§ 1399.803. Application of article

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

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265), effective January 1, 2001.

§ 1399.804. Availability of contracts to federally eligible defined indi- viduals

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

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

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

(2) The federally eligible defined individual, and his or her dependents who are to be covered by the plan contract, work or reside in the service area

in which the plan provides or otherwise arranges for the provision of health care services.

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

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

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

HISTORY:
Added Stats 2000 ch 810 § 2 (SB 265), effective January 1, 2001.

§ 1399.805. Notification of premium charges; Commencement of cov- erage; Changes

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

(A) For health care service plan contracts that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for a federally eligible defined individual who is 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.

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

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

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

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

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

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

(A) 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) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or

postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

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

(e)(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), effective January 1, 2001. Amended Stats 2013 ch 441 § 9 (AB 1180), effective October 1, 2013.