sell the four levels of
8 coverage contained in *subsection (d) of Section ~~1302(d)~~ 1302* of
9 the federal act.

10 (2) Commencing January 1, 2014, a health insurer shall, with
11 respect to *small employer policies that cover hospital, medical,*
12 *or surgical expenses, only sell the four levels of coverage contained*
13 *in subsection (d) of Section 1302 of the federal act.*

14 (e) Commencing January 1, 2014, a health insurer that does not
15 participate in the Exchange shall, with respect to *individual or*
16 *small employer policies that cover hospital, medical, or surgical*
17 *expenses, offer at least one standardized product that has been*
18 *designated by the Exchange in each of the four levels of coverage*
19 *contained in subsection (d) of Section ~~1302(d)~~ 1302* of the federal
20 act. This subdivision shall only apply if the board of the Exchange
21 exercises its authority under subdivision (c) of Section 100504 of
22 the Government Code. Nothing in this subdivision shall require
23 an insurer that does not participate in the Exchange to offer
24 standardized products in the small employer market if the insurer
25 only sells products in the individual market. Nothing in this
26 subdivision shall require an insurer that does not participate in the
27 Exchange to offer standardized products in the individual market
28 if the insurer only sells products in the small employer market.
29 This subdivision shall not be construed to prohibit the insurer from
30 offering other products provided that it complies with subdivision
31 (d).

32 (f) This section shall become operative only if Section 11 of the
33 act that added this section becomes inoperative pursuant to
34 subdivision (g) of that Section 11.

35 *SEC. 19. Section 10113.9 of the Insurance Code is amended*
36 *to read:*

37 10113.9. (a) This section shall not apply to short-term limited
38 duration health insurance, vision-only, dental-only, or
39 CHAMPUS-supplement insurance, or to hospital indemnity,

1 hospital-only, accident-only, or specified disease insurance that
2 does not pay benefits on a fixed benefit, cash payment only basis.

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

10 (2)

11 (b) (1) No change in the premium rate or coverage for an
12 individual health insurance policy shall become effective unless
13 the insurer has delivered a written notice of the change at least *15*
14 *days prior to the start of the annual enrollment period applicable*
15 *to the policy or 60 days prior to the effective date of the policy*
16 *renewal or the date on which the rate or coverage changes. A notice*
17 *of an increase in the premium rate shall include the reasons for the*
18 *rate increase. renewal, whichever occurs earlier in the calendar*
19 *year.*

20 (3)

21 (2) The written notice required pursuant to paragraph ~~(2) (1)~~
22 shall be delivered to the individual policyholder at his or her last
23 address known to the insurer, at least ~~60 days prior to the effective~~
24 ~~date of the change~~ *insurer*. The notice shall state in italics and in
25 12-point type the actual dollar amount of the premium increase
26 and the specific percentage by which the current premium will be
27 increased. The notice shall describe in plain, understandable
28 English any changes in the policy or any changes in benefits,
29 including a reduction in benefits or changes to waivers, exclusions,
30 or conditions, and highlight this information by printing it in italics.
31 The notice shall specify in a minimum of 10-point bold typeface,
32 the reason for a premium rate change or a change in coverage or
33 benefits.

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

1 ~~Section 12739.5). The information provided to the applicant by~~
2 ~~the insurer shall be in accordance with standards developed by the~~
3 ~~department, in consultation with the Managed Risk Medical~~
4 ~~Insurance Board, and shall specifically include the toll-free~~
5 ~~telephone number and Internet Web site address for MRMIP and~~
6 ~~the federal temporary high risk pool. The requirement to notify~~
7 ~~applicants of the availability of MRMIP and the federal temporary~~
8 ~~high risk pool shall not apply when a health plan rejects an~~
9 ~~applicant for Medicare supplement coverage.~~

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

15 *SEC. 20. Section 10181.3 of the Insurance Code is amended*
16 *to read:*

17 10181.3. (a) ~~(1)~~—All health insurers shall file with the
18 department all required rate information for individual and small
19 group health insurance policies at least 60 days prior to
20 implementing any rate change.

21 ~~(2) For individual health insurance policies, the filing shall be~~
22 ~~concurrent with the notice required under Section 10113.9.~~

23 ~~(3) For small group health insurance policies, the filing shall~~
24 ~~be concurrent with the notice required under Section 10199.1.~~

25 (b) An insurer shall disclose to the department all of the
26 following for each individual and small group rate filing:

- 27 (1) Company name and contact information.
- 28 (2) Number of policy forms covered by the filing.
- 29 (3) Policy form numbers covered by the filing.
- 30 (4) Product type, such as indemnity or preferred provider
31 organization.
- 32 (5) Segment type.
- 33 (6) Type of insurer involved, such as for profit or not for profit.
- 34 (7) Whether the products are opened or closed.
- 35 (8) Enrollment in each policy and rating form.
- 36 (9) Insured months in each policy form.
- 37 (10) Annual rate.
- 38 (11) Total earned premiums in each policy form.
- 39 (12) Total incurred claims in each policy form.
- 40 (13) Average rate ~~increase~~ *change* initially requested.

- 1 (14) Review category: initial filing for new product, filing for
2 existing product, or resubmission.
- 3 (15) Average rate of ~~increase~~ *change*.
- 4 (16) Effective date of rate ~~increase~~ *change*.
- 5 (17) Number of policyholders or insureds affected by each
6 policy form.
- 7 (18) The insurer's overall annual medical trend factor
8 assumptions in each rate filing for all benefits and by aggregate
9 benefit category, including hospital inpatient, hospital outpatient,
10 physician services, prescription drugs and other ancillary services,
11 laboratory, and radiology. An insurer may provide aggregated
12 additional data that demonstrates or reasonably estimates
13 year-to-year cost ~~increases~~ *changes* in specific benefit categories
14 ~~in major geographic regions of the state~~ *the geographic regions*
15 *listed in Sections 10753.14 and 10965.9*. For purposes of this
16 paragraph, "major geographic region" shall be defined by the
17 department and shall include no more than nine regions.
- 18 (19) The amount of the projected trend attributable to the use
19 of services, price inflation, or fees and risk for annual policy trends
20 by aggregate benefit category, such as hospital inpatient, hospital
21 outpatient, physician services, prescription drugs and other
22 ancillary services, laboratory, and radiology.
- 23 (20) A comparison of claims cost and rate of changes over time.
- 24 (21) Any changes in insured cost-sharing over the prior year
25 associated with the submitted rate filing.
- 26 (22) Any changes in insured benefits over the prior year
27 associated with the submitted rate filing.
- 28 (23) The certification described in subdivision (b) of Section
29 10181.6.
- 30 (24) Any changes in administrative costs.
- 31 (25) Any other information required for rate review under
32 PPACA.
- 33 (c) An insurer subject to subdivision (a) shall also disclose the
34 following aggregate data for all rate filings submitted under this
35 section in the individual and small group health insurance markets:
- 36 (1) Number and percentage of rate filings reviewed by the
37 following:
- 38 (A) Plan year.
- 39 (B) Segment type.
- 40 (C) Product type.

1 (D) Number of policyholders.

2 (E) Number of covered lives affected.

3 (2) The insurer's average rate ~~increase~~ *change* by the following
4 categories:

5 (A) Plan year.

6 (B) Segment type.

7 (C) Product type.

8 (3) Any cost containment and quality improvement efforts since
9 the insurer's last rate filing for the same category of health benefit
10 plan. To the extent possible, the insurer shall describe any
11 significant new health care cost containment and quality
12 improvement efforts and provide an estimate of potential savings
13 together with an estimated cost or savings for the projection period.

14 (d) The department may require all health insurers to submit all
15 rate filings to the National Association of Insurance
16 Commissioners' System for Electronic Rate and Form Filing
17 (SERFF). Submission of the required rate filings to SERFF shall
18 be deemed to be filing with the department for purposes of
19 compliance with this section.

20 (e) A health insurer shall submit any other information required
21 under PPACA. A health insurer shall also submit any other
22 information required pursuant to any regulation adopted by the
23 department to comply with this article.

24 *SEC. 21. Section 10181.6 of the Insurance Code is amended*
25 *to read:*

26 10181.6. (a) A filing submitted under this article shall be
27 actuarially sound.

28 (b) (1) The health insurer shall contract with an independent
29 actuary or actuaries consistent with this section.

30 (2) A filing submitted under this article shall include a
31 certification by an independent actuary or actuarial firm that the
32 rate ~~increase~~ *change* is reasonable or unreasonable and, if
33 unreasonable, that the justification for the ~~increase~~ *change* is based
34 on accurate and sound actuarial assumptions and methodologies.
35 Unless PPACA requires a certification of actuarial soundness for
36 each large group health insurance policy, a filing submitted under
37 Section 10181.4 shall include a certification by an independent
38 actuary, as described in this section, that the aggregate or average
39 rate increase is based on accurate and sound actuarial assumptions
40 and methodologies.

1 (3) The actuary or actuarial firm acting under paragraph (2)
2 shall not be an affiliate or a subsidiary of, nor in any way owned
3 or controlled by, a health insurer or a trade association of health
4 insurers. A board member, director, officer, or employee of the
5 actuary or actuarial firm shall not serve as a board member,
6 director, or employee of a health insurer. A board member, director,
7 or officer of a health insurer or a trade association of health insurers
8 shall not serve as a board member, director, officer, or employee
9 of the actuary or actuarial firm.

10 (c) Nothing in this article shall be construed to permit the
11 commissioner to establish the rates charged insureds and
12 policyholders for covered health care services.

13 *SEC. 22. Section 10181.7 of the Insurance Code is amended*
14 *to read:*

15 10181.7. (a) Notwithstanding Chapter 3.5 (commencing with
16 Section 6250) of Division 7 of Title 1 of the Government Code,
17 all information submitted under this article shall be made publicly
18 available by the department except as provided in subdivision (b).

19 (b) Any contracted rates between a health insurer and a provider
20 shall be deemed confidential information that shall not be made
21 public by the department and are exempt from disclosure under
22 the California Public Records Act (Chapter 3.5 (commencing with
23 Section 6250) of Division 7 of Title 1 of the Government Code).
24 The contracted rates between a health insurer and a large group
25 shall be deemed confidential information that shall not be made
26 public by the department and are exempt from disclosure under
27 the California Public Records Act (Chapter 3.5 (commencing with
28 Section 6250) of Division 7 of Title 1 of the Government Code).

29 (c) All information submitted to the department under this article
30 shall be submitted electronically in order to facilitate review by
31 the department and the public.

32 (d) In addition, the department and the health insurer shall, at
33 a minimum, make the following information readily available to
34 the public on their Internet Web sites, in plain language and in a
35 manner and format specified by the department, except as provided
36 in subdivision (b). The information shall be made public for 60
37 days prior to the implementation of the rate ~~increase~~ *change*. The
38 information shall include:

1 (1) Justifications for any unreasonable rate ~~increases~~ *changes*,
2 including all information and supporting documentation as to why
3 the rate ~~increase~~ *change* is justified.

4 (2) An insurer's overall annual medical trend factor assumptions
5 in each rate filing for all benefits.

6 (3) An insurer's actual costs, by aggregate benefit category to
7 include, hospital inpatient, hospital outpatient, physician services,
8 prescription drugs and other ancillary services, laboratory, and
9 radiology.

10 (4) The amount of the projected trend attributable to the use of
11 services, price inflation, or fees and risk for annual policy trends
12 by aggregate benefit category, such as hospital inpatient, hospital
13 outpatient, physician services, prescription drugs and other
14 ancillary services, laboratory, and radiology.

15 *SEC. 23. Section 10181.11 of the Insurance Code is amended*
16 *to read:*

17 10181.11. (a) Whenever it appears to the department that any
18 person has engaged, or is about to engage, in any act or practice
19 constituting a violation of this article, including the filing of
20 inaccurate or unjustified rates or inaccurate or unjustified rate
21 information, the department may review rate filing to ensure
22 compliance with the law.

23 (b) The department may review other filings.

24 (c) The department shall accept and post to its Internet Web site
25 any public comment on a rate ~~increase~~ *change* submitted to the
26 department during the 60-day period described in subdivision (d)
27 of Section 10181.7.

28 (d) The department shall report to the Legislature at least
29 quarterly on all unreasonable rate filings.

30 (e) The department shall post on its Internet Web site any
31 ~~changes~~ *modifications* submitted by the insurer to the proposed
32 rate ~~increase~~ *change*, including any documentation submitted by
33 the insurer supporting those ~~changes~~ *modifications*.

34 (f) If the ~~department finds~~ *commissioner makes a decision* that
35 an unreasonable rate ~~increase~~ *change* is not justified or that a rate
36 filing contains inaccurate information, the department shall post
37 ~~its finding that decision~~ on its Internet Web site.

38 (g) Nothing in this article shall be construed to impair or impede
39 the department's authority to administer or enforce any other
40 provision of this code.

1 *SEC. 24. Section 10199.1 of the Insurance Code is amended*
2 *to read:*

3 10199.1. (a) No insurer or nonprofit hospital service plan or
4 administrator acting on its behalf shall terminate a group master
5 policy or contract providing hospital, medical, or surgical benefits,
6 increase premiums or charges therefor, reduce or eliminate benefits
7 thereunder, or restrict eligibility for coverage thereunder without
8 providing prior notice of that action. No such action shall become
9 effective unless written notice of the action was delivered by mail
10 to the last known address of the appropriate insurance producer
11 and the appropriate administrator, if any, at least 45 days prior to
12 the effective date of the action and to the last known address of
13 the group policyholder or group contractholder at least 60 days
14 prior to the effective date of the action. If nonemployee certificate
15 holders or employees of more than one employer are covered under
16 the policy or contract, written notice shall also be delivered by
17 mail to the last known address of each nonemployee certificate
18 holder or affected employer or, if the action does not affect all
19 employees and dependents of one or more employers, to the last
20 known address of each affected employee certificate holder, at
21 least 60 days prior to the effective date of the action.

22 (b) No holder of a master group policy or a master group
23 nonprofit hospital service plan contract or administrator acting on
24 its behalf shall terminate the coverage of, increase premiums or
25 charges for, or reduce or eliminate benefits available to, or restrict
26 eligibility for coverage of a covered person, employer unit, or class
27 of certificate holders covered under the policy or contract for
28 hospital, medical, or surgical benefits without first providing prior
29 notice of the action. No such action shall become effective unless
30 written notice was delivered by mail to the last known address of
31 each affected nonemployee certificate holder or employer, or if
32 the action does not affect all employees and dependents of one or
33 more employers, to the last known address of each affected
34 employee certificate holder, at least 60 days prior to the effective
35 date of the action.

36 (c) A health insurer that declines to offer coverage to or denies
37 enrollment for a large group applying for coverage ~~or that offers~~
38 ~~small group coverage at a rate that is higher than the standard~~
39 ~~employee risk rate shall, at the time of the denial or offer of~~

1 coverage, provide the applicant with the specific reason or reasons
2 for the decision in writing, in clear, easily understandable language.

3 ~~SEC. 3.~~

4 *SEC. 25.* Section 10753.05 of the Insurance Code is amended
5 to read:

6 10753.05. (a) No group or individual policy or contract or
7 certificate of group insurance or statement of group coverage
8 providing benefits to employees of small employers as defined in
9 this chapter shall be issued or delivered by a carrier subject to the
10 jurisdiction of the commissioner regardless of the situs of the
11 contract or master policyholder or of the domicile of the carrier
12 nor, except as otherwise provided in Sections 10270.91 and
13 10270.92, shall a carrier provide coverage subject to this chapter
14 until a copy of the form of the policy, contract, certificate, or
15 statement of coverage is filed with and approved by the
16 commissioner in accordance with Sections 10290 and 10291, and
17 the carrier has complied with the requirements of Section 10753.17.

18 (b) (1) On and after October 1, 2013, each carrier shall fairly
19 and affirmatively offer, market, and sell all of the carrier's health
20 benefit plans that are sold to, offered through, or sponsored by,
21 small employers or associations that include small employers for
22 plan years on or after January 1, 2014, to all small employers in
23 each geographic region in which the carrier makes coverage
24 available or provides benefits.

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

30 (3) A carrier shall provide enrollment periods consistent with
31 PPACA and described in Section 155.725 of Title 45 of the Code
32 of Federal Regulations. Commencing January 1, 2014, a carrier
33 shall provide special enrollment periods consistent with the special
34 enrollment periods described in Section 10965.3, to the extent
35 permitted by PPACA, except for the triggering events identified
36 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
37 the Code of Federal Regulations with respect to health benefit
38 plans offered through the Exchange.

39 (4) Nothing in this section shall be construed to require an
40 association, or a trust established and maintained by an association

1 to receive a master insurance policy issued by an admitted insurer
2 and to administer the benefits thereof solely for association
3 members, to offer, market, or sell a benefit plan design to those
4 who are not members of the association. However, if the
5 association markets, offers, or sells a benefit plan design to those
6 who are not members of the association it is subject to the
7 requirements of this section. This shall apply to an association that
8 otherwise meets the requirements of paragraph (8) formed by
9 merger of two or more associations after January 1, 1992, if the
10 predecessor organizations had been in active existence on January
11 1, 1992, and for at least five years prior to that date and met the
12 requirements of paragraph (5).

13 (5) A carrier which (A) effective January 1, 1992, and at least
14 20 years prior to that date, markets, offers, or sells benefit plan
15 designs only to all members of one association and (B) does not
16 market, offer, or sell any other individual, selected group, or group
17 policy or contract providing medical, hospital, and surgical benefits
18 shall not be required to market, offer, or sell to those who are not
19 members of the association. However, if the carrier markets, offers,
20 or sells any benefit plan design or any other individual, selected
21 group, or group policy or contract providing medical, hospital, and
22 surgical benefits to those who are not members of the association
23 it is subject to the requirements of this section.

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

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

36 (8) For purposes of paragraphs (4) and (6), an association is a
37 nonprofit organization comprised of a group of individuals or
38 employers who associate based solely on participation in a
39 specified profession or industry, accepting for membership any
40 individual or small employer meeting its membership criteria,

1 which do not condition membership directly or indirectly on the
2 health or claims history of any person, which uses membership
3 dues solely for and in consideration of the membership and
4 membership benefits, except that the amount of the dues shall not
5 depend on whether the member applies for or purchases insurance
6 offered by the association, which is organized and maintained in
7 good faith for purposes unrelated to insurance, which has been in
8 active existence on January 1, 1992, and at least five years prior
9 to that date, which has a constitution and bylaws, or other
10 analogous governing documents which provide for election of the
11 governing board of the association by its members, which has
12 contracted with one or more carriers to offer one or more health
13 benefit plans to all individual members and small employer
14 members in this state. Health coverage through an association that
15 is not related to employment shall be considered individual
16 coverage pursuant to Section 144.102(c) of Title 45 of the Code
17 of Federal Regulations.

18 (c) On and after October 1, 2013, each carrier shall make
19 available to each small employer all health benefit plans that the
20 carrier offers or sells to small employers or to associations that
21 include small employers for plan years on or after January 1, 2014.
22 Notwithstanding subdivision (d) of Section 10753, for purposes
23 of this subdivision, companies that are affiliated companies or that
24 are eligible to file a consolidated income tax return shall be treated
25 as one carrier.

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

27 (1) Prepare a brochure that summarizes all of its health benefit
28 plans and make this summary available to small employers, agents,
29 and brokers upon request. The summary shall include for each
30 plan information on benefits provided, a generic description of the
31 manner in which services are provided, such as how access to
32 providers is limited, benefit limitations, required copayments and
33 deductibles, an explanation of how creditable coverage is calculated
34 if a waiting period is imposed, and a telephone number that can
35 be called for more detailed benefit information. Carriers are
36 required to keep the information contained in the brochure accurate
37 and up to date, and, upon updating the brochure, send copies to
38 agents and brokers representing the carrier. Any entity that provides
39 administrative services only with regard to a health benefit plan

1 written or issued by another carrier shall not be required to prepare
2 a summary brochure which includes that benefit plan.

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

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

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

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

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

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

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

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

39 (D) Notify the small employer of the availability of coverage
40 and the availability of tax credits for certain employers consistent

1 with PPACA and state law, including any rules, regulations, or
2 guidance issued in connection therewith.

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

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

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

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

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

20 (f) No carrier, agent, or broker shall induce or otherwise
21 encourage a small employer to separate or otherwise exclude an
22 eligible employee from a health benefit plan which, in the case of
23 an eligible employee meeting the definition in paragraph (1) of
24 subdivision (f) of Section 10753, is provided in connection with
25 the employee's employment or which, in the case of an eligible
26 employee as defined in paragraph (2) of subdivision (f) of Section
27 10753, is provided in connection with a guaranteed association.

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

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

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

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

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

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

11 (3) Employ marketing practices or benefit designs that will have
12 the effect of discouraging the enrollment of individuals with
13 significant health needs or discriminate based on the individual's
14 race, color, national origin, present or predicted disability, age,
15 sex, gender identity, sexual orientation, expected length of life,
16 degree of medical dependency, quality of life, or other health
17 conditions.

18 This subdivision shall be enforced in the same manner as Section
19 790.03, including through Sections 790.035 and 790.05.

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

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

37 (A) Health status.

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

39 (C) Claims experience.

40 (D) Receipt of health care.

- 1 (E) Medical history.
- 2 (F) Genetic information.
- 3 (G) Evidence of insurability, including conditions arising out
- 4 of acts of domestic violence.
- 5 (H) Disability.
- 6 (I) Any other health status-related factor as determined by any
- 7 federal regulations, rules, or guidance issued pursuant to Section
- 8 2705 of the federal Public Health Service Act.

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

15 (k) (1) A carrier shall consider as a single risk pool for rating
16 purposes in the small employer market the claims experience of
17 all insureds in all nongrandfathered small employer health benefit
18 plans offered by the carrier in this state, ~~whether offered as health~~
19 ~~care service plan contracts or health insurance policies, and all~~
20 *enrollees in all nongrandfathered small employer health care*
21 *service plan contracts subject to Article 3.16 (commencing with*
22 *Section 1357.500) of Chapter 2.2 of Division 2 of the Health and*
23 *Safety Code offered by a health care service plan licensed under*
24 *Chapter 2.2 (commencing with Section 1340) of Division 2 of the*
25 *Health and Safety Code that is a corporate affiliate, subsidiary,*
26 *or parent of the insurer, including those insureds and enrollees*
27 *who enroll in coverage through the Exchange and insureds and*
28 *enrollees covered by the carrier who enroll in coverage outside of*
29 *the Exchange.*

30 (2) At least each calendar year, and no more frequently than
31 each calendar quarter, a carrier shall establish an index rate for the
32 small employer market in the state based on the total combined
33 claims costs for providing essential health benefits, as defined
34 pursuant to Section 1302 of PPACA and Section 10112.27, within
35 the single risk pool required under paragraph (1). The index rate
36 shall be adjusted on a marketwide basis based on the total expected
37 marketwide payments and charges under the risk adjustment and
38 reinsurance programs established for the state pursuant to Sections
39 1343 and 1341 of PPACA and Exchange user fees, as described
40 in subdivision (d) of Section 156.80 of Title 45 of the Code of

1 Federal Regulations. The premium rate for all of the ~~carrier's~~
2 nongrandfathered health benefit plans *within the single risk pool*
3 *required under paragraph (1)* shall use the applicable index rate,
4 as adjusted for total expected marketwide payments and charges
5 under the risk adjustment and reinsurance programs established
6 for the state pursuant to Sections 1343 and 1341 of PPACA, subject
7 only to the adjustments permitted under paragraph (3).

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

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

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

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

22 (D) Administrative costs, excluding any user fees required by
23 the Exchange.

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

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

32 (m) (1) Except as provided in paragraph (2), this section shall
33 become inoperative if Section 2702 of the federal Public Health
34 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201
35 of PPACA, is repealed, in which case, 12 months after the repeal,
36 carriers subject to this section shall instead be governed by Section
37 10705 to the extent permitted by federal law, and all references in
38 this chapter to this section shall instead refer to Section 10705,
39 except for purposes of paragraph (2).

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

4 ~~SEC. 4.~~

5 *SEC. 26.* Section 10965.3 of the Insurance Code is amended
6 to read:

7 10965.3. (a) (1) On and after October 1, 2013, a health insurer
8 shall fairly and affirmatively offer, market, and sell all of the
9 insurer's health benefit plans that are sold in the individual market
10 for policy years on or after January 1, 2014, to all individuals and
11 dependents in each service area in which the insurer provides or
12 arranges for the provision of health care services. A health insurer
13 shall limit enrollment in individual health benefit plans to open
14 enrollment periods and special enrollment periods as provided in
15 subdivisions (c) and (d).

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

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

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

29 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code
30 of Federal Regulations, for individuals enrolled in noncalendar-year
31 individual health plan contracts, a plan shall provide a limited open
32 enrollment period beginning on the date that is 30 calendar days
33 prior to the date the policy year ends in 2014.

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

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

- 1 (i) “Minimum essential coverage” has the same meaning as that
2 term is defined in subsection (f) of Section 5000A of the Internal
3 Revenue Code (26 U.S.C. Sec. 5000A).
- 4 (ii) “Loss of minimum essential coverage” includes, but is not
5 limited to, loss of that coverage due to the circumstances described
6 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
7 Code of Federal Regulations and the circumstances described in
8 Section 1163 of Title 29 of the United States Code. “Loss of
9 minimum essential coverage” also includes loss of that coverage
10 for a reason that is not due to the fault of the individual.
- 11 (iii) “Loss of minimum essential coverage” does not include
12 loss of that coverage due to the individual’s failure to pay
13 premiums on a timely basis or situations allowing for a rescission,
14 subject to clause (ii) and Sections 10119.2 and 10384.17.
- 15 (B) He or she gains a dependent or becomes a dependent.
- 16 (C) He or she is mandated to be covered as a dependent pursuant
17 to a valid state or federal court order.
- 18 (D) He or she has been released from incarceration.
- 19 (E) His or her health coverage issuer substantially violated a
20 material provision of the health coverage contract.
- 21 (F) He or she gains access to new health benefit plans as a result
22 of a permanent move.
- 23 (G) He or she was receiving services from a contracting provider
24 under another health benefit plan, as defined in Section 10965 *of*
25 *this code* or Section 1399.845 of the Health and Safety Code for
26 one of the conditions described in subdivision (a) of Section
27 10133.56 and that provider is no longer participating in the health
28 benefit plan.
- 29 (H) He or she demonstrates to the Exchange, with respect to
30 health benefit plans offered through the Exchange, or to the
31 department, with respect to health benefit plans offered outside
32 the Exchange, that he or she did not enroll in a health benefit plan
33 during the immediately preceding enrollment period available to
34 the individual because he or she was misinformed that he or she
35 was covered under minimum essential coverage.
- 36 (I) He or she is a member of the reserve forces of the United
37 States military returning from active duty or a member of the
38 California National Guard returning from active duty service under
39 Title 32 of the United States Code.

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

5 (2) With respect to individual health benefit plans offered
6 outside the Exchange, an individual shall have 60 days from the
7 date of a triggering event identified in paragraph (1) to apply for
8 coverage from a health care service plan subject to this section.
9 With respect to individual health benefit plans offered through the
10 Exchange, an individual shall have 60 days from the date of a
11 triggering event identified in paragraph (1) to select a plan offered
12 through the Exchange, unless a longer period is provided in Part
13 155 (commencing with Section 155.10) of Subchapter B of Subtitle
14 A of Title 45 of the Code of Federal Regulations.

15 (e) With respect to individual health benefit plans offered
16 through the Exchange, the effective date of coverage required
17 pursuant to this section shall be consistent with the dates specified
18 in Section 155.410 or 155.420 of Title 45 of the Code of Federal
19 Regulations, as applicable. A dependent who is a registered
20 domestic partner pursuant to Section 297 of the Family Code shall
21 have the same effective date of coverage as a spouse.

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

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

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

1 December 31, 2013, inclusive, or after the 15th day of any
2 subsequent month, coverage shall become effective no later than
3 the first day of the second month following delivery or postmark
4 of the payment.

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

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

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

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

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

39 (g) (1) A health insurer shall not establish rules for eligibility,
40 including continued eligibility, of any individual to enroll under

1 the terms of an individual health benefit plan based on any of the
2 following factors:

- 3 (A) Health status.
- 4 (B) Medical condition, including physical and mental illnesses.
- 5 (C) Claims experience.
- 6 (D) Receipt of health care.
- 7 (E) Medical history.
- 8 (F) Genetic information.
- 9 (G) Evidence of insurability, including conditions arising out
10 of acts of domestic violence.
- 11 (H) Disability.
- 12 (I) Any other health status-related factor as determined by any
13 federal regulations, rules, or guidance issued pursuant to Section
14 2705 of the federal Public Health Service Act.

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

22 (h) (1) A health insurer shall consider as a single risk pool for
23 rating purposes in the individual market the claims experience of
24 all insureds ~~and enrollees~~ in all nongrandfathered individual health
25 benefit plans offered by that insurer in this state, ~~whether offered~~
26 ~~as health care service plan contracts or individual health insurance~~
27 ~~policies and all enrollees in all nongrandfathered individual health~~
28 ~~benefit plans, as defined in Section 1399.845 of the Health and~~
29 ~~Safety Code, offered in this state by a health care service plan~~
30 ~~licensed under Chapter 2.2 (commencing with Section 1340) of~~
31 ~~Division 2 of the Health and Safety Code that is a corporate~~
32 ~~affiliate, subsidiary, or parent of the insurer, including those~~
33 ~~insureds and enrollees who enroll in individual coverage through~~
34 ~~the Exchange and insureds and enrollees who enroll in individual~~
35 ~~coverage outside the Exchange. Student health insurance coverage,~~
36 ~~as such coverage is defined at in Section 147.145(a) of Title 45 of~~
37 ~~the Code of Federal Regulations, shall not be included in a health~~
38 ~~insurer's single risk pool for individual coverage.~~

39 (2) Each calendar year, a health insurer shall establish an index
40 rate for the individual market in the state based on the total

1 combined claims costs for providing essential health benefits, as
2 defined pursuant to Section 1302 of PPACA, within the single risk
3 pool required under paragraph (1). The index rate shall be adjusted
4 on a marketwide basis based on the total expected marketwide
5 payments and charges under the risk adjustment and reinsurance
6 programs established for the state pursuant to Sections 1343 and
7 1341 of PPACA and Exchange user fees, as described in
8 subdivision (d) of Section 156.80 of Title 45 of the Code of Federal
9 Regulations. The premium rate for all of the ~~health insurer's~~ health
10 benefit plans in the individual market *within the single risk pool*
11 *required under paragraph (1)* shall use the applicable index rate,
12 as adjusted for total expected marketwide payments and charges
13 under the risk adjustment and reinsurance programs established
14 for the state pursuant to Sections 1343 and 1341 of PPACA, subject
15 only to the adjustments permitted under paragraph (3).

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

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

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

23 (C) The benefits provided under the health benefit plan that are
24 in addition to the essential health benefits, as defined pursuant to
25 Section 1302 of PPACA and Section 10112.27. These additional
26 benefits shall be pooled with similar benefits within the single risk
27 pool required under paragraph (1) and the claims experience from
28 those benefits shall be utilized to determine rate variations for
29 plans that offer those benefits in addition to essential health
30 benefits.

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

34 (E) Administrative costs, excluding any user fees required by
35 the Exchange.

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

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

1 (k) 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. Sec. ~~300gg-4~~),
5 ~~300gg-91~~), subdivisions (a), (b), and (g) shall become inoperative
6 12 months after the date of that repeal or amendment and individual
7 health care benefit plans shall thereafter be subject to Sections
8 10901.2, 10951, and 10953.

9 ~~SEC. 5.~~

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