

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 1102

Introduced by Assembly Member Santiago

February 27, 2015

An act to amend Section ~~1569.31~~ 1399.849 of the Health and Safety Code, and to amend Section 10965.3 of the Insurance Code, relating to residential care facilities for the elderly: health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1102, as amended, Santiago. ~~Residential care facilities for the elderly. Health care coverage: special enrollment periods: triggering event.~~

Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms as of January 1, 2014. Among other things, PPACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers, and requires each exchange to provide for an initial open enrollment period, annual open enrollment periods, and special enrollment periods.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's or insurer's health benefit plans that are sold in the individual market for policy years on

or after January 1, 2014, to all individuals and dependents in each service area in which the plan or insurer provides or arranges for the provision of health care services, as specified, but requires plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. Existing law requires a health care service plan and health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events, including that he or she gains a dependent.

This bill would require a health care service plan or health insurer to allow an individual to enroll or change individual health benefits if the individual becomes pregnant. Because a willful violation of this requirement by a health care service plan would be a crime, this bill would impose a state-mandated local program.

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

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

~~Existing law provides for the licensure of residential care facilities for the elderly by the State Department of Social Services, including prescribing standards of safety and sanitation for the physical plant and standards for basic care and supervision, personal care, and services to be provided. Violation of these provisions is a crime.~~

~~This bill would make technical, nonsubstantive changes to these provisions:~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~-yes.
State-mandated local program: ~~no~~-yes.

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

- 1 SECTION 1. Section 1399.849 of the Health and Safety Code
- 2 is amended to read:
- 3 1399.849. (a) (1) On and after October 1, 2013, a plan shall
- 4 fairly and affirmatively offer, market, and sell all of the plan’s
- 5 health benefit plans that are sold in the individual market for policy
- 6 years on or after January 1, 2014, to all individuals and dependents
- 7 in each service area in which the plan provides or arranges for the
- 8 provision of health care services. A plan shall limit enrollment in
- 9 individual health benefit plans to open enrollment periods, annual

1 enrollment periods, and special enrollment periods as provided in
2 subdivisions (c) and (d).

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

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

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

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

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

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

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

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

39 (iii) "Loss of minimum essential coverage" does not include
40 loss of that coverage due to the individual's failure to pay

1 premiums on a timely basis or situations allowing for a rescission,
2 subject to clause (ii) and Sections 1389.7 and 1389.21.

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

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

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

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

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

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

16 (H) He or she demonstrates to the Exchange, with respect to
17 health benefit plans offered through the Exchange, or to the
18 department, with respect to health benefit plans offered outside
19 the Exchange, that he or she did not enroll in a health benefit plan
20 during the immediately preceding enrollment period available to
21 the individual because he or she was misinformed that he or she
22 was covered under minimum essential coverage.

23 (I) He or she is a member of the reserve forces of the United
24 States military returning from active duty or a member of the
25 California National Guard returning from active duty service under
26 Title 32 of the United States Code.

27 (J) *An individual becomes pregnant.*

28 (J)

29 (K) With respect to individual health benefit plans offered
30 through the Exchange, in addition to the triggering events listed
31 in this paragraph, any other events listed in Section 155.420(d) of
32 Title 45 of the Code of Federal Regulations.

33 (2) With respect to individual health benefit plans offered
34 outside the Exchange, an individual shall have 60 days from the
35 date of a triggering event identified in paragraph (1) to apply for
36 coverage from a health care service plan subject to this section.
37 With respect to individual health benefit plans offered through the
38 Exchange, an individual shall have 60 days from the date of a
39 triggering event identified in paragraph (1) to select a plan offered
40 through the Exchange, unless a longer period is provided in Part

1 155 (commencing with Section 155.10) of Subchapter B of Subtitle
2 A of Title 45 of the Code of Federal Regulations.

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

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

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

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

33 (3) With respect to an individual health benefit plan for which
34 an individual applies during the annual open enrollment period
35 described in subdivision (c), when the individual submits a
36 premium payment, based on the quoted premium charges, and that
37 payment is delivered or postmarked, whichever occurs later, by
38 December 15, coverage shall become effective as of the following
39 January 1. When that payment is delivered or postmarked within
40 the first 15 days of any subsequent month, coverage shall become

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

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

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

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

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

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

31 (A) Health status.

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

33 (C) Claims experience.

34 (D) Receipt of health care.

35 (E) Medical history.

36 (F) Genetic information.

37 (G) Evidence of insurability, including conditions arising out
38 of acts of domestic violence.

39 (H) Disability.

1 (I) Any other health status-related factor as determined by any
2 federal regulations, rules, or guidance issued pursuant to Section
3 2705 of the federal Public Health Service Act.

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

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

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

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

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

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

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

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

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

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

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

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

27 *SEC. 2. Section 10965.3 of the Insurance Code is amended to*
28 *read:*

29 10965.3. (a) (1) On and after October 1, 2013, a health insurer
30 shall fairly and affirmatively offer, market, and sell all of the
31 insurer's health benefit plans that are sold in the individual market
32 for policy years on or after January 1, 2014, to all individuals and
33 dependents in each service area in which the insurer provides or
34 arranges for the provision of health care services. A health insurer
35 shall limit enrollment in individual health benefit plans to open
36 enrollment periods, annual enrollment periods, and special
37 enrollment periods as provided in subdivisions (c) and (d).

38 (2) A health insurer shall allow the policyholder of an individual
39 health benefit plan to add a dependent to the policyholder's health
40 benefit plan at the option of the policyholder, consistent with the

1 open enrollment, annual enrollment, and special enrollment period
2 requirements in this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (G) He or she was receiving services from a contracting provider
9 under another health benefit plan, as defined in Section 10965 of
10 this code or Section 1399.845 of the Health and Safety Code, for
11 one of the conditions described in subdivision (a) of Section
12 10133.56 and that provider is no longer participating in the health
13 benefit plan.

14 (H) He or she demonstrates to the Exchange, with respect to
15 health benefit plans offered through the Exchange, or to the
16 department, with respect to health benefit plans offered outside
17 the Exchange, that he or she did not enroll in a health benefit plan
18 during the immediately preceding enrollment period available to
19 the individual because he or she was misinformed that he or she
20 was covered under minimum essential coverage.

21 (I) He or she is a member of the reserve forces of the United
22 States military returning from active duty or a member of the
23 California National Guard returning from active duty service under
24 Title 32 of the United States Code.

25 (J) *An individual becomes pregnant.*

26 (F)

27 (K) With respect to individual health benefit plans offered
28 through the Exchange, in addition to the triggering events listed
29 in this paragraph, any other events listed in Section 155.420(d) of
30 Title 45 of the Code of Federal Regulations.

31 (2) With respect to individual health benefit plans offered
32 outside the Exchange, an individual shall have 60 days from the
33 date of a triggering event identified in paragraph (1) to apply for
34 coverage from a health care service plan subject to this section.
35 With respect to individual health benefit plans offered through the
36 Exchange, an individual shall have 60 days from the date of a
37 triggering event identified in paragraph (1) to select a plan offered
38 through the Exchange, unless a longer period is provided in Part
39 155 (commencing with Section 155.10) of Subchapter B of Subtitle
40 A of Title 45 of the Code of Federal Regulations.

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

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

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

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

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

1 and December 31, inclusive, or after the 15th day of any subsequent
2 month, coverage shall become effective no later than the first day
3 of the second month following delivery or postmark of the
4 payment.

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

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

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

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

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

29 (A) Health status.

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

31 (C) Claims experience.

32 (D) Receipt of health care.

33 (E) Medical history.

34 (F) Genetic information.

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

37 (H) Disability.

38 (I) Any other health status-related factor as determined by any
39 federal regulations, rules, or guidance issued pursuant to Section
40 2705 of the federal Public Health Service Act.

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

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

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

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

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

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

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

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

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

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

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

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

27 *SEC. 3. No reimbursement is required by this act pursuant to*
28 *Section 6 of Article XIII B of the California Constitution because*
29 *the only costs that may be incurred by a local agency or school*
30 *district will be incurred because this act creates a new crime or*
31 *infraction, eliminates a crime or infraction, or changes the penalty*
32 *for a crime or infraction, within the meaning of Section 17556 of*
33 *the Government Code, or changes the definition of a crime within*
34 *the meaning of Section 6 of Article XIII B of the California*
35 *Constitution.*

36 ~~SECTION 1. Section 1569.31 of the Health and Safety Code~~
37 ~~is amended to read:~~

38 ~~1569.31. (a) The regulations for a license shall prescribe~~
39 ~~standards of safety and sanitation for the physical plant and~~

1 standards for basic care and supervision, personal care, and services
2 to be provided.

3 (b) ~~The department's regulations shall allow for the development
4 of new and innovative community programs.~~

5 (c) ~~In adopting regulations that implement this chapter, the
6 department shall provide flexibility to allow facilities conducted
7 by and exclusively for adherents of a well-recognized church or
8 religious denomination who rely solely on prayer or spiritual means
9 for healing to operate a licensed residential care facility for the
10 elderly.~~

O