Assembly Bill No. 2244

CHAPTER 656

An act to amend Sections 1357.06 and 1357.51 of, and to add Article 11.7 (commencing with Section 1399.825) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 10198.7 and 10708 of, and to add Chapter 9.7 (commencing with Section 10950) to Part 2 of Division 2 of, the Insurance Code, relating to health care coverage.

[Approved by Governor September 30, 2010. Filed with Secretary of State September 30, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2244, Feuer. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, on and after January 1, 2014, requires a health insurance issuer offering health insurance coverage in the individual or group market to accept every employer and individual in the state that applies for that coverage, as specified, and allows premiums for coverage in the individual or small group market to vary only by rating area, age, tobacco use, and whether the coverage is for an individual or family, as specified. The act also prohibits a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition for children with respect to plan years beginning on or after September 23, 2010, and for adults with respect to plan years beginning on or after January 1, 2014.

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. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health care service plan or health insurer to exclude an applicant from coverage for a specified time for preexisting conditions. A willful violation of provisions governing health care service plans is a crime.

This bill would prohibit the exclusion or limitation of coverage for children due to any preexisting condition, except as specified. The bill would further require plans and insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements. The bill would prescribe limits on the rates that may be imposed for coverage of a child depending on, among other things, whether the child applies for coverage during an open enrollment period, as defined, or is a late enrollee, as defined, and would, effective January 1, 2014, require plans and insurers to apply standard risk rates to child coverage, except as specified. The bill would prohibit a plan or carrier that does not or ceases to write new plan contracts or policies for children from offering new individual plan contracts or policies in this state for 5 years. The bill would authorize the Department

of Managed Health Care and the Department of Insurance to issue guidance for purposes of implementing these provisions.

By imposing new requirements on health care service plans, the willful violation of which would be a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 1357.06 of the Health and Safety Code is amended to read:

1357.06. (a) (1) Preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(2) Notwithstanding paragraph (1), a plan contract offered to a small employer shall not impose any preexisting condition provision upon any child under 19 years of age.

(b) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period no premiums shall be charged to the enrollee or the subscriber.

(c) In determining whether a preexisting condition provision or a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period,

and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(d) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), health plans providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, no premiums shall be charged to the enrollee or the subscriber.

(e) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(e)).

(f) A health care service plan issuing group coverage may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

SEC. 2. Section 1357.51 of the Health and Safety Code is amended to read:

1357.51. (a) No plan contract that covers three or more enrollees shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No plan contract that covers one or two individuals shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall the plan limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a plan contract for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) Notwithstanding subdivision (b), a plan contract for individual coverage that is not a grandfathered health within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

(d) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) A plan that does not utilize a preexisting condition provision in plan contracts that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No plan may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any enrollee, a plan shall credit the time the enrollee was covered under creditable coverage, provided that the enrollee becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting or affiliation period.

However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(g) No plan shall exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(h) A health care service plan issuing group coverage may not impose a preexisting condition exclusion upon a condition relating to benefits for pregnancy or maternity care.

(i) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(e)).

SEC. 3. Article 11.7 (commencing with Section 1399.825) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.7. Individual Access to Health Care Coverage

1399.825. As used in this article:

(a) "Child" means any individual under 19 years of age.

(b) "Individual grandfathered plan coverage" means health care coverage in which an individual was enrolled on March 23, 2010, consistent with Section 1251 of PPACA and any rules or regulations adopted pursuant to that law.

(c) "Initial open enrollment period" means the open enrollment period beginning on January 1, 2011, and ending 60 days thereafter.

(d) "Late enrollee" means a child without coverage who did not enroll in a health care service plan contract during an open enrollment period because of any of the following:

(1) The child lost dependent coverage due to termination or change in employment status of the child or the person through whom the child was covered; cessation of an employer's contribution toward an employee or dependent's coverage; death of the person through whom the child was covered as a dependent; legal separation; divorce; loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program, or the Medi-Cal program; or adoption of the child.

(2) The child became a resident of California during a month that was not the child's birth month.

(3) The child is born as a resident of California and did not enroll in the month of birth.

(4) The child is mandated to be covered pursuant to a valid state or federal court order.

(e) "Open enrollment period" means the annual open enrollment period, subsequent to the initial open enrollment period, applicable to each individual child that is the month of the child's birth date.

(f) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any subsequent rules or regulations issued pursuant to that law.

(g) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(h) "Responsible party for a child" means an adult having custody of the child or with responsibility for the financial needs of the child, including the responsibility to provide health care coverage.

(i) "Standard risk rate" means the lowest rate that can be offered for a child with the same benefit plan, effective date, age, geographic region, and family status.

1399.826. (a) (1) During each open enrollment period, every health care service plan offering plan contracts in the individual market, other than individual grandfathered plan coverage, shall offer to the responsible party

for a child coverage for the child that does not exclude or limit coverage due to any preexisting condition of the child.

(b) A health care service plan offering coverage in the individual market shall not reject an application for a health care service plan contract from a child or filed on behalf of a child by the responsible party during an open enrollment period or from a late enrollee during a period no longer than 63 days from the qualifying event listed in subdivision (d) of Section 1399.825.

(c) Except to the extent permitted by federal law, rules, regulations, or guidance issued by the relevant federal agency, a health care service plan shall not condition the issuance or offering of individual coverage on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

This subdivision shall not apply to a contract providing individual grandfathered plan coverage.

(d) When a responsible party for a child 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 under the plan contract shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(e) A health care service plan offering coverage in the individual market shall not reject the request of a responsible party for a child to include that child as a dependent on an existing health care service plan contract that includes dependent coverage during an open enrollment period.

(f) Nothing in this article shall be construed to prohibit a health care service plan offering coverage in the individual market from establishing rules for eligibility for coverage and offering coverage pursuant to those rules for children and individuals based on factors otherwise authorized under federal and state law for health plan contracts in addition to those offered on a guaranteed issue basis during an open enrollment period to children or late enrollees pursuant to this article. However, a health care service plan, other than a plan providing individual grandfathered plan coverage, shall not impose a preexisting condition provision on coverage, including dependent coverage, offered to a child.

(g) Nothing in this article shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(h) Nothing in this article shall be construed to prevent a health care service plan from offering coverage to a family member of an enrollee in grandfathered health plan coverage consistent with Section 1251 of PPACA.

1399.827. This article shall not apply to health care service plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement contracts, Medi-Cal contracts with the State Department of Health Care Services, plan contracts offered under the Healthy Families Program, long-term care coverage, or specialized health care service plan contracts.

1399.828. (a) Upon the effective date of this article, a health care service plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are offered and sold to a child or the responsible party for a child in each service area in which the plan provides or arranges for the provision of health care services during any open enrollment period, to late enrollees, and during any other period in which state or federal law, rules, regulations, or guidance expressly provide that a health care service plan shall not condition offer or acceptance of coverage on any preexisting condition.

(b) No health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct a child or responsible party for a child to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the child.

(2) Encourage or direct a child or responsible party for a child to seek coverage from another plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the child.

(c) A health care service plan shall not, 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 the health status, claims experience, industry, occupation, or geographic location of the child. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the child.

1399.829. (a) A health care service plan may use the following characteristics of an eligible child for purposes of establishing the rate of the plan contract for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health care service plan contract selected by the child or the responsible party for the child.

(b) From the effective date of this article to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with any health care service plan or health insurer for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health care service plan contract issued, sold, or renewed prior to December 31, 2013, the health plan shall provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial open enrollment period shall be deemed to have maintained coverage during that period.

(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.

(f) Health care service plans may require documentation from applicants relating to their coverage history.

1399.832. No health care service plan shall be required to offer a health care service plan contract or accept applications for the contract pursuant to this article in the case of any of the following:

(a) To a child, if the child who is to be covered by the plan contract does not work or reside within the plan's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to

ensure that health care services will be available and accessible to the child because of its obligations to existing enrollees.

(2) A health care service plan that cannot offer a health care service plan contract to individuals or children because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the plan is not offering coverage to individuals to new employer groups until the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan.

(3) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired.

1399.833. The director may require a health care service plan to discontinue the offering of contracts or acceptance of applications from any individual or child or responsible party for a child upon a determination by the director that the plan does not have sufficient financial viability or organizational and administrative capacity to ensure 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 1375.1), and the rules adopted under those provisions.

1399.834. (a) All health care service plan contracts offered to a child or on behalf of a child to a responsible party for a child shall conform to the requirements of Sections 1366.3, 1365, and 1373.6 and shall be renewable at the option of the enrollee or responsible party for a child on behalf of the enrollee except as permitted to be canceled, rescinded, or not renewed pursuant to Section 1365.

(b) Any plan that ceases to offer for sale new individual health care service plan contracts pursuant to Section 1365 shall continue to be governed by this article with respect to business conducted under this article.

(c) Except as authorized under Section 1399.833, a plan that, as of the effective date of this article, does not write new health care service plan contracts for children in this state or that, after the effective date of this article, ceases to write new health care service plan contracts for children in this state shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of five years from the date of notice to the director.

1399.835. On or before July 1, 2011, the director may issue guidance to health plans regarding compliance with this article and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The guidance shall only be effective until the director and the Insurance Commissioner adopt joint regulations pursuant to the Administrative Procedure Act.

SEC. 4. Section 10198.7 of the Insurance Code is amended to read:

10198.7. (a) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No health benefit plan that covers one or two individuals and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a health benefit plan for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) Notwithstanding subdivision (b), a health benefit plan for individual coverage that is a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

(d) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) A carrier that does not utilize a preexisting condition provision in health plans that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No carrier may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment,

including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any person, all health benefit plans shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A health benefit plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any affiliation or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated or, an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period.

(g) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(h) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act, 42 U.S.C. Sec. 300gg(e).

(i) A group health benefit plan may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

(j) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

SEC. 5. Section 10708 of the Insurance Code is amended to read:

10708. (a) (1) Preexisting condition provisions of health benefit plans shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including the use of prescription medications, was recommended by or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(2) Notwithstanding paragraph (1), a health benefit plan offered to a small employer shall not impose any preexisting condition provision upon any child under 19 years of age.

(b) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the subscriber or enrollee.

(c) In determining whether a preexisting condition provision or a waiting period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding health benefit plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any postenrollment or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

(d) Group health benefit plans may not impose a preexisting conditions exclusion to a condition relating to benefits for pregnancy or maternity care.

(e) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning preexisting condition provisions and waiting or affiliation periods.

(f) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), carriers providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the insured.

SEC. 6. Chapter 9.7 (commencing with Section 10950) is added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 9.7. Individual Access to Health Insurance

10950. As used in this chapter:

(a) "Child" means any individual under 19 years of age.

(b) "Individual grandfathered plan coverage" means health care coverage in which an individual was enrolled on March 23, 2010, consistent with Section 1251 of PPACA and any rules or regulations adopted pursuant to that law.

(c) "Initial open enrollment period" means the open enrollment period beginning on January 1, 2011, and ending 60 days thereafter.

(d) "Late enrollee" means a child without coverage who did not enroll in a health benefit plan during an open enrollment period because of any of the following:

(1) The child lost dependent coverage due to termination or change in employment status of the child or the person through whom the child was covered; cessation of an employer's contribution toward an employee or dependent's coverage; death of the person through whom the child was covered as a dependent; legal separation; divorce; loss of coverage under the Healthy Families Program, the Access for Infants and Mothers Program, or the Medi-Cal program; or adoption of the child.

(2) The child became a resident of California during a month that was not the child's birth month.

(3) The child is born as a resident of California and did not enroll in the month of birth.

(4) The child is mandated to be covered pursuant to a valid state or federal court order.

(e) "Open enrollment period" means the annual open enrollment period subsequent to the initial open enrollment period, applicable to each individual child that is the month of the child's birth date.

(f) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any subsequent rules or regulations issued pursuant to that law.

(g) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(h) "Responsible party for a child" means an adult having custody of the child or with responsibility for the financial needs of the child, including the responsibility to provide health care coverage.

(i) "Standard risk rate" means the lowest rate that can be offered for a child with the same benefit plan, effective date, age, geographic region, and family status.

10951. (a) (1) During each open enrollment period, every carrier offering health benefit plans in the individual market, other than individual grandfathered plan coverage, shall offer to the responsible party for a child coverage for the child that does not exclude or limit coverage due to any preexisting condition of the child.

(b) A carrier offering coverage in the individual market shall not reject an application for a health benefit plan from a child or filed on behalf of a child by the responsible party during an open enrollment period or from a late enrollee during a period no longer than 63 days from the qualifying event listed in subdivision (d) of Section 10950.

(c) Except to the extent permitted by federal law, rules, regulations, or guidance issued by the relevant federal agency, a carrier shall not condition the issuance or offering of individual coverage on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

This subdivision shall not apply to a health benefit plan providing individual grandfathered plan coverage.

(d) When a responsible party for a child 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 under the health benefit plan shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(e) A carrier offering coverage in the individual market shall not reject the request of a responsible party for a child to include that child as a dependent on an existing health benefit plan that includes dependent coverage during an open enrollment period.

(f) Nothing in this chapter shall be construed to prohibit a carrier offering coverage in the individual market from establishing rules for eligibility for coverage and offering coverage pursuant to those rules for children and individuals based on factors otherwise authorized under federal and state law for health benefit plans in addition to those offered on a guaranteed issue basis during an open enrollment period to children or late enrollees pursuant to this chapter. However, a carrier, other than a carrier providing individual grandfathered plan coverage, shall not impose a preexisting condition provision on coverage, including dependent coverage, offered to a child.

(g) Nothing in this chapter shall be construed to require a carrier to establish a new service area or to offer health care coverage on a statewide basis, outside of the carrier’s existing service area.

(h) Nothing in this chapter shall be construed to prevent a carrier from offering coverage to a family member of an enrollee in grandfathered health plan coverage consistent with Section 1251 of PPACA.

10952. This chapter shall not apply to health benefit plans for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement policies, Medi-Cal contracts with the State Department of Health Care Services, policies offered under the Healthy Families Program, long-term care coverage, or specialized health benefit plans.

10953. (a) Upon the effective date of this chapter, a carrier shall fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are offered and sold to a child or the responsible party for a child in each service area in which the plan provides or arranges for health care coverage during any open enrollment period, to late enrollees, and during any other period in which state or federal law, rules, regulations, or guidance expressly provide that a carrier shall not condition offer or acceptance of coverage on any preexisting condition.

(b) No carrier or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct a child or responsible party for a child to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the carrier's approved service area, of the child.

(2) Encourage or direct a child or responsible party for a child to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the carrier's approved service area, of the child.

(c) A carrier shall not, 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 benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the child. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the child.

10954. (a) A carrier may use the following characteristics of an eligible child for purposes of establishing the rate of the health benefit plan for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health benefit plan selected by the child or the responsible party for a child.

(b) From the effective date of this chapter to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with any carrier or health care service plan for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a carrier may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a carrier may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health benefit plan issued, sold, or renewed prior to December 31, 2013, the carrier shall provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial enrollment period shall be deemed to have maintained coverage during that period.

(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.

(f) Carriers may require documentation from applicants relating to their coverage history.

10957. No carrier shall be required to offer a health benefit plan or accept applications for the contract pursuant to this chapter in the case of any of the following:

(a) To a child, if the child who is to be covered by the health benefit plan does not work or reside within the carrier's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the child because of its obligations to existing insureds.

(2) A carrier that cannot offer a health benefit plan to individuals or children because it is lacking in sufficient health care delivery resources

within a service area or a portion of a service area may not offer a contract in the area in which the carrier is not offering coverage to individuals to new employer groups until the carrier notifies the commissioner that it has the ability to deliver services to individuals, and certifies to the commissioner that from the date of the notice it will enroll all individuals requesting coverage in that area from the carrier.

(3) Nothing in this chapter shall be construed to limit the commissioner's authority to develop and implement a plan of rehabilitation for a carrier whose financial viability or organizational and administrative capacity has become impaired.

10958. The commissioner may require a carrier to discontinue the offering of contracts or acceptance of applications from any individual or child or responsible party for a child upon a determination by the commissioner that the carrier does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its insureds. In determining whether the conditions of this section have been met, the commissioner shall consider, but not be limited to, the carrier's compliance with the requirements of this part and the rules adopted under those provisions.

10959. (a) All health benefit plans offered to a child or on behalf of a child to a responsible party for a child shall conform to the requirements of Section 10127.18, 12682.1, and 10273.4, and shall be renewable at the option of the child or responsible party for a child on behalf of the child except as permitted to be canceled, rescinded or not renewed pursuant to Section 10273.4.

(b) Any carrier that ceases to offer for sale new individual health benefit plans pursuant to Section 10273.4 shall continue to be governed by this chapter with respect to business conducted under this chapter.

(c) Except as authorized under Section 10958, a carrier that as of the effective date of this chapter does not write new health benefit plans for children in this state or that after the effective date of this chapter ceases to write new health benefit plans for children in this state shall be prohibited from offering for sale new individual health benefit plans or in this state for a period of five years from the date of notice to the commissioner.

10960. On or before July 1, 2011, the commissioner may issue guidance to health plans regarding compliance with this chapter and such guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The guidance shall only be effective until the commissioner and the Director of the Department of Managed Health Care adopt joint regulations pursuant to the Administrative Procedure Act.

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

within the meaning of Section 6 of Article XIII B of the California Constitution.

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