

Introduced by Senator Hernandez

January 16, 2015

An act to amend Sections 1399.849, 127660, 127662, 127664, and 127665 of the Health and Safety Code, and to amend Section 10965.3 of the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 125, as introduced, Hernandez. Health care coverage.

(1) Existing federal law, the federal 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 health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual.

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 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 plan

or insurer to provide annual enrollment periods for policy years on or after January 1, 2016, from October 15 to December 7, inclusive, of the preceding calendar year.

This bill would instead require that those annual enrollment periods extend from October 1 to December 15, inclusive. Because a willful violation of that requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(2) Existing law establishes the California Health Benefit Review Program to assess legislation that proposes to mandate or repeal a mandated health benefit or service, as defined. Existing law requests the University of California to provide the analysis to the appropriate policy and fiscal committees of the Legislature within 60 days after receiving a request for the analysis. Existing law also requests that the university report to the Governor and the Legislature on the implementation of the program by January 1, 2014.

This bill would request the University of California to include essential health benefits and the impact on the California Health Benefit Exchange in the analysis prepared under the program. The bill would further request that the University of California assess legislation that impacts health insurance benefit design, cost sharing, premiums, and other health insurance topics. The bill would request that the university provide the analysis to the appropriate policy and fiscal committees of the Legislature not later than 60 days, or in a manner and pursuant to a timeline agreed to by the Legislature and the program, after receiving the request, as specified. The bill would also extend the date by which the university is requested to report to the Governor and the Legislature on the implementation program until January 1, 2017.

Existing law establishes the Health Care Benefits Fund to support the university in implementing the program. Existing law imposes an annual charge on health care service plans and health insurers, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment pursuant to that provision from exceeding \$2,000,000. Under existing law, the fund and the program are repealed as of December 31, 2015.

This bill would extend until June 30, 2017, the operative date of the program and the fund, including the annual charge on health care service plans and health insurers. The bill would repeal the above-described provisions as of June 30, 2017.

(3) 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.

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

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1 SECTION 1. Section 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,
15 annual enrollment, and special enrollment period requirements in
16 this section.

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

20 (c) (1) A plan shall provide an initial open enrollment period
21 from October 1, 2013, to March 31, 2014, inclusive, an annual
22 enrollment period for the policy year beginning on January 1, 2015,
23 from November 15, 2014, to February 15, 2015, inclusive, and
24 annual enrollment periods for policy years beginning on or after
25 January 1, 2016, from October 1 to December 7, 15, inclusive,
26 of the preceding calendar 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

1 year individual health plan contracts, a plan shall also provide a
2 limited open enrollment period beginning on the date that is 30
3 calendar days prior to the date the policy year ends in 2014.

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

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

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

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

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

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

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

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

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

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

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

37 (H) He or she demonstrates to the Exchange, with respect to
38 health benefit plans offered through the Exchange, or to the
39 department, with respect to health benefit plans offered outside
40 the Exchange, that he or she did not enroll in a health benefit plan

1 during the immediately preceding enrollment period available to
2 the individual because he or she was misinformed that he or she
3 was covered under minimum essential coverage.

4 (I) He or she is a member of the reserve forces of the United
5 States military returning from active duty or a member of the
6 California National Guard returning from active duty service under
7 Title 32 of the United States Code.

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

12 (2) With respect to individual health benefit plans offered
13 outside the Exchange, an individual shall have 60 days from the
14 date of a triggering event identified in paragraph (1) to apply for
15 coverage from a health care service plan subject to this section.
16 With respect to individual health benefit plans offered through the
17 Exchange, an individual shall have 60 days from the date of a
18 triggering event identified in paragraph (1) to select a plan offered
19 through the Exchange, unless a longer period is provided in Part
20 155 (commencing with Section 155.10) of Subchapter B of Subtitle
21 A of Title 45 of the Code of Federal Regulations.

22 (e) With respect to individual health benefit plans offered
23 through the Exchange, the effective date of coverage required
24 pursuant to this section shall be consistent with the dates specified
25 in Section 155.410 or 155.420 of Title 45 of the Code of Federal
26 Regulations, as applicable. A dependent who is a registered
27 domestic partner pursuant to Section 297 of the Family Code shall
28 have the same effective date of coverage as a spouse.

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

31 (1) After an individual submits a completed application form
32 for a plan contract, the health care service plan shall, within 30
33 days, notify the individual of the individual's actual premium
34 charges for that plan established in accordance with Section
35 1399.855. The individual shall have 30 days in which to exercise
36 the right to buy coverage at the quoted premium charges.

37 (2) With respect to an individual health benefit plan for which
38 an individual applies during the initial open enrollment period
39 described in subdivision (c), when the subscriber submits a
40 premium payment, based on the quoted premium charges, and that

1 payment is delivered or postmarked, whichever occurs earlier, by
2 December 15, 2013, coverage under the individual health benefit
3 plan shall become effective no later than January 1, 2014. When
4 that payment is delivered or postmarked within the first 15 days
5 of any subsequent month, coverage shall become effective no later
6 than the first day of the following month. When that payment is
7 delivered or postmarked between December 16, 2013, and
8 December 31, 2013, inclusive, or after the 15th day of any
9 subsequent month, coverage shall become effective no later than
10 the first day of the second month following delivery or postmark
11 of the payment.

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

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

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

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

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

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

10 (A) Health status.

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

12 (C) Claims experience.

13 (D) Receipt of health care.

14 (E) Medical history.

15 (F) Genetic information.

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

18 (H) Disability.

19 (I) Any other health status-related factor as determined by any
20 federal regulations, rules, or guidance issued pursuant to Section
21 2705 of the federal Public Health Service Act.

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

29 (h) (1) A health care service plan shall consider as a single risk
30 pool for rating purposes in the individual market the claims
31 experience of all insureds and all enrollees in all nongrandfathered
32 individual health benefit plans offered by that health care service
33 plan in this state, whether offered as health care service plan
34 contracts or individual health insurance policies, including those
35 insureds and enrollees who enroll in individual coverage through
36 the Exchange and insureds and enrollees who enroll in individual
37 coverage outside of the Exchange. Student health insurance
38 coverage, as that coverage is defined in Section 147.145(a) of Title
39 45 of the Code of Federal Regulations, shall not be included in a
40 health care service plan's single risk pool for individual coverage.

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

16 (3) A health care service plan may vary premium rates for a
17 particular health benefit plan from its index rate based only on the
18 following 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 1367.005. 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 user fees required by the
35 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 a grandfathered health plan.

39 (k) If Section 5000A of the Internal Revenue Code, as added
40 by Section 1501 of PPACA, is repealed or amended to no longer

1 apply to the individual market, as defined in Section 2791 of the
2 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),
3 subdivisions (a), (b), and (g) shall become inoperative 12 months
4 after that repeal or amendment.

5 SEC. 2. Section 127660 of the Health and Safety Code is
6 amended to read:

7 127660. (a) The Legislature hereby requests the University of
8 California to establish the California Health Benefit Review
9 Program to assess legislation proposing to mandate a benefit or
10 service, as defined in subdivision ~~(e)~~ (d), and legislation proposing
11 to repeal a mandated benefit or service, as defined in subdivision
12 ~~(d)~~ (e), and to prepare a written analysis with relevant data on the
13 following:

14 (1) Public health impacts, including, but not limited to, all of
15 the following:

16 (A) The impact on the health of the community, including the
17 reduction of communicable disease and the benefits of prevention
18 such as those provided by childhood immunizations and prenatal
19 care.

20 (B) The impact on the health of the community, including
21 diseases and conditions where gender and racial disparities in
22 outcomes are established in peer-reviewed scientific and medical
23 literature.

24 (C) The extent to which the benefit or service reduces premature
25 death and the economic loss associated with disease.

26 (2) Medical impacts, including, but not limited to, all of the
27 following:

28 (A) The extent to which the benefit or service is generally
29 recognized by the medical community as being effective in the
30 screening, diagnosis, or treatment of a condition or disease, as
31 demonstrated by a review of scientific and peer reviewed medical
32 literature.

33 (B) The extent to which the benefit or service is generally
34 available and utilized by treating physicians.

35 (C) The contribution of the benefit or service to the health status
36 of the population, including the results of any research
37 demonstrating the efficacy of the benefit or service compared to
38 alternatives, including not providing the benefit or service.

1 (D) The extent to which mandating or repealing the benefits or
2 services would not diminish or eliminate access to currently
3 available health care benefits or services.

4 (3) Financial impacts, including, but not limited to, all of the
5 following:

6 (A) The extent to which the coverage or repeal of coverage will
7 increase or decrease the benefit or cost of the benefit or service.

8 (B) The extent to which the coverage or repeal of coverage will
9 increase the utilization of the benefit or service, or will be a
10 substitute for, or affect the cost of, alternative benefits or services.

11 (C) The extent to which the coverage or repeal of coverage will
12 increase or decrease the administrative expenses of health care
13 service plans and health insurers and the premium and expenses
14 of subscribers, enrollees, and policyholders.

15 (D) The impact of this coverage or repeal of coverage on the
16 total cost of health care.

17 (E) The potential cost or savings to the private sector, including
18 the impact on small employers as defined in paragraph (1) of
19 subdivision (l) of Section 1357, the Public Employees' Retirement
20 System, other retirement systems funded by the state or by a local
21 government, individuals purchasing individual health insurance,
22 and publicly funded state health insurance programs, including
23 the Medi-Cal program and the Healthy Families Program.

24 (F) The extent to which costs resulting from lack of coverage
25 or repeal of coverage are or would be shifted to other payers,
26 including both public and private entities.

27 (G) The extent to which mandating or repealing the proposed
28 benefit or service would not diminish or eliminate access to
29 currently available health care benefits or services.

30 (H) The extent to which the benefit or service is generally
31 utilized by a significant portion of the population.

32 (I) The extent to which health care coverage for the benefit or
33 service is already generally available.

34 (J) The level of public demand for health care coverage for the
35 benefit or service, including the level of interest of collective
36 bargaining agents in negotiating privately for inclusion of this
37 coverage in group contracts, and the extent to which the mandated
38 benefit or service is covered by self-funded employer groups.

39 (K) In assessing and preparing a written analysis of the financial
40 impact of legislation proposing to mandate a benefit or service and

1 legislation proposing to repeal a mandated benefit or service
2 pursuant to this paragraph, the Legislature requests the University
3 of California to use a certified actuary or other person with relevant
4 knowledge and expertise to determine the financial impact.

5 *(4) The impact on essential health benefits, as defined in Section*
6 *1367.005 of this code and Section 10112.27 of the Insurance Code,*
7 *and the impact on the California Health Benefit Exchange.*

8 *(b) The Legislature further requests that the California Health*
9 *Benefit Review Program assess legislation that impacts health*
10 *insurance benefit design, cost sharing, premiums, and other health*
11 *insurance topics.*

12 ~~(b)~~

13 *(c) The Legislature requests that the University of California*
14 *provide every analysis to the appropriate policy and fiscal*
15 *committees of the Legislature not later than 60-days days, or in a*
16 *manner and pursuant to a timeline agreed to by the Legislature*
17 *and the California Health Benefit Review Program, after receiving*
18 *a request made pursuant to Section 127661. In addition, the*
19 *Legislature requests that the university post every analysis on the*
20 *Internet and make every analysis available to the public upon*
21 *request.*

22 ~~(e)~~

23 *(d) As used in this section, “legislation proposing to mandate a*
24 *benefit or service” means a proposed statute that requires a health*
25 *care service plan or a health insurer, or both, to do any of the*
26 *following:*

27 *(1) Permit a person insured or covered under the policy or*
28 *contract to obtain health care treatment or services from a particular*
29 *type of health care provider.*

30 *(2) Offer or provide coverage for the screening, diagnosis, or*
31 *treatment of a particular disease or condition.*

32 *(3) Offer or provide coverage of a particular type of health care*
33 *treatment or service, or of medical equipment, medical supplies,*
34 *or drugs used in connection with a health care treatment or service.*

35 ~~(d)~~

36 *(e) As used in this section, “legislation proposing to repeal a*
37 *mandated benefit or service” means a proposed statute that, if*
38 *enacted, would become operative on or after January 1, 2008, and*
39 *would repeal an existing requirement that a health care service*
40 *plan or a health insurer, or both, do any of the following:*

1 (1) Permit a person insured or covered under the policy or
2 contract to obtain health care treatment or services from a particular
3 type of health care provider.

4 (2) Offer or provide coverage for the screening, diagnosis, or
5 treatment of a particular disease or condition.

6 (3) Offer or provide coverage of a particular type of health care
7 treatment or service, or of medical equipment, medical supplies,
8 or drugs used in connection with a health care treatment or service.

9 SEC. 3. Section 127662 of the Health and Safety Code is
10 amended to read:

11 127662. (a) In order to effectively support the University of
12 California and its work in implementing this chapter, there is
13 hereby established in the State Treasury, the Health Care Benefits
14 Fund. The university's work in providing the bill analyses shall
15 be supported from the fund.

16 (b) For ~~fiscal years~~ *the* 2010–11 to ~~2014–15~~ 2016–17, inclusive,
17 *fiscal years*, each health care service plan, except a specialized
18 health care service plan, and each health insurer, as defined in
19 Section 106 of the Insurance Code, shall be assessed an annual fee
20 in an amount determined through regulation. The amount of the
21 fee shall be determined by the Department of Managed Health
22 Care and the Department of Insurance in consultation with the
23 university and shall be limited to the amount necessary to fund the
24 actual and necessary expenses of the university and its work in
25 implementing this chapter. The total annual assessment on health
26 care service plans and health insurers shall not exceed two million
27 dollars (\$2,000,000).

28 (c) The Department of Managed Health Care and the Department
29 of Insurance, in coordination with the university, shall assess the
30 health care service plans and health insurers, respectively, for the
31 costs required to fund the university's activities pursuant to
32 subdivision (b).

33 (1) Health care service plans shall be notified of the assessment
34 on or before June 15 of each year with the annual assessment notice
35 issued pursuant to Section 1356. The assessment pursuant to this
36 section is separate and independent of the assessments in Section
37 1356.

38 (2) Health insurers shall be noticed of the assessment in
39 accordance with the notice for the annual assessment or quarterly
40 premium tax revenues.

(3) The assessed fees required pursuant to subdivision (b) shall be paid on an annual basis no later than August 1 of each year. The Department of Managed Health Care and the Department of Insurance shall forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund immediately following their receipt.

(4) “Health insurance,” as used in this subdivision, does not include Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or hospital indemnity, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

SEC. 4. Section 127664 of the Health and Safety Code is amended to read:

127664. The Legislature requests the University of California to submit a report to the Governor and the Legislature by January 1, ~~2014~~ 2017, regarding the implementation of this chapter. *This report shall be submitted in compliance with Section 9795 of the Government Code.*

SEC. 5. Section 127665 of the Health and Safety Code is amended to read:

127665. This chapter shall remain in effect until ~~December 31, 2015~~ June 30, 2017, and shall be repealed as of that date, unless a later enacted statute that becomes operative on or before ~~December 31, 2015~~ June 30, 2017, deletes or extends that date.

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

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

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

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 ~~1~~ to December ~~7~~, 15,
10 inclusive, 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) With respect to individual health benefit plans offered
23 through the Exchange, in addition to the triggering events listed
24 in this paragraph, any other events listed in Section 155.420(d) of
25 Title 45 of the Code of Federal Regulations.

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

36 (e) With respect to individual health benefit plans offered
37 through the Exchange, the effective date of coverage required
38 pursuant to this section shall be consistent with the dates specified
39 in Section 155.410 or 155.420 of Title 45 of the Code of Federal
40 Regulations, as applicable. A dependent who is a registered

1 domestic partner pursuant to Section 297 of the Family Code shall
2 have the same effective date of coverage as a spouse.

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

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

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

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

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

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

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

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

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

25 (A) Health status.

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

27 (C) Claims experience.

28 (D) Receipt of health care.

29 (E) Medical history.

30 (F) Genetic information.

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

33 (H) Disability.

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

37 (2) Notwithstanding subdivision (c) of Section 10291.5, a health
38 insurer shall not require an individual applicant or his or her
39 dependent to fill out a health assessment or medical questionnaire
40 prior to enrollment under an individual health benefit plan. A health

insurer shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

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

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

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

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

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

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27. These additional

benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

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

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

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

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

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

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 8. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to maintain appropriate standards of accuracy and efficiency with respect to matters relating to health care coverage in California, by adjusting the next open enrollment period for the individual health care coverage market as needed to comply with federal law, and ensuring that the University of California is provided with sufficient advance notice regarding the continuing

- 1 duties of the university to plan and carry out necessary health care
- 2 benefit research and analysis as requested pursuant to this act, it
- 3 is necessary that this act take effect immediately.