
SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO: SBX1 2
AUTHOR: Hernandez
INTRODUCED: January 28, 2013
HEARING DATE: February 20, 2013
CONSULTANT: Trueworthy

SUBJECT: Health care coverage.

SUMMARY: Reforms California's individual market in accordance with the federal Patient Protection and Affordable Care Act (ACA) and applies its provisions to health plans and disability insurers in the individual market; requires guaranteed issue of individual market health plans and health insurance policies; prohibits the use of preexisting condition exclusions; establishes open and special enrollment periods consistent with the California Health Benefit Exchange (Covered California); prohibits conditioning the issuance or offering based on specified rating factors; prohibits specified marketing and solicitation practices consistent with small group requirements; requires guaranteed renewability of plans; and permits rating factors based on age, geographic region and family size only. It is necessary to place these ACA reforms in state law in order to give state regulators the required enforcement authority. Makes changes to California's small group law enacted in AB 1083 Monning (Chapter 852, Statutes of 2012) to be consistent with draft federal rules (described below) released in November 2012.

Existing federal law:

1. Establishes the ACA, which imposes various requirements on states, issuers, employers, and individuals regarding health care coverage.
2. Requires each health insurance issuer that offers coverage in the individual or group market to accept every employer and individual that applies for that coverage and to renew that coverage at the option of the employer or the individual. This is known as guarantee issue and guarantee renewability.
3. 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.
4. Allows the premium rate charged by a health insurance issuer offering small group or individual coverage to vary only as specified, and prohibits discrimination against individuals based on health status.
5. Defines "grandfathered plan" as any group or individual health insurance product that was in effect on March 23, 2010.

Existing state law:

1. Provides for regulation of health insurers by the California Department of Insurance (CDI) under the Insurance Code and provides for the regulation of health plans by the Department

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of Managed Health Care (DMHC) pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), collectively referred to as carriers.

2. Establishes the California Health Benefits Exchange, known today as Covered California, to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and qualified small employers by January 1, 2014.
3. Requires, as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to fairly and affirmatively offer, market, and sell all products made available in the Exchange to individuals and small employers purchasing coverage outside of the Exchange.
4. Requires health plans to fairly and affirmatively offer, market, and sell health coverage to small employers, known as "guaranteed issue."
5. Defines a preexisting condition provision as a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as 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.
6. Prohibits a plan contract for group coverage from imposing any preexisting condition provision upon any child under 19 years of age.
7. Prohibits a plan contract for individual coverage that is not a grandfathered health plan, as defined by the ACA, from imposing any preexisting condition provision upon any children under 19 years of age.
8. Prohibits, with respect to the individual market coverage for children, except to the extent permitted by federal law, carriers from conditioning the issuance or offering of individual coverage on any of the following factors:
 - a. Health status;
 - b. Medical condition, including physical and mental illness;
 - 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; and
 - i. Any other health status-related factor as determined by the regulators.
9. Defines a "rating period" as the period for which premium rates established by a plan are in effect, and requires the rating period to be in effect no less than six months.
10. Establishes the following risk categories for rating purposes in the small group market: age, geographic region, and family composition, plus the health benefit plan selected by the small employer. Specifies age categories, family size categories, and up to nine geographic regions, as determined by the carriers.

11. Prohibits a plan in the small group market from, directly or indirectly, entering 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 plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.
12. Prohibits a policy or contract that covers two or more employees from establishing rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related 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; and
 - h. Disability.

This bill:

While the ACA establishes new health insurance requirements, changes in state law are needed to conform to those requirements and to give enforcement powers to the state regulators. The ACA also gives flexibility to states on various issues. Outlined below are the conforming provisions contained in the bill and the provisions that a policy choice needed to be made or state law needed to be updated to reflect the ACA changes.

Conforming provisions:

1. Prohibits a carrier (except grandfathered plans, as specified) from imposing any preexisting condition provision upon any individual.
2. Requires guaranteed issue of individual market health plans and health insurance policies.
3. Requires carriers to fairly and affirmatively offer, market, and sell all of the plan's and insurer's health benefit plans that are sold in the individual market to all individuals in each service area in which the plan or insurer provides or arranges for the provision of health care services.
4. Requires a plan or insurer to provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive and after January 1, 2015, annual enrollment periods from October 15 to December 7 inclusive of the preceding calendar year.
5. Requires carriers to only set premium rates based on the following:
 - a) Age, using age bands established by the Secretary of Health and Human Services and the age rating curve established by the Centers for Medicare & Medicaid Services (CMS);
 - b) Geographic region as described below; and
 - c) Whether the contract covers an individual or family, as defined in the ACA.
6. Requires a carrier to allow an individual to enroll in or change individual health benefit plans, as a result of the following triggering events:

- a. He or she loses minimum essential coverage (MEC), as defined in the Internal Revenue Code, as specified. Loss of MEC 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;
 - b. He or she gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;
 - c. He or she becomes a resident of California;
 - d. He or she is released from incarceration;
 - e. His or her health benefit plan substantially violated a material provision of the contract;
 - f. He or she gains access to a new health benefit plan as a result of a move; or
 - g. With respect to individual health benefit plans offered through the Exchange, the individual meets any of the requirements listed in federal regulations, as specified.
7. Establishes, for special enrollment effective dates, coverage to be effective no later than the first day of the first calendar month beginning after the date the plan receives the request, except in the case of birth, adoption, or placement for adoption, which is the effective date of the birth, adoption, or placement for adoption.
 8. Requires a carrier, with respect to individual health plans offered outside the Exchange, after an individual submits a completed application form for a plan, to notify the individual of the individual's actual premium charges for that plan within 30 days. Requires the individual to have 30 days in which to exercise the right to buy coverage at the quoted premium charges.
 9. Prohibits a carrier from conditioning the issuance or offering of an individual health benefit plan on any of the following factors:
 - a. Health status;
 - b. Medical condition, including physical and mental illness;
 - 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; and
 - i. Any other health status-related factor as determined by federal regulations, rules, or guidance.
 10. Requires a carrier to consider the claims experience of all enrollees or insureds of its nongrandfathered individual health benefit plans to be part of a single-risk pool.
 11. Requires a carrier to consider the claims experience of all enrollees in nongrandfathered small employer health benefit plans to be part of a single-risk pool.
 12. Requires all individual health plans to conform to specified requirements, and to be renewable at the option of the enrollee except as permitted to be canceled, rescinded, or not renewed, as specified. Requires any plan that ceases to offer for sale new individual health benefit plans, as specified, to continue to be governed by specified law with respect to business conducted under the specified law.

13. Permits a carrier to vary premium rates for a particular plan from its index rate based only on the following actuarially justified plan-specific factors:
 - a. The actuarial value and cost-sharing design of the health benefit plan;
 - b. The health benefit plan's provider network, delivery system characteristics, and utilization management practices;
 - c. The benefits provided by the carrier that are in addition to the essential health benefits. These additional benefits are required to be pooled with similar benefits within a single risk pool and the claims experience from those benefits to be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits; and,
 - d. With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

14. Modifies the exceptions from the guarantee issue requirement in existing small group law and the manner in which a carrier determines premium rates for a small employer health benefit plan, as specified.

Non-conforming and other provisions:

1. Repeals existing law that would have required the rate for any child to be identical to the standard-risk rate.
2. Sunsets existing law, on December 31, 2013, related to rating categories for child coverage.
3. Exempts grandfathered plans from the ACA requirements as allowed under federal law.
4. Modifies the small employer special enrollment periods and coverage effective dates for purposes of consistency with the draft federal rules.
5. Adds the following triggering events that will require a plan or insurer to allow an individual to enroll in or change individual health benefit plans, as a result of the following:
 - a. He or she was receiving services from a contracting provider and that provider is no longer participating in the health benefit plan; or
 - b. He or she demonstrates that they did not enroll during the available enrollment period because they were misinformed about MEC;
6. Requires an individual, with respect to plans offered inside or outside the Exchange, to have 63 days from the date of a triggering event identified above to apply for coverage. This is to be consistent with the current practice for the Health Insurance Portability and Accountability Act (HIPPA) coverage.
7. Prohibits a carrier, solicitor, agent or broker from directly or indirectly, engaging in the following activities:
 - a. Encouraging or directing an individual to refrain from filing an application for individual 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; and
 - b. Encouraging or directing an individual to seek individual coverage from another plan or health insurer or the Exchange because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's

approved services area.

8. Prohibits a carrier, from directly or indirectly, entering into contracts, agreement, or arrangement with a solicitor, agent or broker that provides for or results in the compensation paid to a solicitor for the sale of an individual health benefit plan to be varied because of health status, claims experience, industry, occupation, or geographic location of the individual. Prohibits this provision from applying to a compensation arrangement that provides compensation to a solicitor, agent or broker on the basis of percentage of premium, provided that the percentage cannot vary because of the health status, claims experience, industry, occupation, or geographic area.
9. Prohibits tobacco use from being a rating factor.
10. Establishes the following rating regions for 2014:
 - a. Region 1: Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.
 - b. Region 2: Counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.
 - c. Region 3: Counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.
 - d. Region 4: Counties of Orange, Santa Barbara, and Ventura.
 - e. Region 5: County of Los Angeles
 - f. Region 6: Counties of Riverside, San Bernardino, and San Diego.
11. Establishes the following rating regions for the 2015 plan year and plan years thereafter, subject to federal approval:
 - a. Region 1: Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.
 - b. Region 2: Counties of Marin, Napa, Solano, and Sonoma.
 - c. Region 3: Counties of El Dorado, Placer, Sacramento, and Yolo.
 - d. Region 4: Counties of Alameda, Contra Costa, San Francisco, San Mateo, and Santa Clara.
 - e. Region 5: Counties of Monterey, San Benito, and Santa Cruz.
 - f. Region 6: Counties of Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.
 - g. Region 7: Counties of San Luis Obispo, Santa Barbara, and Ventura.
 - h. Region 8: Counties of Imperial, Inyo, Kern, and Mono.
 - i. Region 9: ZIP Codes in Los Angeles County starting with 906 to 912, inclusive, 915, 917, 918, and 935.
 - j. Region 10: ZIP Codes in Los Angeles County other than those identified above.
 - k. Region 11: Counties of Riverside and San Bernardino.
 - l. Region 12: County of Orange.
 - m. Region 13: County of San Diego.

12. Requires, by June 1, 2017, DMHC, Covered California and CDI, to review the geographic rating regions and the impacts of those regions on the health care coverage market in California, and submit a report to the appropriate policy committees of the Legislature.
13. Requires carriers to provide specified information regarding the Exchange to applicants for products offered outside the Exchange.
14. Prohibits carriers from advertising or marketing an individual grandfathered health plan for the purpose of enrolling a dependent of the subscriber or policyholder in the plan.
15. Requires carriers to annually issue a specified notice to those enrolled in a grandfathered plan about the availability of other health insurance options.
16. Prohibits a carrier from requiring an individual applicant or his or her dependent to fill out a health assessment or medical questionnaire prior to enrollment. Prohibits a carrier from acquiring or requesting information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment.
17. Deletes the provisions making the guarantee issue and community rating provisions inoperative if the guarantee issue and community rating provisions of the ACA are repealed, in the small group market law.
18. Requires any data submitted by carriers to the United States Health and Human Services Secretary for purposes of the risk adjustment program required under the ACA to also be submitted to DMHC or CDI.
19. Authorizes DMHC to waive or modify existing requirements related to uniform health plan benefits and coverage matrix for purposes of compliance with the ACA through issuance of all-plan letters.
20. Prohibits the premium for HIPAA policies and contracts from exceeding the premium for the second-lowest cost silver plan offered in the individual market through Covered California in the rating area in which the individual resides.
21. Requires every participating health, dental and vision plan offering coverage to Healthy Families Program enrollees, on or after January 1, 2012, including those transitioned to the Medi-Cal program, to offer 18 months of coverage, until a specified date, to individuals who were or are disenrolled from the program due to ineligibility because of age and are not eligible for full scope coverage under Medi-Cal. Would require beneficiaries electing this coverage to pay no more than 110 percent of the average per subscriber payment made to all participating health, dental, or vision plans for program coverage, as specified.
22. Requires every carrier, in addition to complying with the Knox-Keene Act and specified provisions of the Insurance Code and rules adopted thereunder, to comply with this bill.
23. Requires the provisions of this bill to only be implemented to the extent that it meets or exceeds the requirements set forth in the ACA.

24. Authorizes the Insurance Commissioner (IC) to adopt regulations to implement the changes made by the Insurance Code by this act pursuant to the Administrative Procedures Act, as specified. Requires the IC to consult with the Director of DMHC prior to adopting any regulations for the purposes of ensuring consistency of regulations.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1. **Author's statement.** This bill is necessary to implement provisions of the ACA in California's individual health insurance market and make conforming technical changes in the small group market. California has a history of strong consumer protections in its insurance market for small group purchasers but California's individual market has been referred to as the "wild west of health insurance," with little or no restrictions on health insurers in terms of their ability to deny coverage based on preexisting conditions and from charging higher rates based on health status, employment, or any other factor. The ACA limits what factors plans can use to determine premium rates, eliminates the use of preexisting condition exclusions and requires plans to issue and renew policies for willing purchasers. The rules established in this bill will affect plans operating through the Exchange and in the outside commercial insurance market for individual purchasers. The reforms in this bill will help expand health insurance coverage in the private commercial market and help millions of Californians access health care in more cost effective manner. The author notes he was greatly disappointed by the Governor's veto of SB 961 (Hernandez) last year and is concerned about the impact that veto will have on Covered California. Covered California is on a path to be fully running by January 1, 2014, and the author contends it is critical the reforms contained in this bill be acted upon immediately.
2. **Individual market.** California's individual and small group health insurance markets together currently serve just fewer than 15 percent of the state's population, with approximately 2 million people being covered through individually purchased health insurance. In California, 3 carriers serve over 75 percent of the market: Anthem Blue Cross PPO, Blue Shield PPO, and Kaiser HMO. California's two regulators allow variation in product design. Plans under DMHC must provide a defined set of basic health care services, while plans under CDI have more flexibility and may offer slimmer benefits. CDI-regulated products are far more prevalent in the individual market.

According to a 2011 report published by the California HealthCare Foundation (CHCF), approximately 2 million Californians are covered through individually purchased health insurance. About 40 percent of current individual market purchasers would likely qualify for subsidies and another 18 percent would be eligible for Medicaid (Medi-Cal in California) if the ACA rules were in effect today. There are between five and seven million uninsured in the state and 39 percent (2.7 million) may be eligible for Medi-Cal, half (3.5 million) may be eligible for subsidies to purchase individual insurance, and 11 percent (800,000) would not likely qualify for subsidies. More than one million of the uninsured are undocumented immigrants, who would not qualify for subsidies and would be excluded from the Exchange.

At the time, CHCF found that individual premiums varied by age as much as five-fold, meaning a 60 year old would pay five times what a 25 year old might pay. However, there is evidence that California individual market premiums are already closer to the 2014 allowable 3:1 ratio. For example, 2013 premium rate filings for the Anthem Blue Cross three most popular non-grandfathered product families all have age ratios below 3.9. In addition, 2013

premiums in the state high-risk pool, the Major Risk Medical Insurance Program, which bases rates on carrier filings of premiums for open market individual coverage, have an age ratio for 64 year olds that ranges from 2.3 – 2.9, depending on the health plan. In the CHCF report, premiums ranged from \$113 to \$777 a month.

Individual market insurance provides less comprehensive coverage, with CHCF reporting that individual coverage paid an average of 55 percent of medical expenses, compared to 80-90 percent of expenses for group coverage. Purchasers in the individual market pay 100 percent of their coverage; the market is very price sensitive and purchasers are medically screened by insurers concerned about high risk consumers buying and keeping coverage.

3. **Small group market.** AB 1672 (Margolin and Hansen), Chapter 1128, Statutes of 1992, enacted a number of reforms to the small group market, making health insurance more accessible to small employers through guaranteed issue and renewability provisions, regulating pre-existing conditions limitations, underwriting protections, and disclosure requirements. Before AB 1672, a carrier would examine an employer's health history and could either increase the premiums significantly or decline the entire group.

California's small group market has been shaped by guaranteed issue and other protections established in small group reform in 1992. In this market, carriers may impose participation requirements and contribution requirements. As a result, enrollees in small group coverage typically pay a fraction of their premium. A 2011 CHCH report indicates that 3.4 million, or 9 percent, of Californians have health coverage through small group insurance products. Roughly 67 percent of small group products are regulated by DMHC, compared to 33 percent regulated by CDI.

The ACA eliminates the pricing of premiums based on health status, limits the range of premiums based on age, adds the self-employed to those eligible for guaranteed issue of coverage, and expands the rules to small group employers with one to 100 employees. AB 1083 (Monning) established these reforms in California's small group health insurance market. SBX1 2 updates these reforms to be consistent with draft federal rules released in November 2012.

4. **Federal health care reform.** On March 23, 2010, President Obama signed the ACA (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). Among other provisions, the new law makes statutory changes affecting the regulation of and payment for certain types of private health insurance. Beginning in 2014, individuals will be required to maintain health insurance or pay a penalty, with exceptions for financial hardship (if health insurance premiums exceed eight percent of household adjusted gross income), religion, incarceration, and immigration status. Several insurance market reforms are required such as the prohibitions against health insurers imposing lifetime benefit limits and preexisting health condition exclusions. These reforms impose new requirements on states related to the allocation of insurance risk, prohibit insurers from basing eligibility for coverage on health status-related factors, allow the offering of premium discounts or rewards based on enrollee participation in wellness programs, impose nondiscrimination requirements, require insurers to offer coverage on a guaranteed issue and renewal basis, determine premiums based on adjusted community rating (age, family, geography and tobacco use). While the ACA establishes these new health insurance requirements, state law is needed to

allow our state regulators to enforce them.

- 5. Health Benefit Exchanges.** The ACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that makes qualified health plans (QHPs) available to qualified individuals and qualified employers or a state may defer to the federal government. Federal law establishes requirements for the Exchange, for health plans participating in the Exchange, and defines who is eligible to receive coverage in the Exchange. Beginning January 1, 2014, individual taxpayers whose household income equals or exceeds 100 percent, but does not exceed 400 percent of the federal poverty level, will receive a refundable tax credit for a percentage of the cost of premiums for coverage under a qualified health plan. The ACA also allows “qualified small employers” to elect a tax credit worth up to 35 percent of a small business’ health insurance premium costs and establishes requirements for a qualifying employer. The ACA also requires reductions in the maximum limits for out-of-pocket expenses for individuals enrolled in QHPs whose incomes are between 100 percent and 400 percent of the federal poverty level.

In 2010, California was the first state to create a state-based exchange, today known as Covered California. State exchanges are required to certify QHPs, operate a toll-free hotline and website, rate QHPs, present plan options in a standard format, inform individuals of the eligibility requirements for Medicaid (Medi-Cal in California) and the Children’s Health Insurance Program (Healthy Families in California), provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual requirement to have health insurance.

According to Covered California’s January 2013 annual report, Covered California is currently in the process of choosing health plan offerings and will begin testing the online enrollment portal. Over the next few months, grants will be awarded to community organizations for public awareness efforts, and assisters will be trained to understand Covered California enrollment offerings. In November 2012, Covered California released its QHP solicitation and proposed regulations. Final bids were submitted on March 1, 2013, and Covered California anticipates it will conduct its selection and certification process for QHPs in early to mid-2013 for pre-enrolment on October 1, 2013.

- 6. U.S. Supreme Court.** In March of 2012, the U.S. Supreme court held three days of testimony on the constitutionality of two major provisions, the individual mandate and the Medicaid expansion, of the ACA arising out of two cases in the 11th Circuit Court of Appeals, *National Federation of Independent Business v. Sebelius* and *Florida v. Department of Health and Human Services*. With regard to the individual mandate, the ACA requires most people to maintain minimum essential coverage for themselves and their dependents. The mandate can be satisfied by obtaining coverage through employer-sponsored insurance, individual insurance plans, including those offered through the Exchange, a grandfathered health plan, or government-sponsored coverage.

On a 5-4 vote the Supreme Court upheld the ACA, saying its requirement that most Americans obtain insurance or pay a penalty was authorized by Congress’s power to levy taxes. According to a July 2012 Kaiser Family Foundation brief, the fact that the Court upheld the mandate under Congress’ taxing power rather than the commerce or necessary and proper powers changes nothing about the language of the ACA or how the individual mandate will function.

The report states that mandate will go into effect in 2014 as Congress intended according to the terms of the ACA.

7. **Rates.** According to a February 6, 2013, Kaiser Family Foundation article, "*Why Premiums Will Change for People Who Now Have Nongroup Insurance*," overall, it is expected that the average, unsubsidized premiums in the individual market will be somewhat higher under the ACA as compared to today. This is because many people will be getting better insurance with essential health benefits like maternity care and mental health. (Note: California already mandates maternity and mental health parity for severe mental illness). Also, patient cost sharing for out-of-pocket costs will be capped and guaranteed access to coverage for people with preexisting conditions may increase average premiums as well as people with higher costs coming into the system. However, this should be balanced by more, healthy young uninsured participating because of the availability of subsidies and the individual mandate requirement. The ACA provides for \$20 billion in transitional reinsurance to offset adverse selection in the first three years of the program. The Kaiser Family Foundation article details how each of the insurance market changes in the ACA may raise or lower premiums overall or redistribute them among different groups of people.

In the big picture, the ACA addresses many of the shortcomings of the current individual market. The more competitive marketplace created under the ACA, greatly enhanced by the structure of premium tax credits, will push in the other direction forcing health plans to become more efficient and better managers of the premiums they receive.

8. **Proposed federal rules:** On November 20, 2012, CMS issued proposed rules pertaining to the ACA, which generally take effect beginning on or after January 1, 2014. In the proposed rule, CMS specifically seeks comments on a number of topics, including strategies that CMS or states might use to avoid or minimize disruption of rates in the current market and encourage timely enrollment in coverage in 2014. CMS also seeks information from both issuers and states relative to the magnitude of the costs and benefits associated with implementing these new requirements. DMHC, CDI and Covered California submitted joint comments on the proposed rules. Below is a summary of the proposed rules.

- **Guaranteed Availability / Guaranteed Issue.** Propose to require issuers to offer all products that are approved for sale in the applicable market. There are exceptions to the guaranteed availability / guaranteed issue rule that allow enrollment to be limited to:
 - a. Open or special enrollment periods;
 - b. Individuals or eligible employees who live, work or reside in the network plan's service area;
 - c. Small employers who satisfy the same contribution and participation requirements at issuance that the issuer is permitted to consider at renewal; and
 - d. Network and/or financial capacity, in certain circumstances.
- **Guaranteed Renewability.** For non-grandfathered health plans, carriers will be required to renew all coverage in the individual and group markets. There are exceptions to the guaranteed renewability rule that allows coverage to be non-renewed in the following circumstances:
 - a. Non-payment of premium;
 - b. Fraud or intentional misrepresentation of material fact;

- c. In the case of group health coverage, failure to comply with a material plan provision relating to contribution or participation requirements;
 - d. Movement outside the network service area;
 - e. Issuer ceases to offer coverage of this type; and
 - f. Issuer exits the market.
- **Open Enrollment Periods.** For the group market, create a year-round open enrollment period. For the individual market, the proposal would require open enrollment periods consistent with those required by Exchanges for individual market qualified health plans (QHPs).
 - **New Marketing Standards.** Prohibits marketing practices and benefit designs that have the effect of discouraging enrollment of individuals with significant health needs.
 - **New Special Enrollment Period.** Create a new special enrollment period in both the individual and group markets in connection with the events that would trigger eligibility for COBRA coverage.
 - a. For employees, this would include a loss of coverage due to voluntary or involuntary termination of employment for reasons other than gross misconduct and reduction in the number of hours of employed.
 - b. For spouses of covered employees, this would include a loss of coverage due to reasons that would make the employee eligible for COBRA, the employee becoming entitled to Medicare, divorce or legal separation of the covered employee, and the death of the covered employee.
 - c. For children of covered employees, this would include a loss of coverage due to reasons that would make the employee eligible for COBRA, the employee becoming entitled to Medicare, divorce or legal separation of the covered employee, the death of the covered employee, and loss of dependent child status.
 - **Adjusted Community Rating.** Will only allow health insurance coverage in the individual and small group market to vary by:
 - a. Whether the plan covers an individual or family;
 - b. Geographic rating region;
 - c. 3:1 age rating band (the ratio limits the amount an older individual will pay to no more than three times what a younger individual pays in premium dollars); and
 - d. Tobacco use.
 - **Individual or family coverage and per-member rating.** Issuers must utilize a per-member rating process whereby the issuer adds up the rate of each family member to arrive at a family premium. Rates for only the three oldest family members under age 21 would be taken in account.
 - **Geographic rating region.** Allow States to establish rating areas by selecting from the following options:
 - a. One single rating area for the state;
 - b. No more than seven rating areas based on county, three-digit zip code, or metropolitan statistical areas (MSAs) and non-MSA geographic divisions;
 - c. Other existing geographic divisions; or

- d. A number of rating regions greater than seven, if granted approval from CMS.
- **Age rating.** Rates based on age may not vary by more than 3:1 for individuals ages 21 and older, and rate variation must be actuarially justified for individuals under age 21. States are permitted to use a narrower age ratio. For applying the appropriate age adjustments, the enrollee’s age as of the date of the policy issuance or renewal would be used. The proposed rule also requires uniform age bands: a single band for ages 0 to 20; one-year bands for ages 21 to 63; and a single band for ages 64 and older. It also requires states to establish uniform age rating curves, and provides for a default CMS rating curve if a state does not establish such a curve.
 - **Tobacco use.** Rates based on tobacco use may not vary by more than 1.5:1. An issuer may use a lower tobacco use factor (e.g., 1.3:1) for a younger enrollee as long as the factor does not exceed 1.5:1 for any age group. State laws that allow for a narrower ratio or prohibit varying rates for tobacco use would not be preempted under the ACA. SB X1 2 does not allow tobacco use to be used as a rating factor.
 - **Small group market.** The premium charged to small employers will be based on the per-member rating, where the total premium charged is the sum of the premiums of covered participants and beneficiaries. Nothing prohibits a “state from requiring issuers to offer, or an issuer from voluntarily offering, group premiums that are based on average enrollee amounts, provided that the total group premium is the same total amount derived” under the per-member rating methodology under this rule.
 - **Single Risk Pool.** The ACA requires issuers to consider all enrollees in the individual market in a single risk pool and all enrollees in small group health plans in single risk pool (excluding grandfathered health plans). CMS interprets this provision as being effective for plan years or policy years starting on or after January 1, 2014. Issuers must consider the claims experience of all enrollees in each of these risk pools when determining the index rate for a state market. The index rate must be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in the state.
 - **Catastrophic Health Plans.** Provide further guidance with respect to the definition and criteria for catastrophic health plan coverage, including the requirement the prohibition against catastrophic plans imposing cost-sharing on preventive services.
 - **Enforcement.** The enforcement process allows states to exercise primary enforcement over health insurance regarding the federal individual and group market reforms. CMS has enforcement authority if the state notifies CMS that it has not enacted legislation to enforce the federal requirements, or is not otherwise enforcing, or if CMS determines that the state is not substantially enforcing a federal market reform.
9. **Related legislation** ABX1 2 (Pan) is identical to SBX1 2.
10. **Prior legislation.** SB 961 (Hernandez) of 2012 and AB 1461 (Monning) were identical bills that would have reformed California’s individual market similar to the provisions in SBX1 2. *SB 961 and AB 1461 were vetoed by Governor Brown.*

AB 1083 (Monning) Chapter 854, Statutes of 2012 establishes reforms in the small group health insurance market to implement the ACA.

SB 951 (Hernandez) Chapter 866, Statutes of 2012 and AB 1453 (Monning) Chapter 854, Statutes of 2012 designates the Kaiser Small Group HMO as California's benchmark plan to serve as the essential health benefit standard, as required by federal health care reform.

SB 51 (Alquist), Chapter 644, Statutes of 2011, establishes enforcement authority in California law to implement provisions of the ACA related to medical loss ratio requirements on health plans and health insurers and enacted prohibitions on annual and lifetime benefits.

AB 2244 (Feuer), Chapter 656, Statutes of 2010, requires guaranteed issue of health plan and health insurance products for children beginning in January 1, 2011.

SB 900 (Alquist), Chapter 659, Statutes of 2010, and AB 1602 (Perez), Chapter 655, Statutes of 2010, establishes the California Health Benefit Exchange.

AB 1X 1 (Nunez) of 2008 would have enacted the Health Care Security and Cost Reduction Act, a comprehensive health reform proposal. *AB 1X 1 died in the Senate Health Committee.*

11. Support. Health Access California (HAC), a statewide health care consumer advocacy coalition, writes in support of SBX1 2 (Hernandez) stating the bill will reform California's individual insurance market to provide guaranteed issue and modified community rating. HAC writes that the repeal or modification of the protections of the ACA are highly unlikely and, if in the future, the ACA provisions on the individual market are repealed or altered, the first choice should not be to revert to the status quo ante in which consumers may be denied health insurance for any reason or no reason. The first choice should be to figure out a policy response that protects consumers and gives them the opportunity to obtain affordable coverage. Other states have done this, and HAC argues California should protect its own consumers and do the same.

On the issue of rating regions, HAC writes that the 19 rating region proposal rested on at least one faulty premise: that the lowest cost silver plan in a geographic region did not take into account the service areas of the health plans offering coverage. Why does this matter? The Bay Area region in the 19 region proposal was split along county lines because of this faulty premise. The Alameda Alliance, the local initiative in Alameda County, is not the lowest cost silver plan available to someone who lives in San Francisco or San Mateo because its service area does not include those counties. Given the recent federal guidance limiting geographic regions in a state to no more than seven regions, HAC supports the provisions that provide fewer than 19 regions. HAC also supports the provision of the bill that limits rate increases to once annually arguing consumers should be able to budget and plan. HAC is concerned about the limits imposed on guaranteed issue writing that people will not be able to get coverage at any time but only during limited open enrollment periods. While these restrictions will limit the availability of coverage for Californians during much of the year, HAC reluctantly accepts this given the federal rule on Exchanges which impose the same rules.

The 100% campaign writes in support of SBX1 2 stating they are committed to creating an equitable market for consumers and ensuring standardized and consistent premium risk rating rules for children with all types of health insurance coverage. The 100% campaign also supports

and appreciates the interim coverage opportunities created for children and youth in advance of 2014.

California Public Interest Research Group writes in support of the bill and the importance of ending denials for pre-existing conditions and limiting the ability of insurers to charge consumers different rates. The Transgender Law Center writes that the bill contains multiple provisions that will optimize coverage for all Californians. The Greenlining Institute states that bill is of critical importance to communities of color who suffer disproportionately from preventable chronic illnesses but who are less likely to have health insurance. The Greenlining Institute argues the bill will improve access to and affordability of health insurance for communities of color. AFSCME writes in support that the bill will help expand health insurance coverage in the commercial market.

12. Oppose Unless Amended. CDI writes that the selection of the geographic rating regions is one of the most significant choices the state has to make that will impact the affordability of health insurance for consumers. CDI is greatly concerned that geographic rating regions contained in AB 1083 (Monning) Chapter 854, Statutes of 2012 and in SBX1 2 will result in premium increases and should not be adopted. CDI is proposing an alternative 18 geographic ratings region proposal. *See attached document for comparison of the regions.*

The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) jointly write in opposition to the bill highlighting the following 4 areas of concern:

- a. **Linkage to the ACA.** CAHP and ACLHIC write that if the underwriting reforms of the ACA – including guarantee issue and community rating -are placed into state law they must be linked to their equivalent federal reforms.
- b. **More Flexibility.** CAHP and ACLHIC are concerned that the bills adopt proposed rules into state law and would like to see flexibility in order to allow the state to adapt to final federal rules or to take advantage of any additional flexibility provided by federal guidance.
- c. **Geographic Rating Regions.** CAHP and ACLHIC write that in 2012 the Legislature passed, and the Governor signed into law, a nineteen rating regions in the small group market and they support extending that nineteen rating region configuration to the individual health care marketplace. CAHP and ACLHIC argue that the six geographic rating regions created in SBX1 2 will cause significant rate increases for millions of Californians who currently purchase health insurance. CAHP and ACLHIC note that the proposed federal rules require states to seek a federal waiver to establish more than seven rating regions and contend that the federal rules should be amended to allow states to determine what is best for their residents.
- d. **Obsolete Provisions of Existing Law.** ACLHIC and CAHP would like to modify existing laws related to continuation of coverage laws, high risk pools, and other underwriting and reporting requirements that they argue make little sense in an environment of guaranteed issue.

13. Policy Issues

Geographic rating areas. The ACA requires that each state establish geographic rating areas that must be applied consistently inside and outside the Exchange. The proposed rules allow States to establish rating areas by selecting from the following options: (1) one single rating area for the state, (2) no more than seven rating areas based on county, three-digit zip code, or

metropolitan statistical areas (MSAs) and non-MSA geographic divisions, or (3) other existing geographic divisions or a number of rating areas greater than seven, if granted approval from CMS.

AB 1083 (Monning) Chapter 854, Statutes of 2012 established a 19 rating region proposal for the small group market, different than the region proposal in SBX1 2. To be consistent with the draft rules, the bill establishes, for both the small group market and the individual market, the geographic rating regions for the first year to be the existing Pre-Existing Condition Insurance Plan (PCIP) six rating regions. The bill then establishes 13 rating regions for future years if federal approval is granted, again consistent with the proposed rules.

CDI has raised concerns with the six, 13 and 19 rating region proposals stating they are disruptive and should not be adopted. CDI has developed its own 18 rating region proposal that CDI believes will minimize risk shock associated with rating areas.

See attached document for comparison of the regions.

Tie back to the ACA. In the Governor's veto message of SB 961 (Hernandez) and AB 1461 (Monning), he wrote "*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."

SB 961 and AB 1461 contained a tie back to the ACA for the state guarantee issue provision and the state community rating provision. The Administration states they want a broader tie-back to the ACA to be included in SBX1 2. Proponents of including a tie-back to the ACA argue it is important to include the framework of the federal law in the event that the reform provisions of the ACA are repealed, delayed or amended.

Opponents of including a tie-back contend that the ACA is the law of the land today and it is critical for California to move ahead in implementing these reforms. Opponents further state that should the ACA be modified in the future, California at that time should evaluate the state reforms enacted to date and respond accordingly.

Is it still appropriate to include a tie-back to the ACA? If yes, what is the appropriate tie-back?

Summary of Benefits. Under the ACA, health insurers and group health plans will be required to provide clear, consistent and comparable information about their health plan benefits and coverage. Consumers will have access information that will help them understand and evaluate their health insurance choices. The forms include an easy-to-understand summary of benefits and coverage and a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "co-payment."

Under the Knox-Keene Act carriers offering a contract to an individual or small group are required to provide a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. Many of the ACA

requirements are already included in the current process and there is concern that carriers will be providing duplicative information which could result in confusion. DMHC has proposed language (below) to alleviate this concern.

A health care service plan that issues the uniform summary of benefits referenced in paragraph (3) of subdivision (b) shall:

1. **Meet the requirements of section 1367.04 and Section 1300.67.04 of Title 28 of the California Code of Regulations, and**
2. **Issue a one-page document at the same time the uniform summary of benefits is issued, but which may not be affixed to this document, that advises applicants and enrollees of the following:**
 - a. **If the plan allows the use of preferred providers: “You may use health care providers that are not included in the health plan’s network for non-emergency services, but you may pay more.” If the plan uses a network, but does not cover out-of-network services except for emergency services: “This plan uses a network of preferred providers. Except for emergency services, this plan does not cover services outside the network.”**
 - b. **“Balance billing is when a provider bills you for the difference between the provider’s charge and the amount allowed by the health plan (allowed amount). An in-network provider may not balance bill you. An out-of-network provider may not balance bill you for emergency services.”**

HIPAA. HIPAA allows people to buy individual health insurance when they lose their group health insurance, even if they have a pre-existing health condition. All health plans that sell individual plans must offer a HIPAA product and a person cannot be denied insurance because of their medical history. SB 265 (Speier) Chapter 810, Statutes of 2000 established the following related to premiums for a HIPAA product:

- i. For health plans and insurers offering contracts through a preferred provider arrangement (PPO), the premium for a HIPAA eligible who is younger than age 60, is prohibited from exceeding the average premium paid by a Major Risk Medical Insurance Program (MRMIP) subscriber who is of the same age and resides in the same geographic area as the HIPAA eligible;
- ii. For HIPAA eligible individuals between the ages of 60 and 64 who purchase PPO products, the premium is prohibited from exceeding the average premium paid by a MRMIP subscriber who is 59 years of age and resides in the same geographic area as the federally defined individual; and,
- iii. For health plans and insurers that do not offer a PPO product, the HIPAA eligible premium is capped at 170% of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the HIPAA eligible individual. However, for HIPAA eligible between the ages of 60 and 64, the premium is prohibited from exceeding 170% of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the HIPAA eligible individuals.

In 2014 MRMIP, the state-sponsored health insurance risk pool that subsidizes coverage for individuals who have been unable to secure it on the open market due to health problems or high costs, will no longer be a needed program due to the reforms enacted in the ACA, such as guarantee issue. There is also question if HIPAA products will be needed after 2014. Because

the HIPAA premiums for PPO contracts are tied to MRMIP rates, a decision on the premiums or the continuation of the program all together, must be decided.

Risk Adjustment. The ACA calls for a risk adjustment program to help eliminate incentives for health insurance plans to avoid people with pre-existing conditions or those who are in poor health. The goal of risk adjustment is to ensure carriers have additional money to provide services to the people who need them most by providing more funds to plans that provide care to people that are likely to have high health costs. The anticipated result is that carriers can then compete on the basis of quality and service, and not on the basis of whether they can attract healthy people. The state is currently deferring to the federal government's risk adjustment program. The bill would require carriers to submit any data submitted to the federal government to also be submitted to the state regulators. Should the bill be clarified to define what the role of the regulator would be in collecting this data?

SUPPORT AND OPPOSITION:

Support:

American Federation of State, County and Municipal Employees, AFL-CIO
California Academy of Family Physicians
California Public Interest Research Group
Children Now
Greenlining
Health Access
National Association of Social Workers – California Chapter
Transgender Law Center
100% Campaign

Oppose unless amended:

Association of California Life and Health Insurance Companies
California Association of Health Plans
California Department of Insurance

-- END --