

AMENDED IN ASSEMBLY JUNE 3, 2015

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, ~~until October 1, 2021,~~ *on and after January 1, 2017, and until October 1, 2020,* a health care service plan or health insurer to allow an individual *who does not have minimum essential coverage* to enroll ~~or change in an individual health benefits benefit plan~~ 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

1 option of the subscriber, consistent with the open enrollment,  
2 annual enrollment, and special enrollment period requirements in  
3 this section.

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

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

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

19 (d) (1) Subject to paragraph ~~(2)~~, (3), commencing January 1,  
20 2014, a plan shall allow an individual to enroll in or change  
21 individual health benefit plans as a result of the following triggering  
22 events:

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

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

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

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

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

- 1 (C) He or she is mandated to be covered as a dependent pursuant
- 2 to a valid state or federal court order.
- 3 (D) He or she has been released from incarceration.
- 4 (E) His or her health coverage issuer substantially violated a
- 5 material provision of the health coverage contract.
- 6 (F) He or she gains access to new health benefit plans as a result
- 7 of a permanent move.
- 8 (G) He or she was receiving services from a contracting provider
- 9 under another health benefit plan, as defined in Section 1399.845
- 10 of this code or Section 10965 of the Insurance Code, for one of
- 11 the conditions described in subdivision (c) of Section 1373.96 and
- 12 that provider is no longer participating in the health benefit plan.
- 13 (H) He or she demonstrates to the Exchange, with respect to
- 14 health benefit plans offered through the Exchange, or to the
- 15 department, with respect to health benefit plans offered outside
- 16 the Exchange, that he or she did not enroll in a health benefit plan
- 17 during the immediately preceding enrollment period available to
- 18 the individual because he or she was misinformed that he or she
- 19 was covered under minimum essential coverage.
- 20 (I) He or she is a member of the reserve forces of the United
- 21 States military returning from active duty or a member of the
- 22 California National Guard returning from active duty service under
- 23 Title 32 of the United States Code.
- 24 ~~(J) On and after January 1, 2016, and until October 1, 2021, an~~
- 25 ~~individual becomes pregnant.~~
- 26 ~~(K)~~
- 27 (J) With respect to individual health benefit plans offered
- 28 through the Exchange, in addition to the triggering events listed
- 29 in this paragraph, any other events listed in Section 155.420(d) of
- 30 Title 45 of the Code of Federal Regulations.
- 31 (2) *Subject to paragraph (3), commencing January 1, 2017, and*
- 32 *until October 1, 2020, a plan shall allow an individual who does*
- 33 *not have minimum essential coverage to enroll in an individual*
- 34 *health benefit plan if she becomes pregnant.*
- 35 ~~(2)~~
- 36 (3) With respect to individual health benefit plans offered
- 37 outside the Exchange, an individual shall have 60 days from the
- 38 date of a triggering event identified in paragraph (1) to apply for
- 39 coverage from a health care service plan subject to this section.
- 40 With respect to individual health benefit plans offered through the

1 Exchange, an individual shall have 60 days from the date of a  
2 triggering event identified in paragraph (1) to select a plan offered  
3 through the Exchange, unless a longer period is provided in Part  
4 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
5 A of Title 45 of the Code of Federal Regulations.

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

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

15 (1) After an individual submits a completed application form  
16 for a plan contract, the health care service plan shall, within 30  
17 days, notify the individual of the individual's actual premium  
18 charges for that plan established in accordance with Section  
19 1399.855. The individual shall have 30 days in which to exercise  
20 the right to buy coverage at the quoted premium charges.

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

36 (3) With respect to an individual health benefit plan for which  
37 an individual applies during the annual open enrollment period  
38 described in subdivision (c), when the individual submits a  
39 premium payment, based on the quoted premium charges, and that  
40 payment is delivered or postmarked, whichever occurs later, by

1 December 15, coverage shall become effective as of the following  
2 January 1. When that payment is delivered or postmarked within  
3 the first 15 days of any subsequent month, coverage shall become  
4 effective no later than the first day of the following month. When  
5 that payment is delivered or postmarked between December 16  
6 and December 31, inclusive, or after the 15th day of any subsequent  
7 month, coverage shall become effective no later than the first day  
8 of the second month following delivery or postmark of the  
9 payment.

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

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

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

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

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

34 (A) Health status.

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

36 (C) Claims experience.

37 (D) Receipt of health care.

38 (E) Medical history.

39 (F) Genetic information.

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

3 (H) Disability.

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

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

14 (h) (1) A health care service plan shall consider as a single risk  
15 pool for rating purposes in the individual market the claims  
16 experience of all insureds and all enrollees in all nongrandfathered  
17 individual health benefit plans offered by that health care service  
18 plan in this state, whether offered as health care service plan  
19 contracts or individual health insurance policies, including those  
20 insureds and enrollees who enroll in individual coverage through  
21 the Exchange and insureds and enrollees who enroll in individual  
22 coverage outside of the Exchange. Student health insurance  
23 coverage, as that coverage is defined in Section 147.145(a) of Title  
24 45 of the Code of Federal Regulations, shall not be included in a  
25 health care service plan's single risk pool for individual coverage.

26 (2) Each calendar year, a health care service plan shall establish  
27 an index rate for the individual market in the state based on the  
28 total combined claims costs for providing essential health benefits,  
29 as defined pursuant to Section 1302 of PPACA, within the single  
30 risk pool required under paragraph (1). The index rate shall be  
31 adjusted on a marketwide basis based on the total expected  
32 marketwide payments and charges under the risk adjustment and  
33 reinsurance programs established for the state pursuant to Sections  
34 1343 and 1341 of PPACA and Exchange user fees, as described  
35 in subdivision (d) of Section 156.80 of Title 45 of the Code of  
36 Federal Regulations. The premium rate for all of the health benefit  
37 plans in the individual market within the single risk pool required  
38 under paragraph (1) shall use the applicable marketwide adjusted  
39 index rate, subject only to the adjustments permitted under  
40 paragraph (3).

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

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

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

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

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

19 (E) Administrative costs, excluding user fees required by the  
20 Exchange.

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

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

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

30 SEC. 2. Section 10965.3 of the Insurance Code is amended to  
31 read:

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

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

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

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

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

21 (d) (1) Subject to paragraph ~~(2)~~, (3), commencing January 1,  
22 2014, a health insurer shall allow an individual to enroll in or  
23 change individual health benefit plans as a result of the following  
24 triggering events:

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

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

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

38 (iii) “Loss of minimum essential coverage” does not include  
39 loss of that coverage due to the individual’s failure to pay

- 1 premiums on a timely basis or situations allowing for a rescission,
- 2 subject to clause (ii) and Sections 10119.2 and 10384.17.
- 3 (B) He or she gains a dependent or becomes a dependent.
- 4 (C) He or she is mandated to be covered as a dependent pursuant
- 5 to a valid state or federal court order.
- 6 (D) He or she has been released from incarceration.
- 7 (E) His or her health coverage issuer substantially violated a
- 8 material provision of the health coverage contract.
- 9 (F) He or she gains access to new health benefit plans as a result
- 10 of a permanent move.
- 11 (G) He or she was receiving services from a contracting provider
- 12 under another health benefit plan, as defined in Section 10965 of
- 13 this code or Section 1399.845 of the Health and Safety Code, for
- 14 one of the conditions described in subdivision (a) of Section
- 15 10133.56 and that provider is no longer participating in the health
- 16 benefit plan.
- 17 (H) He or she demonstrates to the Exchange, with respect to
- 18 health benefit plans offered through the Exchange, or to the
- 19 department, with respect to health benefit plans offered outside
- 20 the Exchange, that he or she did not enroll in a health benefit plan
- 21 during the immediately preceding enrollment period available to
- 22 the individual because he or she was misinformed that he or she
- 23 was covered under minimum essential coverage.
- 24 (I) He or she is a member of the reserve forces of the United
- 25 States military returning from active duty or a member of the
- 26 California National Guard returning from active duty service under
- 27 Title 32 of the United States Code.
- 28 ~~(J) On and after January 1, 2016, and until October 1, 2021, an~~
- 29 ~~individual becomes pregnant.~~
- 30 ~~(K)~~
- 31 (J) With respect to individual health benefit plans offered
- 32 through the Exchange, in addition to the triggering events listed
- 33 in this paragraph, any other events listed in Section 155.420(d) of
- 34 Title 45 of the Code of Federal Regulations.
- 35 (2) *Subject to paragraph (3), commencing January 1, 2017, and*
- 36 *until October 1, 2020, a plan shall allow an individual who does*
- 37 *not have minimum essential coverage to enroll in an individual*
- 38 *health benefit plan if she becomes pregnant.*
- 39 ~~(2)~~

1 (3) 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 an individual health benefit plan offered  
19 outside the Exchange, the following provisions shall apply:

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

35 (g) (1) A health insurer shall not establish rules for eligibility,  
36 including continued eligibility, of any individual to enroll under  
37 the terms of an individual health benefit plan based on any of the  
38 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 subdivision (c) of Section 10291.5, a health  
12 insurer shall not require an individual applicant or his or her  
13 dependent to fill out a health assessment or medical questionnaire  
14 prior to enrollment under an individual health benefit plan. A health  
15 insurer shall not acquire or request information that relates to a  
16 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 insurer shall consider as a single risk pool for  
19 rating purposes in the individual market the claims experience of  
20 all insureds and enrollees in all nongrandfathered individual health  
21 benefit plans offered by that insurer in this state, whether offered  
22 as health care service plan contracts or individual health insurance  
23 policies, including those insureds and enrollees who enroll in  
24 individual coverage through the Exchange and insureds and  
25 enrollees who enroll in individual coverage outside the Exchange.  
26 Student health insurance coverage, as such coverage is defined in  
27 Section 147.145(a) of Title 45 of the Code of Federal Regulations,  
28 shall not be included in a health insurer's single risk pool for  
29 individual coverage.

30 (2) Each calendar year, a health insurer shall establish an index  
31 rate for the individual market in the state based on the total  
32 combined claims costs for providing essential health benefits, as  
33 defined pursuant to Section 1302 of PPACA, within the single risk  
34 pool required under paragraph (1). The index rate shall be adjusted  
35 on a marketwide basis based on the total expected marketwide  
36 payments and charges under the risk adjustment and reinsurance  
37 programs established for the state pursuant to Sections 1343 and  
38 1341 of PPACA and Exchange user fees, as described in  
39 subdivision (d) of Section 156.80 of Title 45 of the Code of Federal  
40 Regulations. The premium rate for all of the health benefit plans

1 in the individual market within the single risk pool required under  
2 paragraph (1) shall use the applicable marketwide adjusted index  
3 rate, subject only to the adjustments permitted under paragraph  
4 (3).

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

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

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

12 (C) The benefits provided under the health benefit plan that are  
13 in addition to the essential health benefits, as defined pursuant to  
14 Section 1302 of PPACA and Section 10112.27. These additional  
15 benefits shall be pooled with similar benefits within the single risk  
16 pool required under paragraph (1) and the claims experience from  
17 those benefits shall be utilized to determine rate variations for  
18 plans that offer those benefits in addition to essential health  
19 benefits.

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

23 (E) Administrative costs, excluding any user fees required by  
24 the Exchange.

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

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

28 (k) If Section 5000A of the Internal Revenue Code, as added  
29 by Section 1501 of PPACA, is repealed or amended to no longer  
30 apply to the individual market, as defined in Section 2791 of the  
31 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),  
32 subdivisions (a), (b), and (g) shall become inoperative 12 months  
33 after the date of that repeal or amendment and individual health  
34 care benefit plans shall thereafter be subject to Sections 10901.2,  
35 10951, and 10953.

36 SEC. 3. No reimbursement is required by this act pursuant to  
37 Section 6 of Article XIII B of the California Constitution because  
38 the only costs that may be incurred by a local agency or school  
39 district will be incurred because this act creates a new crime or  
40 infraction, eliminates a crime or infraction, or changes the penalty

1 for a crime or infraction, within the meaning of Section 17556 of  
2 the Government Code, or changes the definition of a crime within  
3 the meaning of Section 6 of Article XIII B of the California  
4 Constitution.

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