SB 961 (Hernandez) – Individual Health Care Coverage

Introduced January 10, 2012, Vetoed September 30, 2012

This bill reforms California's health insurance market for individual purchasers and implements provisions of the Patient Protection and Affordable Care Act (ACA) prohibiting preexisting condition exclusions, requiring guaranteed issuance of products, establishing statewide open and special enrollment periods, and limiting premium rating factors to age, geography, and family size.

This bill also establishes geographic rating regions, to prohibit a health care service plan from acquiring or requesting information related to a health status factor, and requires if the federal ACA provisions on guarantee issue and rating factors are repealed in the ACA, these sections in state law would also be repealed.

OFFICE OF THE GOVERNOR

SEP 30 2012

To the Members of the California State Senate:

I am returning Senate Bill 961 without my signature.

I realize how important it is to align our individual health insurance market rules with the federal Patient Protection and Affordable Care Act. This bill got almost all the way there. Unfortunately, the measure failed to adequately link our state reforms to the federal law.

The Affordable Care Act requires insurers to provide health coverage to all individuals regardless of their health status. This mandate on insurers is balanced by the mandate on individuals to obtain health coverage, with federal subsidies available to help lower-income people purchase it.

Without the strong foundation that federal law provides, a state-level mandate on insurers alone could encourage healthy people to wait until they got sick or injured before purchasing coverage. This would lead to skyrocketing premiums, making coverage more unaffordable.

I look forward to working with the Legislature to correct this problem and adopt the remaining essential provisions of this bill.

Sincerely,

Edmund G. Brown Jr.

Senate Bill No. 961

Passed the Senate August 29, 2012

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Secretary of the Senate

Passed the Assembly August 28, 2012

_____

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2012, at _____ o'clock ___M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to amend Section 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, to add Section 10960.5 to, to add Chapter 9.9 (commencing with Section 10965) to Part 2 of Division 2 of, and to repeal Section 10902.4 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 961, Hernandez. Individual health care coverage.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA) enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate charge by a health insurance issuer offering small group or individual coverage to vary only by family composition, rating area, age, and tobacco use, as specified, and prohibits discrimination against individuals based on health status.

Existing law provides for the regulation of health insurers by the Insurance Commissioner and requires insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements.

This bill would require a health insurer, on and after October 1, 2013, to offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market to all individuals and dependents in each service area in which the insurer provides or arranges for the provision of health care services, with coverage effective on or after January 1, 2014, as specified, but would require insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. The bill would prohibit these health benefit plans from imposing

any preexisting condition upon any individual. Commencing January 1, 2014, the bill would prohibit a health insurer from establishing rules of eligibility for individual health benefit plans on any health status-related factor, as specified, and would authorize insurers to use only age, geographic region, and whether the plan covers an individual or family for purposes of establishing rates for individual health benefit plans, as specified. The bill would require a health insurer to issue a specified notice at least 60 days prior to the renewal date of an individual grandfathered health plan to all subscribers and policyholders of the plan. The bill would make certain of these provisions inoperative if the corresponding provisions of PPACA are repealed and would make other conforming changes. The bill would provide that it shall become operative only if AB 1461 is also enacted.

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

SECTION 1. Section 10902.4 of the Insurance Code is repealed.

SEC. 2. The heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of the Insurance Code is amended to read:

CHAPTER 9.7. CHILD ACCESS TO HEALTH INSURANCE

SEC. 3. Section 10954 of the Insurance Code is amended to read:

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 renewing 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 shall not require documentation from applicants relating to their coverage history.

(g) (1) On and after January 1, 2013, and until January 1, 2014, a carrier shall provide a notice to all applicants for coverage under this chapter and to all insureds, or the responsible party for an

insured, renewing coverage under this chapter that contains the following information:

(A) Information about the open enrollment period provided under Section 10965.3.

(B) An explanation that obtaining coverage during the open enrollment period described in Section 10965.3 will not affect the effective dates of coverage for coverage purchased pursuant to this chapter unless the applicant cancels that coverage.

(C) An explanation that coverage purchased pursuant to this section shall be effective as required under subdivision (d) of Section 10951 and that such coverage shall not prevent an applicant from obtaining new coverage during the open enrollment period described in Section 10965.3.

(D) Information about the Medi-Cal program and the Healthy Families Program and about subsidies available through the California Health Benefit Exchange.

(2) The notice described in paragraph (1) shall be in plain language and 14-point type.

(3) The department may adopt a model notice to be used by carriers in order to comply with this subdivision and shall consult with the Department of Managed Health Care in adopting that model notice. Use of the model notice shall not require prior approval of the department. Any model notice designated by the department for purposes of this section 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).

SEC. 4. Section 10960.5 is added to the Insurance Code, to read:

10960.5. Commencing January 1, 2014, in the event of a conflict between the provisions of this chapter and the provisions of Chapter 9.9 (commencing with Section 10965), the provisions of Chapter 9.9 (commencing with Section 10965) shall prevail, except where subdivision (j) of Section 10965.3 or subdivision (e) of Section 10965.9 makes any of the provisions of Chapter 9.9 (commencing with Section 10965) inoperative, in which case the provisions of this chapter and the operative provisions of Chapter 9.9 (commencing with Section 10965) shall be harmonized to the extent permitted by federal law.

SEC. 5. Chapter 9.9 (commencing with Section 10965) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.9. INDIVIDUAL ACCESS TO HEALTH INSURANCE

10965. For purposes of this chapter, the following definitions shall apply:

(a) "Child" means a child described in Section 22775 of the Government Code and subdivisions (n) to (p), inclusive, of Section 599.500 of Title 2 of the California Code of Regulations.

(b) "Dependent" means the spouse or registered domestic partner, or child, of an individual, subject to applicable terms of the health benefit plan.

(c) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(d) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(e) "Health benefit plan" means any individual or group policy of health insurance, as defined in Section 106. The term does not include a health insurance policy that provides excepted benefits, as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91), subject to Section 10965.01, a health insurance conversion policy offered pursuant to Section 12682.1, a health insurance policy provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2), or the program under Part 6.4 (commencing with Section 12699.50) of Division 2, or a health insurance policy offered to a federally eligible defined individual under Chapter 8.5 (commencing with Section 10785), to the extent consistent with PPACA.

(f) "Policy year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

(g) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010

(Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(h) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, 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.

(i) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of PPACA.

(j) "Rating period" means the period for which premium rates established by an insurer are in effect.

(k) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

10965.01. (a) For purposes of this chapter, "health benefit plan" does not include policies or certificates of specified disease or hospital confinement indemnity provided that the carrier offering those policies or certificates complies with the following:

(1) The carrier files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in paragraph (2).

(2) The certification required in paragraph (1) shall contain the following:

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for coverage that provides essential health benefits as defined by the state pursuant to Section 1302 of PPACA, and (ii) the disclosure forms as described in Section 10603 contains the following statement prominently on the first page:

"This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

(B) A summary description of each policy or certificate described in this section, including the average annual premium rates, or range of premium rates in cases where premiums vary by

age, gender, or other factors, charged for the policies and certificates in this state.

(3) In the case of a policy or certificate that is described in this section and that is offered for the first time in this state on or after January 1, 2013, the carrier files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

(b) As used in this section, "policies or certificates of specified disease" and "policies or certificates of hospital confinement indemnity" mean policies or certificates of insurance sold to an insured to supplement other health insurance coverage as specified in this section.

10965.1. Every health insurer offering individual health benefit plans shall, in addition to complying with the provisions of this part and rules adopted thereunder, comply with the provisions of this chapter.

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

(2) A health insurer that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraph (1) with respect to an individual health benefit plan offered through the Exchange in those geographic regions in which the insurer offers health benefit plans through the Exchange.

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

(4) A health insurer offering coverage in the individual market shall not reject the request of a policyholder during an open enrollment period to include a dependent of the policyholder as a dependent on an existing individual health benefit plan.

(b) An individual health benefit plan issued, amended, or renewed shall not impose any preexisting condition provision upon any individual.

(c) A health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.

(d) (1) Subject to subdivision (e), commencing January 1, 2014, a health insurer shall allow an individual to enroll in or change individual health benefit plans offered outside the Exchange as a result of the following triggering events:

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

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

(ii) "Loss of minimum essential coverage" includes loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations. "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to Section 10384.17.

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

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

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

(E) His or her health benefit plan substantially violated a material provision of the policy.

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

(G) He or she was receiving services from a contracting provider under another health benefit plan, as defined in Section 10965 or Section 1399.845 of the Health and Safety Code, for one of the conditions described in subdivision (a) of Section 10133.56 and that provider is terminated.

(2) Subject to subdivision (e), commencing January 1, 2014, a health insurer shall allow an individual to enroll in or change

individual health benefit plans offered through the Exchange as a result of the triggering events listed in Section 155.420(d) of Title 45 of the Code of Federal Regulations. To the extent permitted by federal law, any triggering event described in paragraph (1) that is not listed in Section 155.420(d)(1) to (8), inclusive, of Title 45 of the Code of Federal Regulations shall be considered an exceptional circumstance under Section 155.420(d)(9) of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in subdivision (d) to apply for coverage from a health benefit plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 60 days from the date of a triggering event identified in subdivision (d) to select a plan offered through the Exchange.

(f) With respect to individual health benefit plans offered outside the Exchange, after an individual submits a completed application form for a plan, the insurer shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 10965.9. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

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

(2) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the

annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

(A) When the 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 under the plan shall become effective no later than the first day of the following month.

(B) When the premium 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.

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

(D) Notwithstanding subparagraph (A) or (B), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the following month.

(4) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage selected pursuant to this section shall be the same as the applicable date specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(h) (1) On or after January 1, 2014, a health insurer shall not establish rules for eligibility, including continued eligibility, of

any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

(i) This section shall not apply to an individual health benefit plan that is a grandfathered health plan.

(j) The following provisions of this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed:

(1) Subdivision (a).

(2) Subdivisions (c), (d), (e), and (g), except as they relate to health benefit plans offered through the Exchange.

10965.5. (a) Commencing January 1, 2014, no health insurer or agent or broker shall, directly or indirectly, engage in the following activities:

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

(2) Encourage or direct an individual to seek individual coverage from another health care service plan or health insurer or the

California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the insurer's approved service area, of the individual.

(b) Commencing January 1, 2014, a health insurer shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a broker or agent that provides for or results in the compensation paid to a broker or agent for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision does not apply to a compensation arrangement that provides compensation to a broker or agent 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 individual.

(c) This section shall be enforced in the same manner as Section 790.03, including through Sections 790.05 and 790.035.

10965.7. (a) All individual health benefit plans shall conform to the requirements of Sections 10112.1, 10127.18, 10273.6, and 12682.1, and any other requirements imposed by this code, and shall be renewable at the option of the insured except as permitted to be canceled, rescinded, or not renewed pursuant to Section 10273.6.

(b) Any insurer that ceases to offer for sale new individual health benefit plans pursuant to Section 10273.6 shall continue to be governed by this chapter with respect to business conducted under this chapter.

10965.9. (a) With respect to individual health benefit plans issued, amended, or renewed on or after January 1, 2014, a health insurer may use only the following characteristics of an individual, and any dependent thereof, for purposes of establishing the rate of the individual health benefit plan covering the individual and the eligible dependents thereof, along with the health benefit plan selected by the individual:

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined based

on the individual's birthday and shall not vary by more than three to one for adults.

(2) (A) Geographic region. The geographic regions for purposes of rating shall be the following:

(i) Region 1 shall consist of the Counties of Alpine, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, and Tuolumne.

(ii) Region 2 shall consist of the Counties of Napa, Sonoma, Solano, and Marin.

(iii) Region 3 shall consist of the Counties of Sacramento, Placer, El Dorado, and Yolo.

(iv) Region 4 shall consist of the County of San Francisco.

(v) Region 5 shall consist of the County of Contra Costa.

(vi) Region 6 shall consist of the County of Alameda.

(vii) Region 7 shall consist of the County of Santa Clara.

(viii) Region 8 shall consist of the County of San Mateo.

(ix) Region 9 shall consist of the Counties of Santa Cruz, Monterey, and San Benito.

(x) Region 10 shall consist of the Counties of San Joaquin, Stanislaus, Merced, Mariposa, and Tulare.

(xi) Region 11 shall consist of the Counties of Madera, Fresno, and Kings.

(xii) Region 12 shall consist of the Counties of San Luis Obispo, Santa Barbara, and Ventura.

(xiii) Region 13 shall consist of the Counties of Mono, Inyo, and Imperial.

(xiv) Region 14 shall consist of the County of Kern.

(xv) Region 15 shall consist of the ZIP Codes in Los Angeles County starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(xvi) Region 16 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (xv).

(xvii) Region 17 shall consist of the Counties of San Bernardino and Riverside.

(xviii) Region 18 shall consist of the County of Orange.

(xix) Region 19 shall consist of the County of San Diego.

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Heath Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care

coverage market in California, and make a report to the appropriate policy committees of the Legislature.

(3) Whether the health benefit plan covers an individual or family, as described in PPACA.

(b) The rate for a health benefit plan subject to this section shall not vary by any factor not described in this section.

(c) The rating period for rates subject to this section shall be from January 1 to December 31, inclusive.

(d) This section shall not apply to an individual health benefit plan that is a grandfathered health plan.

(e) This section shall become inoperative if Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added by Section 1201 of PPACA, is repealed.

10965.11. A health insurer shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to this chapter in the case of any of the following:

(a) To an individual who does not work or reside within the insurer's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the insurer 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 individual because of its obligations to existing insureds.

(2) A health insurer that cannot offer an individual health benefit plan to individuals 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 health benefit plan in the area in which the insurer is not offering coverage to individuals to new employer groups until the insurer 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 insurer.

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

10965.13. The commissioner may require a health insurer to discontinue the offering of individual health benefit plans or acceptance of applications from any individual upon a

determination by the commissioner that the insurer 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 insurer's compliance with the requirements of this part and the rules adopted under those provisions.

10965.14. (a) On or before October 1, 2013, and annually thereafter, a health insurer shall issue the following notice to all policyholders enrolled in an individual health benefit plan that is a grandfathered health plan:

New improved health insurance options are available in California. You currently have health insurance that is exempt from many of the new requirements. For instance, your policy may not include certain consumer protections that apply to other policies, such as the requirement for the provision of preventive health services without any cost sharing and the prohibition against increasing your rates based on your health status. You have the option to remain in your current policy or switch to a new policy. Under the new rules, a health insurance company cannot deny your application based on any health conditions you may have. For more information about your options, please contact the California Health Benefit Exchange, the Office of Patient Advocate, your policy representative, an insurance broker, or a health care navigator.

(b) A health insurer shall include the notice described in subdivision (a) in any renewal material of the individual grandfathered health plan and in any application for dependent coverage under the individual grandfathered health plan.

10965.15. Except as otherwise provided in this chapter, this chapter shall be implemented to the extent that it meets or exceeds the requirements set forth in the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 6. This act shall become operative only if Assembly Bill 1461 of the 2011–12 Regular Session is also enacted and becomes operative.

THE SACRAMENTO BEE sacbee.com

Jerry Brown veto seeks stronger ties between California health law and federal act

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Gov. Jerry Brown vetoed legislation Sunday requiring California health insurers to cover all individuals regardless of medical condition, citing a technical flaw rather than opposition to the most popular part of the federal health care overhaul.

The Democratic governor was concerned that Senate Bill 961 and Assembly Bill 1461 would force health insurers to carry out the federal Patient Protection and Affordable Care Act in California even if federal leaders dramatically change the law, such as eliminating the requirement that everyone carry insurance or pay a penalty.

He wanted a stronger tether to the federal act, whose fate may depend on the November presidential election.

"Without the strong foundation that federal law provides, a state-level mandate on insurers alone could encourage healthy people to wait until they got sick or injured before purchasing coverage," Brown wrote in his veto message. "This would lead to skyrocketing premiums, making coverage more unaffordable."

The two vetoed bills would have required insurers and health plans to cover all individuals, often called "guaranteed issue." That protection had support from 85 percent of Americans in a March New York Times/ CBS News poll despite a plurality that disapproved of the entire health care act.

The governor supported the ideas in Senate Bill 961 and Assembly Bill 1461, but wanted more thorough language tying the measures to ongoing changes in the federal Affordable Care Act, said Diana S. Dooley, his Health and Human Services secretary.

Dooley appeared Monday morning with legislative authors and supporters to discuss the range of health care bills Brown acted on – and mostly signed. But Brown's vetoes appeared to dampen the advocates' enthusiasm. Proponents said lawmakers could enact new laws later to respond to any federal changes.

"These bills contain the most meaningful provisions of the president's Affordable Care Act," said Sen. Ed Hernandez, D-West Covina, author of SB 961 and chairman of the Senate Health Committee. "And by vetoing these bills, the governor has unnecessarily set back part of our ability to implement part of the ACA."

Dooley disagreed, saying there remains enough time before health care expansion in 2014 to address Brown's concerns. President Barack Obama and federal lawmakers set

parameters in the 2010 Affordable Care Act, but California still must enact laws enabling the state to carry out the national changes.

During the final month of legislative session, insurers raised concerns about a scenario in which they would have to cover sick individuals at low rates while healthy individuals could avoid insurance if federal leaders eliminate the individual mandate. The state bills did not leave enough flexibility to account for changes in the Affordable Care Act, the California Association of Health Plans said.

The health care industry remains influential in Sacramento and has contributed at least $650,000 to Brown's tax initiative, Proposition 30. That includes $250,000 from Kaiser Permanente, $150,000 each from Blue Shield of California and Dignity Health, and $100,000 from Anthem Blue Cross.

Another part of the legislation would have prohibited insurers from charging higher prices for smokers, one of the few rate exceptions allowed in the Affordable Care Act. Anti-smoking and health organizations generally support insurance protections for smokers under the belief that higher costs would drive them away from cessation programs and early disease treatment.

The insurance industry opposed that idea, saying it would force nonsmokers to subsidize tobacco users. But Dooley said Brown supports keeping rates the same for smokers and nonsmokers.

Brown signed other health care bills in the final month of the session, including legislation that establishes a bare-minimum list of "essential" benefits insurers must provide in California. Anthony Wright of Health Access California said that helps prevent consumers from signing up for "junk insurance" that excludes various treatments in the fine print.

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