Senate Bill No. 265

CHAPTER 810

An act to add Article 4.6 (commencing with Section 1366.35) and Article 10.5 (commencing with Section 1399.801) to, Chapter 2.2 of Division 2 of the Health and Safety Code, and to add Section 10844 to, and to add Chapter 8.5 (commencing with Section 10785) and Chapter 9.5 (commencing with Section 10900) to, Part 2 of Division 2 of, the Insurance Code, relating to health care coverage.

[Approved by Governor September 28, 2000. Filed with Secretary of State September 28, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

SB 265, Speier. Health care coverage: federally eligible defined individuals.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Care, and provides that a willful violation of these provisions is a crime. Existing law also provides for the licensure and regulation of disability insurers by the Department of Insurance.

This bill would prohibit a health care service plan or disability insurer providing coverage under an individual plan contract or individual insurer benefit plan from declining to offer coverage to, or denying enrollment of, a federally eligible defined individual, or imposing any preexisting condition exclusion with respect to the coverage. This bill would require each plan and insurer to fairly and affirmatively offer, market, and sell to federally eligible defined individuals certain plan contracts and benefit plans that are sold to individuals or to associations that include individuals in each service area served by the plan or insurer.

The bill would impose various requirements relating to coverage required to be offered to federally eligible defined individuals and to associated premiums.

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

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.

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

SECTION 1. Article 4.6 (commencing with Section 1366.35) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 4.6. Coverage for Federally Eligible Defined Individuals

1366.35. (a) A health care service plan providing coverage for hospital, medical, or surgical benefits under an individual health care service plan contract may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, ''federally eligible defined individual'' means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(c) Every health care service plan shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

(d) A health care service plan shall offer the following health benefit plan contracts under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the plan in compliance with federal law. A health care service plan that offers only one health benefit plan contract to individuals, excluding

health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this article if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this article.

(e) (1) In the case of a health care service plan that offers health insurance coverage in the individual market through a network plan, the plan may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area of the plan, deny coverage to individuals if the plan has demonstrated to the director that the plan will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contractholders and enrollees and individual enrollees, and that the plan is applying this paragraph uniformly to individuals without regard to any health status related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A health care service plan, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer coverage in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A health care service plan may deny health insurance coverage in the individual market to a federally eligible defined individual if the plan has demonstrated to the director both of the following:

(A) The plan does not have the financial reserves necessary to underwrite additional coverage.

(B) The plan is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible individuals.

(2) A health care service plan, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the issuer has demonstrated to the director that the plan has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health insurance coverage offered by a health care service plan in the individual market in the same manner as it applies to a health care service plan in connection with a group health benefit plan.

(h) A health care service plan shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the plan compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan contract.

(i) Every health care service plan shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.

(j) No health care service plan may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(*l*) This section shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.

SEC. 2. Article 10.5 (commencing with Section 1399.801) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 10.5. Individual Access to Contracts for Health Care Services

1399.801. As used in this article:

(a) ''Creditable coverage'' means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(*l*) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under 22 U.S.C.A. 2504(e) of the Peace Corps Act.

(b) ''Dependent'' means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health care plan contract covering the eligible person.

(c) ''Federally eligible defined individual'' means an individual who as of the date on which the individual seeks coverage under this part, (1) has 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and has no other health insurance coverage, (3) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud, and (4) if offered continuation coverage under COBRA or Cal-COBRA, had elected and exhausted this coverage.

(d) ''In force business'' means an existing health benefit plan contract issued by the plan to a federally eligible defined individual.

(e) ''New business'' means a health care service plan contract issued to an eligible individual that is not the plan's in force business.

(f) ''Preexisting condition provision'' means a contract provision that excludes coverage for charges and expenses incurred during a specified period following the eligible individual's effective date, as to a condition for which medical advice, diagnosis, and care of treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

1399.802. Every health care service plan offering plan contracts to individuals shall, in addition to complying with the provisions of

this chapter and the rules adopted thereunder, comply with the provisions of this article.

1399.803. Nothing in this article shall be construed to preclude the application of this chapter to either of the following: (a) an association, trust, or other organization acting as a health care service plan as defined under Section 1345, or (b) an association, trust, multiple employer welfare arrangement, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.

1399.804. (a) Commencing January 1, 2001, a plan shall fairly and affirmatively offer, market, and sell the health care service plan contracts described in subdivision (d) of Section 1366.35 that are sold to individuals or to associations that include individuals to all federally eligible defined individuals in each service area in which the plan provides or arranges for the provision of health care services. Each plan shall make available to each federally eligible defined individual the identified health care service plan contracts which the plan offers and sells to individuals or to associations that include individuals.

(b) The plan may not reject an application from a federally eligible defined individual for a health care service plan contract under the following circumstances:

(1) The federally eligible defined individual as defined by subdivision (c) of Section 1399.801 agrees to make the required premium payments.

(2) The federally eligible defined individual, and his or her dependents who are to be covered by the plan contract, work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(c) No plan or solicitor shall, directly or indirectly, encourage or direct federally eligible defined individuals to refrain from filing an application for coverage with a plan because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location provided that it is within the plan's approved service area.

(d) No plan shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location of the individual.

(e) Each plan shall comply with the requirements of Section 1374.3.

1399.805. (a) (1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the following amounts:

(A) For health care service plan contracts that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A plan may adjust the premium based on family size, not to exceed the following amounts:

(A) For health care service plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.

(B) For health care service plans identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month,

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

(c) During the first 30 days after the effective date of the plan contract, the individual shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If an enrolled individual notified the plan of the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.

1399.806. A plan may not exclude any federally eligible defined individual, or his or her dependents, who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that individual or dependent. No plan contract may limit or exclude coverage for a specific federally eligible defined individual, or his or her dependents, by type of illness, treatment, medical condition, or accident.

1399.809. The director may require a plan to discontinue the offering of contracts or the acceptance of applications from any individual upon a determination by the director that the plan does not have sufficient financial viability, organization, and administrative capacity to assure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

1399.810. All health care service plan contracts offered to a federally eligible defined individual shall be renewable with respect to the individual and dependents at the option of the contractholder except in cases of:

(a) Nonpayment of the required premiums.

(b) Fraud or misrepresentation by the contractholder.

(c) The plan ceases to provide or arrange for the provision of health care services for individual health care service plan contracts in this state, provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the director and to the contractholder.

(2) Individual health care service plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any plan that ceases to offer for sale new individual health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.

(3) A plan that ceases to write new individual business in this state after January 1, 2001, shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of three years from the date of the notice to the director.

(d) When the plan withdraws a health care service plan contract from the individual market, provided that the plan makes available to eligible individuals all plan contracts that it makes available to new individual business, and provided that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1399.811.

1399.811. Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2001, shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(2) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

1399.812. Plans shall apply premiums consistently with respect to all federally eligible defined individuals who apply for coverage.

1399.813. In connection with the offering for sale of any plan contract to an individual, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of all individual contracts.

1399.814. Nothing in this article shall be construed to require a health benefit plan to offer a contract to an individual if the plan does not otherwise offer contracts to individuals.

1399.815. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article, or at least 20 business days prior to the initial offering of a plan contract subject to this article, a plan shall file a notice of an amendment with the director in accordance with the provisions of Section 1352. The notice of an amendment shall include a statement certifying that the plan is in

compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons the plan contract does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the plan shall file an amendment in accordance with the provisions of Section 1352, and shall include a statement certifying the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. All other changes to a plan contract previously filed with the director pursuant to subdivision (a) shall be filed as an amendment in accordance with the provisions of Section 1352, unless the change otherwise would require the filing of a material modification.

1399.816. Carriers and health care service plans that offer contracts to individuals may elect to establish a mechanism or method to share in the financing of high-risk individuals. This mechanism or method shall be established through a committee of all carriers and health care service plans offering coverage to individuals by July 1, 2002, and shall be implemented by January 1, 2003. If carriers and health care service plans wish to establish a risk-sharing mechanism but cannot agree on the terms and conditions of such an agreement, the Managed Risk Medical Insurance Board shall develop a risk-sharing mechanism or method by January 1, 2003, and it shall be implemented by July 1, 2003.

1399.817. The director may issue regulations that are necessary to carry out the purposes of this article. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Until December 31, 2001, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall be enforced by the director.

1399.818. This article shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.

SEC. 3. Chapter 8.5 (commencing with Section 10785) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 8.5. COVERAGE FOR FEDERALLY ELIGIBLE DEFINED INDIVIDUALS

10785. (a) A disability insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan as defined in subdivision (a) of Section 10198.6 may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny

enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, ''federally eligible defined individual'' means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

(c) Every disability insurer that covers hospital, medical, or surgical expenses shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

(d) A disability insurer shall offer the following health benefit plans under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the insurer in compliance with federal law. An insurer that offers only one health benefit plan to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this chapter if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this chapter.

(e) (1) In the case of a disability insurer that offers health benefit plans in the individual market through a network plan, the insurer may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area covered by the health benefit plan, deny coverage to individuals if the insurer has demonstrated to the commissioner that the insured will not have the capacity to deliver

services adequately to additional individual insureds because of its obligations to existing group policyholders, group contractholders and insureds, and individual insureds, and that the insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer health benefit plans through a network in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A disability insurer may deny health insurance coverage in the individual market to a federally eligible defined individual if the insurer has demonstrated to the commissioner both of the following:

(A) The insurer does not have the financial reserves necessary to underwrite additional coverage.

(B) The insurer is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the insurer has demonstrated to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health benefits plans offered by a disability insurer in the individual market in the same manner as it applies to an insurer in connection with a group health benefit plan policy or group health benefit plan contract.

(h) A disability insurer shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the insurer compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan.

(i) Every disability insurer shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual.

(j) No disability insurer may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

(*l*) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

SEC. 4. Section 10844 is added to the Insurance Code, to read:

10844. A purchasing alliance may offer coverage pursuant to Chapter 9.5 (commencing with Section 10900).

SEC. 5. Chapter 9.5 (commencing with Section 10900) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.5. INDIVIDUAL ACCESS TO CONTRACTS FOR HEALTH CARE SERVICES

10900. As used in this chapter:

(a) ''Benefit plan design'' means a specific health coverage policy issued by a carrier to individuals, to trustees of associations that cover individuals. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health services that has significant incentives for the covered individuals to use the system.

(b) ''Carrier'' means any disability insurance company or any other entity that writes, issues, or administers health benefit plans, as defined in subdivision (a) of Section 10198.6, that cover individuals, regardless of the situs of the contract or master policyholder.

(c) ''Creditable coverage'' means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(*l*) of the Public Health Service Act, as amended by Public Law 104-191.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504(e)).

(d) ''Dependent'' means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health benefit plan covering the eligible person.

(e) ''Federally eligible defined individual'' means an individual who as of the date on which the individual seeks coverage under this part, (1) has 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under an employer-sponsored health benefit plan, Medicare, or Medi-Cal, and has no other health insurance coverage, (3) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud, and (4) if offered continuation coverage under COBRA or Cal-COBRA, had elected and exhausted such coverage.

(f) ''In force business'' means an existing health benefit plan issued by a carrier to a federally eligible defined individual.

(g) ''New business'' means a health benefit plan issued to an eligible individual that is not the carrier's in force business.

(h) ''Preexisting condition provision'' means a policy provision that excludes coverage for charges and expenses incurred during a specified period following the eligible individual's effective date, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

10901. Every carrier offering health benefit plans to individuals shall comply with the provisions of this chapter and the rules adopted thereunder.

10901.1. Nothing in this chapter shall be construed to preclude the application of this chapter to either of the following: (a) an association, trust, or other organization acting as a health care service plan as defined under Section 1345, (b) an association, trust, multiple employer welfare arrangement, or other organization or person presenting information regarding a health benefit plan to persons who may be interested in subscribing or enrolling in the plan.

10901.2. (a) Commencing January 1, 2001, a carrier shall fairly and affirmatively offer, market, and sell the health benefit plan designs described in subdivision (d) of Section 10785 that are sold to individuals or to associations that include individuals to all federally eligible defined individuals in each geographic region in which the carrier provides coverage for health care services. Each carrier shall make available to each federally eligible defined individual the identified health benefit plan designs which the plan offers and sells to individuals or to associations that include individuals.

(b) A carrier may not reject an application from a federally eligible defined individual for a benefit plan design under the following circumstances:

(1) The federally eligible defined individual as defined by subdivision (e) of Section 10900 agrees to make the required premium payments.

(2) The federally eligible defined individual, and his or her dependents who are to be covered by the carrier, work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(c) No carrier or agent or broker shall, directly or indirectly, encourage or direct federally eligible defined individuals to refrain from filing an application for coverage with a carrier because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location provided that it is within the carrier’s approved service area.

(d) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to a solicitor for the sale of a health benefit plan design to be varied because of health status, claims experience, industry, occupation, receipt of health care, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence, disability, or geographic location of the individual. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent

or broker on the basis of percentage of premium, provided that the percentage shall not vary for the reasons listed in this subdivision.

(e) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to individuals in this state, the third-party administrator shall be subject to this chapter.

10901.3. (a) (1) After the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A carrier may adjust the premium based on family size, not to exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(c) During the first 30 days after the effective date of the health benefit plan, the individual shall have the option of changing coverage to a different health benefit plan design offered by the same carrier. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new health benefit plan shall become effective no later than the first day of the following month. If an enrolled individual notified the carrier of the change after the 15th day of a month, coverage under the health benefit plan shall become effective no later than the first day of the second month following notification.

10901.4. A carrier may not exclude any federally eligible defined individual, or his or her dependents, who would otherwise be entitled to health care services, on the basis of an actual or expected health condition of that individual or dependent. No health benefit plan may limit or exclude coverage for a specific federally eligible defined individual, or his or her dependents, by type of illness, treatment, medical condition, or accident.

10901.7. (a) The commissioner may require a carrier to discontinue the offering of health benefit plans or the acceptance of applications from any individual upon a determination by the commissioner that the plan carrier does not have sufficient financial viability, organization, and administrative capacity to assure the delivery of health care services to its enrollees.

(b) The commissioner's determination shall follow an evaluation that includes a certification by the commissioner that the acceptance of an application or applications would place the carrier in a financially impaired condition.

(c) A carrier that has not offered coverage or accepted applications pursuant to this chapter shall not offer coverage or accept applications for any individual until the commissioner has determined that the carrier has ceased to be financially impaired.

10901.8. All health benefit plans offered to a federally eligible defined individual shall be renewable with respect to the individual and dependents at the option of the enrolled individual except in cases of:

(a) Nonpayment of the required premiums.

(b) Fraud or misrepresentation by the enrolled individual.

(c) The carrier ceases to provide or arrange for the provision of health care services for individual health benefit plan contracts in this state, provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the contractholder.

(2) Individual health benefit plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a carrier that remains in force, any carrier that ceases to offer for sale new individual health benefit plan contracts shall continue to be governed by this article with respect to business conducted under this chapter.

(3) A carrier that ceases to write new individual business in this state after the effective date of this chapter shall be prohibited from offering for sale new individual health benefit plan contracts in this state for a period of three years from the date of the notice to the commissioner.

(d) When a carrier withdraws a health benefit plan design from the individual market, provided that a carrier makes available to eligible individuals all health plan benefit designs that it makes available to new individual business, and provided that premium for the new health benefit plan complies with the renewal increase requirements set forth in Section 10901.9.

10901.9. Commencing January 1, 2001, premiums for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides

in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(2) For a contract that a carrier has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

10902. Carriers shall apply premiums consistently with respect to all federally eligible defined individuals who apply for coverage.

10902.1. In connection with the offering for sale of any health benefit plan designed to an individual, each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all individual contracts.

10902.2. Nothing in this chapter shall be construed to require a health benefit plan to offer a contract to an individual if the carrier does not otherwise offer contracts to individuals.

10902.3. (a) At least 20 business days prior to renewing or amending a health benefit plan contract subject to this chapter, or at least 20 business days prior to the initial offering of a health benefit plan subject to this chapter, a carrier shall file a statement with the commissioner in the same manner as required for small employers as outlined in Section 10717. The statement shall include a statement certifying that the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. Any action by the commissioner, as permitted under Section 10717, to disapprove, suspend, or postpone the plan's use of a carrier's health benefit plan design shall be in writing, specifying the reasons the health benefit plan does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the carrier shall file an amendment in the same manner as required for small employers as outlined in Section 10717, and shall include a statement certifying the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. All other changes to a health benefit plan previously filed with the commissioner pursuant to subdivision (a) shall be filed as an amendment in the same manner as required for small employers as outlined in Section 10717.

10902.4. Carriers and health care service plans that offer contracts to individuals may elect to establish a mechanism or method to share in the financing of high-risk individuals. This mechanism or method shall be established through a committee of all carriers and health care service plans offering coverage to individuals by July 1, 2002, and shall be implemented by January 1, 2003. If carriers and health care service plans wish to establish a risk-sharing mechanism but cannot agree on the terms and conditions of such an agreement, the Managed Risk Medical Insurance Board shall develop a risk-sharing mechanism or method by January 1, 2003, and it shall be implemented by July 1, 2003.

10902.5. The commissioner may issue regulations that are necessary to carry out the purposes of this chapter. Any rules and regulations adopted pursuant to this chapter may be adopted as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Until December 31, 2001, the adoption of these regulations shall be deemed an emergency and necessary for

the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall be enforced by the commissioner.

10902.6. This chapter shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.

SEC. 6. 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.

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