

AMENDED IN SENATE APRIL 6, 2015

AMENDED IN SENATE FEBRUARY 26, 2015

SENATE BILL

No. 125

Introduced by Senator Hernandez

January 16, 2015

An act to amend Sections 1399.849, 127660, 127662, and 127664 of, and to repeal and add Section 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 amended, 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 November 1, of the preceding calendar year, to January 31 of the benefit year, 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 January 1, 2018.

(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

1 January 1, 2016, from November 1, of the preceding calendar year,
2 to January 31 of the benefit year, inclusive.

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

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

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

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

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

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

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

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

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

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

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

36 (G) He or she was receiving services from a contracting provider
37 under another health benefit plan, as defined in Section 1399.845
38 of this code or Section 10965 of the Insurance Code, for one of
39 the conditions described in subdivision (c) of Section 1373.96 of

1 this code and that provider is no longer participating in the health
2 benefit plan.

3 (H) He or she demonstrates to the Exchange, with respect to
4 health benefit plans offered through the Exchange, or to the
5 department, with respect to health benefit plans offered outside
6 the Exchange, that he or she did not enroll in a health benefit plan
7 during the immediately preceding enrollment period available to
8 the individual because he or she was misinformed that he or she
9 was covered under minimum essential coverage.

10 (I) He or she is a member of the reserve forces of the United
11 States military returning from active duty or a member of the
12 California National Guard returning from active duty service under
13 Title 32 of the United States Code.

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

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

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

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

37 (1) After an individual submits a completed application form
38 for a plan contract, the health care service plan shall, within 30
39 days, notify the individual of the individual's actual premium
40 charges for that plan established in accordance with Section

1 1399.855. The individual shall have 30 days in which to exercise
2 the right to buy coverage at the quoted premium charges.

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

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

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

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

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

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

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

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

15 (A) Health status.

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

17 (C) Claims experience.

18 (D) Receipt of health care.

19 (E) Medical history.

20 (F) Genetic information.

21 (G) Evidence of insurability, including conditions arising out
22 of acts of domestic violence.

23 (H) Disability.

24 (I) Any other health status-related factor as determined by any
25 federal regulations, rules, or guidance issued pursuant to Section
26 2705 of the federal Public Health Service Act (Public Law 78-410).

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

34 (h) (1) A health care service plan shall consider as a single risk
35 pool for rating purposes in the individual market the claims
36 experience of all insureds and all enrollees in all nongrandfathered
37 individual health benefit plans offered by that health care service
38 plan in this state, whether offered as health care service plan
39 contracts or individual health insurance policies, including those
40 insureds and enrollees who enroll in individual coverage through

1 the Exchange and insureds and enrollees who enroll in individual
2 coverage outside of the Exchange. Student health insurance
3 coverage, as that coverage is defined in Section 147.145(a) of Title
4 45 of the Code of Federal Regulations, shall not be included in a
5 health care service plan's single risk pool for individual coverage.

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

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

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

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

28 (C) The benefits provided under the health benefit plan that are
29 in addition to the essential health benefits, as defined pursuant to
30 Section 1302 of PPACA and Section 1367.005. These additional
31 benefits shall be pooled with similar benefits within the single risk
32 pool required under paragraph (1) and the claims experience from
33 those benefits shall be utilized to determine rate variations for
34 plans that offer those benefits in addition to essential health
35 benefits.

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

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

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

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

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

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

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

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

21 (A) The impact on the health of the community, including the
22 reduction of communicable disease and the benefits of prevention
23 such as those provided by childhood immunizations and prenatal
24 care.

25 (B) The impact on the health of the community, including
26 diseases and conditions where ~~gender and racial~~ disparities in
27 outcomes *associated with the social determinants of health as well*
28 *as gender, race, sexual orientation, or gender identity* are
29 established in peer-reviewed scientific and medical literature.

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

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

34 (A) The extent to which the benefit or service is generally
35 recognized by the medical community as being effective in the
36 screening, diagnosis, or treatment of a condition or disease, as
37 demonstrated by a review of scientific and peer-reviewed medical
38 literature.

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

1 (C) The contribution of the benefit or service to the health status
2 of the population, including the results of any research
3 demonstrating the efficacy of the benefit or service compared to
4 alternatives, including not providing the benefit or service.

5 (D) The extent to which mandating or repealing the benefits or
6 services would not diminish or eliminate access to currently
7 available health care benefits or services.

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

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

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

15 (C) The extent to which the coverage or repeal of coverage will
16 increase or decrease the administrative expenses of health care
17 service plans and health insurers and the premium and expenses
18 of subscribers, enrollees, and policyholders.

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

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

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

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

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

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

38 (J) The level of public demand for health care coverage for the
39 benefit or service, including the level of interest of collective
40 bargaining agents in negotiating privately for inclusion of this

1 coverage in group contracts, and the extent to which the mandated
2 benefit or service is covered by self-funded employer groups.

3 (K) In assessing and preparing a written analysis of the financial
4 impact of legislation proposing to mandate a benefit or service and
5 legislation proposing to repeal a mandated benefit or service
6 pursuant to this paragraph, the Legislature requests the University
7 of California to use a certified actuary or other person with relevant
8 knowledge and expertise to determine the financial impact.

9 (4) The impact on essential health benefits, as defined in Section
10 1367.005 of this code and Section 10112.27 of the Insurance Code,
11 and the impact on the California Health Benefit Exchange.

12 (b) The Legislature further requests that the California Health
13 Benefit Review Program assess legislation that impacts health
14 insurance benefit design, cost sharing, premiums, and other health
15 insurance topics.

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

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

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

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

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

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

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

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

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

14 127664. The Legislature requests the University of California
15 to submit a report to the Governor and the Legislature by January
16 1, 2017, regarding the implementation of this chapter. This report
17 shall be submitted in compliance with Section 9795 of the
18 Government Code.

19 SEC. 5. Section 127665 of the Health and Safety Code is
20 repealed.

21 SEC. 6. Section 127665 is added to the Health and Safety Code,
22 to read:

23 127665. This chapter shall become inoperative on July 1, 2017,
24 and, as of January 1, 2018, is repealed, unless a later enacted
25 statute, that becomes operative on or before January 1, 2018,
26 deletes or extends the dates on which it becomes inoperative and
27 is repealed.

28 SEC. 7. Section 10965.3 of the Insurance Code is amended to
29 read:

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

39 (2) A health insurer shall allow the policyholder of an individual
40 health benefit plan to add a dependent to the policyholder’s health

1 benefit plan at the option of the policyholder, consistent with the
2 open enrollment, annual enrollment, and special enrollment period
3 requirements in 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 health insurer shall provide an initial open enrollment
8 period from October 1, 2013, to March 31, 2014, inclusive, an
9 annual enrollment period for the policy year beginning on January
10 1, 2015, from November 15, 2014, to February 15, 2015, inclusive,
11 and annual enrollment periods for policy years beginning on or
12 after January 1, 2016, from November 1, of the preceding calendar
13 year, to January 31 of the benefit year, inclusive.

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 health insurer shall also
17 provide a limited open enrollment period beginning on the date
18 that is 30 calendar days prior to the date the policy year ends in
19 2014.

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

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

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

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

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

- 1 (B) He or she gains a dependent or becomes a dependent.
2 (C) He or she is mandated to be covered as a dependent pursuant
3 to a valid state or federal court order.
4 (D) He or she has been released from incarceration.
5 (E) His or her health coverage issuer substantially violated a
6 material provision of the health coverage contract.
7 (F) He or she gains access to new health benefit plans as a result
8 of a permanent move.
9 (G) He or she was receiving services from a contracting provider
10 under another health benefit plan, as defined in Section 10965 of
11 this code or Section 1399.845 of the Health and Safety Code, for
12 one of the conditions described in subdivision (a) of Section
13 10133.56 of this code and that provider is no longer participating
14 in the health benefit plan.
15 (H) He or she demonstrates to the Exchange, with respect to
16 health benefit plans offered through the Exchange, or to the
17 department, with respect to health benefit plans offered outside
18 the Exchange, that he or she did not enroll in a health benefit plan
19 during the immediately preceding enrollment period available to
20 the individual because he or she was misinformed that he or she
21 was covered under minimum essential coverage.
22 (I) He or she is a member of the reserve forces of the United
23 States military returning from active duty or a member of the
24 California National Guard returning from active duty service under
25 Title 32 of the United States Code.
26 (J) With respect to individual health benefit plans offered
27 through the Exchange, in addition to the triggering events listed
28 in this paragraph, any other events listed in Section 155.420(d) of
29 Title 45 of the Code of Federal Regulations.
30 (2) With respect to individual health benefit plans offered
31 outside the Exchange, an individual shall have 60 days from the
32 date of a triggering event identified in paragraph (1) to apply for
33 coverage from a health care service plan subject to this section.
34 With respect to individual health benefit plans offered through the
35 Exchange, an individual shall have 60 days from the date of a
36 triggering event identified in paragraph (1) to select a plan offered
37 through the Exchange, unless a longer period is provided in Part
38 155 (commencing with Section 155.10) of Subchapter B of Subtitle
39 A of Title 45 of the Code of Federal Regulations.

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

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

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

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

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

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

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

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

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

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

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

28 (A) Health status.

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

30 (C) Claims experience.

31 (D) Receipt of health care.

32 (E) Medical history.

33 (F) Genetic information.

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

36 (H) Disability.

37 (I) Any other health status-related factor as determined by any
38 federal regulations, rules, or guidance issued pursuant to Section
39 2705 of the federal Public Health Service Act (Public Law 78-410).

1 (2) Notwithstanding subdivision (c) of Section 10291.5, a health
2 insurer shall not require an individual applicant or his or her
3 dependent to fill out a health assessment or medical questionnaire
4 prior to enrollment under an individual health benefit plan. A health
5 insurer shall not acquire or request information that relates to a
6 health status-related factor from the applicant or his or her
7 dependent or any other source prior to enrollment of the individual.

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

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

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

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

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

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

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

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

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

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

19 (k) If Section 5000A of the Internal Revenue Code, as added
20 by Section 1501 of PPACA, is repealed or amended to no longer
21 apply to the individual market, as defined in Section 2791 of the
22 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),
23 subdivisions (a), (b), and (g) shall become inoperative 12 months
24 after the date of that repeal or amendment and individual health
25 care benefit plans shall thereafter be subject to Sections 10901.2,
26 10951, and 10953.

27 SEC. 8. No reimbursement is required by this act pursuant to
28 Section 6 of Article XIII B of the California Constitution because
29 the only costs that may be incurred by a local agency or school
30 district will be incurred because this act creates a new crime or
31 infraction, eliminates a crime or infraction, or changes the penalty
32 for a crime or infraction, within the meaning of Section 17556 of
33 the Government Code, or changes the definition of a crime within
34 the meaning of Section 6 of Article XIII B of the California
35 Constitution.

36 SEC. 9. This act is an urgency statute necessary for the
37 immediate preservation of the public peace, health, or safety within
38 the meaning of Article IV of the Constitution and shall go into
39 immediate effect. The facts constituting the necessity are:

1 In order to maintain appropriate standards of accuracy and
2 efficiency with respect to matters relating to health care coverage
3 in California, by adjusting the next open enrollment period for the
4 individual health care coverage market as needed to comply with
5 federal law, and ensuring that the University of California is
6 provided with sufficient advance notice regarding the continuing
7 duties of the university to plan and carry out necessary health care
8 benefit research and analysis as requested pursuant to this act, it
9 is necessary that this act take effect immediately.

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