

AMENDED IN ASSEMBLY MAY 5, 2015

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1102**

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**Introduced by Assembly Member Santiago**

February 27, 2015

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An act to amend Section 1399.849 of the Health and Safety Code, and to amend Section 10965.3 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1102, as amended, Santiago. Health care coverage: special enrollment periods: triggering event.

Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms as of January 1, 2014. Among other things, PPACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, and requires each exchange to provide for an initial open enrollment period, annual open enrollment periods, and special enrollment periods.

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 or health insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's or insurer's health benefit

plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan or insurer provides or arranges for the provision of health care services, as specified, but requires plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. Existing law requires a health care service plan and health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events, including that he or she gains a dependent.

This bill would ~~require~~ *require, until October 1, 2021*, a health care service plan or health insurer to allow an individual to enroll or change individual health benefits if the individual becomes pregnant. Because a willful violation of this requirement by a health care service plan would be a crime, this 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 1399.849 of the Health and Safety Code  
2 is amended to read:  
3 1399.849. (a) (1) On and after October 1, 2013, a plan shall  
4 fairly and affirmatively offer, market, and sell all of the plan’s  
5 health benefit plans that are sold in the individual market for policy  
6 years on or after January 1, 2014, to all individuals and dependents  
7 in each service area in which the plan provides or arranges for the  
8 provision of health care services. A plan shall limit enrollment in  
9 individual health benefit plans to open enrollment periods, annual  
10 enrollment periods, and special enrollment periods as provided in  
11 subdivisions (c) and (d).  
12 (2) A plan shall allow the subscriber of an individual health  
13 benefit plan to add a dependent to the subscriber’s plan at the  
14 option of the subscriber, consistent with the open enrollment,

1 annual enrollment, and special enrollment period requirements in  
2 this section.

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

6 (c) (1) A plan shall provide an initial open enrollment period  
7 from October 1, 2013, to March 31, 2014, inclusive, an annual  
8 enrollment period for the policy year beginning on January 1, 2015,  
9 from November 15, 2014, to February 15, 2015, inclusive, and  
10 annual enrollment periods for policy years beginning on or after  
11 January 1, 2016, from October 15 to December 7, inclusive, of the  
12 preceding calendar year.

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

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

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

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

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

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

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

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

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

2 (E) His or her health coverage issuer substantially violated a  
3 material provision of the health coverage contract.

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

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

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

18 (I) He or she is a member of the reserve forces of the United  
19 States military returning from active duty or a member of the  
20 California National Guard returning from active duty service under  
21 Title 32 of the United States Code.

22 (J) ~~An~~ *On and after January 1, 2016, and until October 1, 2021,*  
23 *an individual becomes pregnant.*

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

28 (2) With respect to individual health benefit plans offered  
29 outside the Exchange, an individual shall have 60 days from the  
30 date of a triggering event identified in paragraph (1) to apply for  
31 coverage from a health care service plan subject to this section.  
32 With respect to individual health benefit plans offered through the  
33 Exchange, an individual shall have 60 days from the date of a  
34 triggering event identified in paragraph (1) to select a plan offered  
35 through the Exchange, unless a longer period is provided in Part  
36 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
37 A of Title 45 of the Code of Federal Regulations.

38 (e) With respect to individual health benefit plans offered  
39 through the Exchange, the effective date of coverage required  
40 pursuant to this section shall be consistent with the dates specified

1 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
2 Regulations, as applicable. A dependent who is a registered  
3 domestic partner pursuant to Section 297 of the Family Code shall  
4 have the same effective date of coverage as a spouse.

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

7 (1) After an individual submits a completed application form  
8 for a plan contract, the health care service plan shall, within 30  
9 days, notify the individual of the individual's actual premium  
10 charges for that plan established in accordance with Section  
11 1399.855. The individual shall have 30 days in which to exercise  
12 the right to buy coverage at the quoted premium charges.

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

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

1 of the second month following delivery or postmark of the  
2 payment.

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

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

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

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

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

27 (A) Health status.

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

29 (C) Claims experience.

30 (D) Receipt of health care.

31 (E) Medical history.

32 (F) Genetic information.

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

35 (H) Disability.

36 (I) Any other health status-related factor as determined by any  
37 federal regulations, rules, or guidance issued pursuant to Section  
38 2705 of the federal Public Health Service Act.

39 (2) Notwithstanding Section 1389.1, a health care service plan  
40 shall not require an individual applicant or his or her dependent

1 to fill out a health assessment or medical questionnaire prior to  
2 enrollment under an individual health benefit plan. A health care  
3 service plan shall not acquire or request information that relates  
4 to a health status-related factor from the applicant or his or her  
5 dependent or any other source prior to enrollment of the individual.

6 (h) (1) A health care service plan shall consider as a single risk  
7 pool for rating purposes in the individual market the claims  
8 experience of all insureds and all enrollees in all nongrandfathered  
9 individual health benefit plans offered by that health care service  
10 plan in this state, whether offered as health care service plan  
11 contracts or individual health insurance policies, including those  
12 insureds and enrollees who enroll in individual coverage through  
13 the Exchange and insureds and enrollees who enroll in individual  
14 coverage outside of the Exchange. Student health insurance  
15 coverage, as that coverage is defined in Section 147.145(a) of Title  
16 45 of the Code of Federal Regulations, shall not be included in a  
17 health care service plan's single risk pool for individual coverage.

18 (2) Each calendar year, a health care service plan shall establish  
19 an index rate for the individual market in the state based on the  
20 total combined claims costs for providing essential health benefits,  
21 as defined pursuant to Section 1302 of PPACA, within the single  
22 risk pool required under paragraph (1). The index rate shall be  
23 adjusted on a marketwide basis based on the total expected  
24 marketwide payments and charges under the risk adjustment and  
25 reinsurance programs established for the state pursuant to Sections  
26 1343 and 1341 of PPACA and Exchange user fees, as described  
27 in subdivision (d) of Section 156.80 of Title 45 of the Code of  
28 Federal Regulations. The premium rate for all of the health benefit  
29 plans in the individual market within the single risk pool required  
30 under paragraph (1) shall use the applicable marketwide adjusted  
31 index rate, subject only to the adjustments permitted under  
32 paragraph (3).

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

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

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

1 (C) The benefits provided under the health benefit plan that are  
 2 in addition to the essential health benefits, as defined pursuant to  
 3 Section 1302 of PPACA and Section 1367.005. These additional  
 4 benefits shall be pooled with similar benefits within the single risk  
 5 pool required under paragraph (1) and the claims experience from  
 6 those benefits shall be utilized to determine rate variations for  
 7 plans that offer those benefits in addition to essential health  
 8 benefits.

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

12 (E) Administrative costs, excluding user fees required by the  
 13 Exchange.

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

16 (j) This section shall not apply to a grandfathered health plan.

17 (k) If Section 5000A of the Internal Revenue Code, as added  
 18 by Section 1501 of PPACA, is repealed or amended to no longer  
 19 apply to the individual market, as defined in Section 2791 of the  
 20 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),  
 21 subdivisions (a), (b), and (g) shall become inoperative 12 months  
 22 after that repeal or amendment.

23 SEC. 2. Section 10965.3 of the Insurance Code is amended to  
 24 read:

25 10965.3. (a) (1) On and after October 1, 2013, a health insurer  
 26 shall fairly and affirmatively offer, market, and sell all of the  
 27 insurer’s health benefit plans that are sold in the individual market  
 28 for policy years on or after January 1, 2014, to all individuals and  
 29 dependents in each service area in which the insurer provides or  
 30 arranges for the provision of health care services. A health insurer  
 31 shall limit enrollment in individual health benefit plans to open  
 32 enrollment periods, annual enrollment periods, and special  
 33 enrollment periods as provided in subdivisions (c) and (d).

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

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

4 (c) (1) A health insurer shall provide an initial open enrollment  
5 period from October 1, 2013, to March 31, 2014, inclusive, an  
6 annual enrollment period for the policy year beginning on January  
7 1, 2015, from November 15, 2014, to February 15, 2015, inclusive,  
8 and annual enrollment periods for policy years beginning on or  
9 after January 1, 2016, from October 15 to December 7, inclusive,  
10 of the preceding calendar year.

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

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

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

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

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

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

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

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

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

1 (E) His or her health coverage issuer substantially violated a  
2 material provision of the health coverage contract.

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

5 (G) He or she was receiving services from a contracting provider  
6 under another health benefit plan, as defined in Section 10965 of  
7 this code or Section 1399.845 of the Health and Safety Code, for  
8 one of the conditions described in subdivision (a) of Section  
9 10133.56 and that provider is no longer participating in the health  
10 benefit plan.

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

18 (I) He or she is a member of the reserve forces of the United  
19 States military returning from active duty or a member of the  
20 California National Guard returning from active duty service under  
21 Title 32 of the United States Code.

22 (J) ~~An~~ *On and after January 1, 2016, and until October 1, 2021,*  
23 *an individual becomes pregnant.*

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

28 (2) With respect to individual health benefit plans offered  
29 outside the Exchange, an individual shall have 60 days from the  
30 date of a triggering event identified in paragraph (1) to apply for  
31 coverage from a health care service plan subject to this section.  
32 With respect to individual health benefit plans offered through the  
33 Exchange, an individual shall have 60 days from the date of a  
34 triggering event identified in paragraph (1) to select a plan offered  
35 through the Exchange, unless a longer period is provided in Part  
36 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
37 A of Title 45 of the Code of Federal Regulations.

38 (e) With respect to individual health benefit plans offered  
39 through the Exchange, the effective date of coverage required  
40 pursuant to this section shall be consistent with the dates specified

1 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
2 Regulations, as applicable. A dependent who is a registered  
3 domestic partner pursuant to Section 297 of the Family Code shall  
4 have the same effective date of coverage as a spouse.

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

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

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

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

1 of the second month following delivery or postmark of the  
2 payment.

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

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

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

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

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

27 (A) Health status.

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

29 (C) Claims experience.

30 (D) Receipt of health care.

31 (E) Medical history.

32 (F) Genetic information.

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

35 (H) Disability.

36 (I) Any other health status-related factor as determined by any  
37 federal regulations, rules, or guidance issued pursuant to Section  
38 2705 of the federal Public Health Service Act.

39 (2) Notwithstanding subdivision (c) of Section 10291.5, a health  
40 insurer shall not require an individual applicant or his or her

1 dependent to fill out a health assessment or medical questionnaire  
2 prior to enrollment under an individual health benefit plan. A health  
3 insurer shall not acquire or request information that relates to a  
4 health status-related factor from the applicant or his or her  
5 dependent or any other source prior to enrollment of the individual.

6 (h) (1) A health insurer shall consider as a single risk pool for  
7 rating purposes in the individual market the claims experience of  
8 all insureds and enrollees in all nongrandfathered individual health  
9 benefit plans offered by that insurer in this state, whether offered  
10 as health care service plan contracts or individual health insurance  
11 policies, including those insureds and enrollees who enroll in  
12 individual coverage through the Exchange and insureds and  
13 enrollees who enroll in individual coverage outside the Exchange.  
14 Student health insurance coverage, as such coverage is defined in  
15 Section 147.145(a) of Title 45 of the Code of Federal Regulations,  
16 shall not be included in a health insurer's single risk pool for  
17 individual coverage.

18 (2) Each calendar year, a health insurer shall establish an index  
19 rate for the individual market in the state based on the total  
20 combined claims costs for providing essential health benefits, as  
21 defined pursuant to Section 1302 of PPACA, within the single risk  
22 pool required under paragraph (1). The index rate shall be adjusted  
23 on a marketwide basis based on the total expected marketwide  
24 payments and charges under the risk adjustment and reinsurance  
25 programs established for the state pursuant to Sections 1343 and  
26 1341 of PPACA and Exchange user fees, as described in  
27 subdivision (d) of Section 156.80 of Title 45 of the Code of Federal  
28 Regulations. The premium rate for all of the health benefit plans  
29 in the individual market within the single risk pool required under  
30 paragraph (1) shall use the applicable marketwide adjusted index  
31 rate, subject only to the adjustments permitted under paragraph  
32 (3).

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

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

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

1 (C) The benefits provided under the health benefit plan that are  
2 in addition to the essential health benefits, as defined pursuant to  
3 Section 1302 of PPACA and Section 10112.27. These additional  
4 benefits shall be pooled with similar benefits within the single risk  
5 pool required under paragraph (1) and the claims experience from  
6 those benefits shall be utilized to determine rate variations for  
7 plans that offer those benefits in addition to essential health  
8 benefits.

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

12 (E) Administrative costs, excluding any user fees required by  
13 the Exchange.

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

16 (j) This section shall not apply to a grandfathered health plan.

17 (k) If Section 5000A of the Internal Revenue Code, as added  
18 by Section 1501 of PPACA, is repealed or amended to no longer  
19 apply to the individual market, as defined in Section 2791 of the  
20 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),  
21 subdivisions (a), (b), and (g) shall become inoperative 12 months  
22 after the date of that repeal or amendment and individual health  
23 care benefit plans shall thereafter be subject to Sections 10901.2,  
24 10951, and 10953.

25 SEC. 3. No reimbursement is required by this act pursuant to  
26 Section 6 of Article XIII B of the California Constitution because  
27 the only costs that may be incurred by a local agency or school  
28 district will be incurred because this act creates a new crime or  
29 infraction, eliminates a crime or infraction, or changes the penalty  
30 for a crime or infraction, within the meaning of Section 17556 of  
31 the Government Code, or changes the definition of a crime within  
32 the meaning of Section 6 of Article XIII B of the California  
33 Constitution.