**§ 1399.811. Premium requirements**

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

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

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

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

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

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

(ii) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider

arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally eligible defined individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(2) This subdivision shall become inoperative on January 1, 2014. This subdivision shall become operative on January 1, 2020.

(b)(1) Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2014, shall be subject to the following requirements:

(A) With respect to the rate charged for coverage provided in 2014, the rate charged in 2013 for that coverage multiplied by 1.09.

(B) With respect to the rate charged for coverage provided in 2015 and each subsequent year, the rate charged in the prior year multiplied by a factor of one plus the percentage change in the statewide average premium for the second lowest cost silver plan offered on the Exchange. The Exchange shall determine the percentage change in the statewide average premium for the second lowest cost silver plan by subtracting clause (i) from clause (ii) and dividing the result by clause (i).

(i) The average of the premiums charged in the year prior to the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(ii) The average of the premiums to be charged in the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based on the region's relative share of the Exchange's total individual enrollment according to the latest data available to the Exchange.

(C) The Exchange shall determine the percentage change in the statewide average premium no later than 30 days after the Exchange's rates for individual coverage for the applicable year have been finalized.

(2) For purposes of this subdivision, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(3) This subdivision shall become operative on January 1, 2014. This subdivision shall become inoperative on January 1, 2020.

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

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

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider

arrangement, the increase in premiums charged to a nonfederally eligible defined individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

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

(d)(1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health care service plan contracts issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

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

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

**HISTORY:**

Added Stats 2000 ch 810 § 2 (SB 265). Amended Stats 2006 ch 538 § 354 (SB 1852), effective January 1, 2007; Stats 2013 ch 441 § 11 (AB 1180), effective October 1, 2013.