December 2013

Individual Coverage Under the ACA: California vs. Federal Provisions

California HealthCare Foundation

Since passage of the federal Affordable Care Act (ACA) in 2010, California has enacted implementing state legislation in key areas, including establishment of a state-administered exchange, health insurance premium rate review, benefit standards and cost-sharing limits, and detailed rules for the offering and sale of private coverage to individuals and small groups. California developed ACA implementing legislation in the context of pre-existing state laws and programs, requiring policymakers to analyze and reconcile state and federal standards.

This overview compares California law and the ACA affecting the offer and sale of individual health insurance **effective January 1, 2014**.

CALIFORNIA	FEDERAL
Availability of Coverage	
Guaranteed Availability (Guaranteed Issue)	
Beginning October 1, 2013, health plans and health insurers (collectively, "issuers")[1] must fairly and affirmatively offer, market, *and sell*[2] all non-grandfathered individual health benefit plans,[3] for policy years beginning on or after January 1, 2014, to all individuals and dependents in the issuer's service area(s). Applies to issuers inside and outside of the exchange. Coverage is guaranteed available only if an individual applies during open, annual, and special enrollment periods as below. ✚ S [HSC §1399.849; CIC §10965.1]	Issuers offering coverage in the individual market must offer all products sold to individuals and accept every individual that applies, except for grandfathered coverage. Issuer option to impose open enrollment periods with specific related requirements as below. [ACA §1201; PHSA §2702; 42 USC §300gg-1] (45 CFR §147.140) **Exchanges** Issuers of exchange qualified health plans (QHPs) must accept the selection of coverage in a QHP from any applicant determined eligible by the exchange. (45 CFR §155.400)
Prohibited Eligibility Factors	
Prohibited factors for determining eligibility or continued eligibility mirror federal law and apply to all issuers (with a contingency for any other factors that arise in federal rules, regulations, or guidance) as follows: ▪ Health status ▪ Medical condition (physical or mental illness) ▪ Claims experience ▪ Receipt of health care ▪ Medical history ▪ Genetic information ▪ Evidence of insurability (including domestic violence) ▪ Disability ▪ Any other health status–related factor in federal law ☑ S [HSC §1399.849; CIC §10965.3]	Same prohibited factors. [ACA §1201; PHSA §2705; 42 USC §300gg-4]

☑ Adopts federal standard ✚ Exceeds federal standard and/or preserves California pre-existing law
S Same rules apply to exchange and outside market D Difference between exchange and outside market
Abbreviations, page 11. [ ] Denotes statutory citations. ( ) Denotes regulatory citations.

CALIFORNIA	FEDERAL
Prohibited Exclusions and Limitations	
Issuers may not impose any coverage exclusion or limitation because of a pre-existing condition. Such exclusions were prohibited for children under 19 starting in 2010. ☑ S [HSC §1399.849(b), §1399.826(f); CIC §10951(f), §10965.3(b)]	Same prohibition for all issuers of non-grandfathered individual coverage. [ACA §1201; PHSA §2704; 42 USC §300gg-3] (45 CFR §147.108)
Issuers may not impose any waiting period for individual coverage. ✚ S [HSC §1357.51(c)(2); CIC §10198.7(c)(2)]	A specific authorization or prohibition on waiting periods does not exist in the federal law or rules but is implied by the guaranteed availability rules.
Issuers may not require an applicant or dependent to fill out a health assessment or questionnaire prior to enrollment, or acquire or request information that relates to a health status factor from any source prior to enrollment. ✚ S [HSC §1399.849(g)(2); CIC §10965.3(g)(2)]	There is no similarly broad prohibition, though issuers may not request, require, or purchase genetic information prior to enrollment or for underwriting purposes. [42 USC §300gg-53] (45 CFR §147.180)
Exceptions to Guaranteed Availability	
Issuers may deny coverage to individuals if: ▪ The individual does not live or reside within the issuer's approved service area(s). ▪ The issuer demonstrates to the satisfaction of the state regulator that it will not have sufficient health care delivery resources within a service area or portion of a service area, but if an issuer exercises this option it cannot offer coverage to any individual for at least 180 days, or, thereafter, only upon notice and certification to the state regulator that the issuer has the ability to deliver services to individuals. ▪ Financial capacity — the issuer demonstrates to the satisfaction of the state regulator that the issuer does not have the financial reserves to underwrite additional coverage, but if an issuer implements this option it cannot offer coverage for at least 180 days, or, thereafter, only upon notice and certification to the licensing agency that the issuer has sufficient financial reserves to underwrite additional coverage. Federal rules only require issuers to notify regulators and make a certification if seeking to invoke these exceptions to guaranteed issue, whereas California law requires issuers to demonstrate eligibility for the exceptions to the *satisfaction of regulators.*	Similar federal exceptions apply to "network plans," defined as issuers who deliver and finance medical care, in whole or in part, through a defined set of contracted providers (45 CFR §144.103). [ACA §1201; 42 USC §300gg-1] (45 CFR §147.104) **Exchanges** Same rules apply to exchange issuers.

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Exceptions to Guaranteed Availability *(cont.)*	
The DMHC may continue to require issuers to discontinue offering coverage if it finds the issuer does not have sufficient financial viability, or organizational and administrative capacity. Similarly, CDI retains the ability to implement a plan of rehabilitation for an issuer whose financial viability, or organizational and administrative capacity, is impaired. ✚ S [HSC §1399.857, §1399.858; CIC §10965.11]	
Enrollment Periods	
Open Enrollment	
Issuers *must* limit guaranteed availability to initial and annual open enrollment and specified special enrollment periods during which individuals can enroll in or change individual coverage. ✚ S [HSC §1399.849; CIC §10965.1]	Issuers *may* limit availability to open or special enrollment periods. If availability is limited to open enrollment periods, issuers must establish special enrollment periods for specified qualifying events. [ACA §1201; PHSA §2702; 42 USC §300gg-1] (45 CFR §147.104)
Issuers of non-grandfathered plans both inside and outside of the California exchange must offer enrollment periods as outlined in federal exchange rules — an initial open enrollment period from October 1, 2013, through March 31, 2014, and annual open enrollment starting in 2014 (for the 2015 policy year), and annually thereafter, from October 15 through December 7. ✚ S [HSC §1399.849(c); CIC §10965.3(c)]	**Exchanges** Specifies the initial and annual open enrollment periods for exchanges and limits guaranteed availability in exchanges to those periods. (45 CFR §155.410)
Issuers must provide a limited open enrollment period for individuals who have coverage in non-calendar year plans at least 30 days prior to the date the policy ends in 2014. ☑ S [HSC §1399.849(c); CIC §10965.3(c)]	Same provision is applicable to all issuers. (45 CFR §147.104(b)(2))
Issuers must allow an individual subscriber to add a dependent at the subscriber's option, consistent with open, annual, and special enrollment periods. In California law, a dependent can be a registered domestic partner. ✚ S [HSC §1399.849(a)(2), (b), and (k); CIC §10965.3(a)(2), (b), and (k)]	Same provisions for adding dependents applicable to all issuers. Different definition of dependents than in California law. (45 CFR §147.104, §155.420)
Issuers must not set a limiting age — age at which coverage of a dependent child must terminate — less than 26 years of age. This provision was effective for plan years on and after September 23, 2010. [HSC §1373(d)(5)(B); CIC §10277(b)]	Issuers of individual coverage that includes coverage for dependents must provide coverage of an adult child up to age 26. Effective September 23, 2010. [USC §300gg-14] (45 CFR §147.120)

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Special Enrollment	
Issuers must allow an individual to enroll in or change health benefit plans for up to 60 days from specific triggering events defined in state law. California triggering events are based on the combination of: (1) federal COBRA qualifying events, (2) some triggering events in federal exchange rules, and (3) new and pre-existing state-specific events. Exchange issuers must also comply with all triggering events in federal exchange rules.	Issuers outside the exchange must allow individuals to purchase coverage during initial and annual open enrollment periods, and if they limit guaranteed availability to enrollment periods must, at a minimum, offer guaranteed coverage during specified special enrollment periods. Special enrollment must apply for 60 days from COBRA qualifying events and any other triggering events in state or federal law. (45 CFR §147.104)
California-specific triggering events include: ■ Individual is mandated by state or federal court to be covered as a dependent. ■ Individual is released from incarceration. ■ Individual is a member of the military reserve returning from active duty or the California National Guard. ■ Individual was receiving services from a contracting provider under another health benefit plan for conditions specified in state law,[4] and the provider is no longer participating in that plan. Triggering events in federal exchange rules applicable to issuers both inside and outside of the exchange: ■ Individual or dependent loses minimum essential coverage as defined in federal law and rules. ■ Individual gains or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care. ■ Issuer substantially violated a material provision of the health coverage policy or contract. ■ Individual or dependent gains access to new QHPs as a result of a permanent move. ■ Individual demonstrates to the exchange *or to the issuer's licensing agency*[5] that the individual failed to enroll during available open enrollment because of being misinformed about having had minimum essential coverage. ✚ D [HSC §1399.849(d); CIC §10965.3(d)]	**Exchanges** The exchange must allow an individual 60 days to enroll in or change from one qualified health plan to another for any of the specified triggering events in federal law and exchange rules. Exchange-only triggering events include: ■ Enrollee is determined newly eligible or ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions. ■ Individual or dependent's enrollment or non-enrollment is unintentional as the result of an error, misrepresentation, inaction, or action of the exchange. ■ Qualifying American Indians may enroll or change QHPs once per month. ■ Individual gains status as a citizen, national, or lawfully present individual who did not previously have such status. ■ Other exceptional circumstances as determined by the exchange or the federal Department of Health and Human Services. (45 CFR §147.104, §155.420)

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Coverage Effective Dates	
Issuers must make coverage effective consistent with specified and detailed timelines in state law. Coverage effective dates adopted in state law are generally based on federal rules for exchanges.[6] ☑ S [HSC §1399.849(e) and (f); CIC §10965.3(e) and (f)]	Coverage effective dates outlined in federal exchange rules apply to all issuers of individual non-grandfathered coverage and generally depend on the dates premium payments are received. For example, for coverage to begin January 1, 2014, payments must be received (or postmarked) by December 15, 2013. In subsequent months, for payments received before the 15th of the month, coverage will generally begin the first of the following month, and for payments received after the 15th, coverage will begin the first day of the second month. For annual open enrollment, coverage must be effective as of the first day of the following benefit year (calendar year). In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective on the date of the event. In the case of marriage or loss of minimum essential coverage, coverage is effective on the first day of the month following the event. Similar timelines apply to special enrollment opportunities. (45 CFR §147.104, §155.410, §155.240) **Exchanges** Exchanges may adopt earlier coverage effective dates if the exchange demonstrates that all QHP issuers can meet earlier timelines. (45 CFR §147.104)
Renewal of Coverage	
Guaranteed Renewability	
Issuers must renew individual coverage at the option of the enrollee except as permitted to be cancelled, rescinded, or not renewed under state and federal law and regulation, including federal exchange rules. California revised pre-existing state law and regulation prohibiting coverage rescissions and established an appeals process with state regulators for individuals whose coverage is rescinded, cancelled, or not renewed. ✚ S [HSC §1365, §1368(a)(6), §1389.21, §1389.3, §1399.853; CIC §10273.6, §10273.7, §10384.17, §10965.7]	Issuers must renew or continue in force coverage at the option of the individual, except for one or more of the following: ▪ Nonpayment of premium. ▪ Fraud. ▪ Enrollee moves outside of the service area of a network plan. ▪ Discontinuing a particular product, with a required 180-day notice and the offer to purchase any other individual product on a guaranteed availability basis. Must be applied uniformly to all individuals. ▪ Issuer ceases to offer coverage to individuals (specific notices required, and issuer may not issue coverage to individuals for five years). [ACA §1201; 42 USC §300gg-2] (45 CFR §147.106)

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Guaranteed Renewability *(cont.)*	
	Exchanges The exchange must permit QHP issuers to terminate coverage under specified circumstances, such as an enrollee's request to terminate coverage, loss of eligibility for the exchange, decertification of an issuer, or nonpayment of premium, including an individual's failure to pay premiums within the federal three-month grace period required for individuals receiving federal advanced premium tax credits. (45 CFR §155.430)
Rates and Rating Factors	
Rating Factors	
As in federal law, issuers of non-grandfathered coverage inside and outside of the exchange may use only the following factors in setting rates for coverage issued, amended, or renewed on or after January 1, 2014: ■ Age, except rates may not vary by more than 3:1 for adults, using uniform federal age bands (brackets) and the federal default age rating curve. Federal uniform bands include one single band for ages 0–20, one-year increments for ages 21–63, and one age band for persons 64 and older. ■ Geographic region, using 19 standard regions established in state law. ■ Whether the coverage is for an individual or a family. As in federal law, family rates are based on the sum of rates for each family member, except that in families with more than three children, only rates for the three oldest children may be considered. ☑ S California law does not allow for tobacco rating. ✚ S Rating period (benefit year) for all individual non-grandfathered coverage is the calendar year, January 1–December 31, as defined in federal exchange rules. ✚ S [HSC §1399.855; CIC §10965.9]	Issuers may only vary rates based on: ■ Age, with no more than 3:1 variation for adults. States may establish an age rating curve, or the federal default curve will apply.[7] ■ Geographic rating areas established by the state consistent with federal rules. ■ Whether coverage is for an individual or a family, with rules for family rating. ■ Tobacco use, except rates cannot vary by more than 1.5:1 for this factor. [ACA §1201; PHSA §2701; 42 USC §300gg] (45 CFR §147.102) **Exchanges** Federal rating rules and factors apply to exchange issuers. Federal exchange rules define the "benefit year" for exchange coverage only as the calendar year. (45 CFR §155.20)

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Risk Pooling — Single Risk Pool	
Issuers must consider as one single risk pool for rating purposes the claims experience of all enrollees and insureds in non-grandfathered coverage offered by an issuer in the individual market in California. As in federal law, issuers must set rates based on using one single risk pool for all individual non-grandfathered coverage, whether inside or outside of the exchange, so that experience across the individual market is used to determine rates. Rates may only be adjusted beyond the index rate for limited factors, which are generally the same as in federal law.[8] ☑ S [HSC §1399.849(h); CIC §10965.3(h)]	Issuers must consider as one single risk pool for rating purposes the claims experience of all enrollees in all health plans (other than grandfathered health plans) offered by an issuer in the individual market in a state.[9] Federal rules outline the formula for issuers to develop an "index rate" based on claims costs for essential health benefits, adjusted for any payments or charges from risk adjustment and reinsurance. Issuers *may* make adjustments to rates beyond the index rate only for the following: ■ Actuarial value and cost sharing of the specific product ■ Provider network, delivery system characteristics, and utilization management practices ■ Benefits beyond essential health benefits (pooled with all individual products with those benefits) ■ For catastrophic plans, the impact of the eligibility categories for those plans (individuals under 30 and those exempt from the requirement to have coverage) ■ Administrative costs (excluding exchange user fees) However, federal rules *require* issuers to adjust the market-wide index rate based on total expected payments and charges under the risk adjustment and reinsurance programs and exchange user fees. [ACA §1312.42; USC §18032] (45 CFR §156.80) **Exchanges** Same rules apply to exchange issuers.
Regulatory Rate Review	
All issuers must file a rate change for individual (and small group) coverage, along with specified data and documentation, with the respective state regulator at least 60 days prior to implementing a rate change. California has a CMS-approved effective rate review program. Regulators review proposed changes to determine whether the rate increases are unreasonable as defined in state and federal law. ✚ S [HSC §1385.01–1385.13; CIC §10181–10181.13]	Issuers in states with an effective rate review program approved by CMS must submit rate increases above specified thresholds to the state and CMS along with a justification for the increase. CMS will adopt state determinations of unreasonableness in states with an effective rate review program such as California. [ACA §1003; 42 USC §300gg-94] (45 CFR §154.200 et seq.) **Exchanges** Exchanges must ensure that QHP issuers submit justification prior to a rate increase and post it on their website. The exchange must provide access to the issuer's justification through its website. (45 CFR §155.1020)

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Limited Benefit and Special Programs	
Limited Benefit Plans (Excepted Benefits)	
Excepted benefits include specialized health plans under the HSC and CIC (dental, vision, etc.) as well as other excepted benefit policies under the CIC such as hospital indemnity or disease-specific policies. Consistent with federal law, policies covering excepted benefits are exempt from most individual market reforms but are subject to specified state notice, offer, and regulatory filing requirements, including that the policies must be offered as supplements to other health insurance coverage, and that consumers are notified that the coverage is not a substitute for essential health benefits or minimum essential coverage. The state exception generally mirrors federal law with additional state notice and offering requirements. ✚S [HSC §1389.5(e)(3), §1399.845(f); CIC §10965.1]	ACA insurance market reforms generally do not apply to "excepted benefits," as defined in federal law, including, among other types of policies, specific disease policies, hospital or fixed indemnity, limited scope dental and vision or long term care benefits, so long as certain conditions are met. [ACA §1001.42; USC §300gg-21]
Guaranteed Issue Programs	
Existing state guaranteed issue programs for individuals losing job-based coverage and in other limited circumstances (HIPAA, conversion, Guaranteed Issue Program [GIP] for long-time Major Risk Medical Insurance Program [MRMIP], etc.) are suspended, made inoperative, or not applicable effective January 1, 2014, except that grandfathered coverage issued to individuals with rights under these programs must be renewed at the enrollee's option, and issuers must provide specified notices to such enrollees. ✚S [HSC §1366.3, §1366.35, §1373.6, §1373.621, §1373.622, §1373.810, §1399.805, §1399.811; CIC §10127.18, §10785, §10901.3, §10901.9, §12682.1, §10116.5, §10127.16, §10901.3, §12672, §12682.1]	The ACA did not eliminate federal guaranteed issue requirements that predated its enactment, such as HIPAA and COBRA. Federal guidance issued April 26, 2013, "Questions and Answers Related to the Health Insurance Market Reforms," states that the ACA's guaranteed issue provision has rendered moot the federal requirement for states to implement HIPAA coverage rules with regard to non-grandfathered plans. The guidance allows states to determine what HIPAA coverage requirements will remain in place.
Consumer Protections	
Marketing Prohibitions	
Issuers or their agents must not: ▪ Discourage application due to an individual's health status, among other things ▪ Encourage an applicant to seek coverage elsewhere due to health status ▪ Employ marketing practices that discourage enrollment of persons with significant health needs or discriminate based on race, color, national origin, and other factors specified in federal law and rules ▪ Provide varying compensation to solicitors or agents based on an individual's health status ✚S [HSC §1399.851; CIC §10965.5]	Issuers, including issuers in the exchanges, must comply with state laws regarding marketing and may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. [ACA §1311; 42 USC §18031] (45 CFR §147.104, §156.255)

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Notice of Coverage Options	
Issuers of individual or group coverage must provide a notice to any enrollees or subscribers losing coverage informing them of the availability of coverage in the exchange, as specified. ✚ S [HSC §1366.50; CIC §10786]	Issuers must disclose to applicants the benefits and premiums available under all health insurance coverage for which the individual is qualified. [ACA §1001; PHSA §2709; 42 USC §300gg-9]
Individuals who apply for insurance outside of the exchange must receive notice from the issuer that lower-cost coverage may be available through the exchange, with information about the applicable enrollment periods. ✚ D [HSC §1388.859; CIC §10965.13]	No similar provisions
Issuers offering individual coverage and those not offering individual coverage must provide specified notices to individuals enrolled in existing guaranteed issue programs such as HIPAA, conversion, and MRMIP/GIP. ✚ S [HSC §1373.620; CIC §12682.2]	No similar provisions
Notice of Grandfathered Plan Status	
Issuers of grandfathered plans must provide the notice specified in state law starting October 1, 2013, and annually thereafter, to all individuals enrolled in grandfathered plans, outlining options for coverage. ✚ S [HSC §1399.861, §1373.622(a)(2)(B); CIC §10965.15, §10127.6(a)(2)(B)]	Issuers of grandfathered plans must provide notice to individuals in grandfathered plans disclosing the grandfathered plan status and including a contact number for questions and complaints. (45 CFR §147.140)
Other Issuer Disclosures	
The exchange must ensure that issuers participating in the exchange make the detailed list of information based in federal law and rules publicly available. ☑ D [GOV §100502] In addition, pre-existing state laws require similar disclosures by all issuers, such as the requirement to provide consumers with information on potential financial liability for out-of-network providers. ✚ S [HSC §1363, §1367.10; CIC §10123.12] Issuers must report to regulators starting March 1, 2013, and annually thereafter the number of enrollees by product type (PPO, HMO, point-of-service, etc.) and market (individual, small group, large group, and administrative services only). DMHC and CDI must make the information public on their respective websites. [HSC §1348.95; CIC §10127.19]	Issuers seeking certification in the exchange must make the following information publicly available: ▪ Claims payment policies and practices ▪ Periodic financial disclosures ▪ Data on enrollment and disenrollment ▪ Data on the number of claims that are denied ▪ Data on rating practices ▪ Information on cost-sharing and payments with respect to any out-of-network coverage ▪ Information on enrollee and participant rights under this title [ACA §1311; 42 USC §18031] (45 CFR §156.220)

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Monitoring and Oversight	
Regulatory Reports and Review	
DMHC and CDI must report to the Legislature by June 1, 2017, following review of the impacts of the geographic rating regions adopted in California law. ✚ S [HSC §1399.855; CIC §10965.9] DMHC and CDI must consult with the exchange and consider whether to exercise state-level flexibility with respect to the actuarial value calculator taking into account the unique characteristics of the California health care coverage market, including the prevalence of issuers, total costs of care, price of care, patterns of service utilization, and relevant demographic factors. ✚ S [HSC §1367.008(b)(5); CIC 10112.297]	GAO must study rates of denial of coverage and enrollment. [ACA §1562]
State Contingencies	
Individual market requirements implementing the ACA must only be implemented to the extent a requirement meets or exceeds provisions of the ACA. [HSC §1399.862; CIC §10965.16]	No similar provisions
If federal law is changed to no longer require that individuals maintain minimum essential coverage, the following individual market reforms will become inoperative 12 months later: ▪ Guaranteed availability ▪ Prohibition on pre-existing condition exclusion, except that the prohibition for children under age 19 will remain ▪ Prohibited eligibility rules based on health status, claims experience, etc. ▪ Premium rating factors limited to age, family, and geographic region [HSC §1357.51, §1399.825 et seq., §1399.855, §1399.836; CIC §10950 et seq., §10119.2, §10198.7, §10965, §10965.5]	

California Health Reform Legislation Reflected in This Comparison

Individual market rules

ABx 1-2 (Pan), Chapter 1, Statutes of 2013-14, First Extraordinary Session
SBx 1-2 (Hernandez), Chapter 2, Statutes of 2013-14, First Extraordinary Session
AB 1180 (Pan), Chapter 441, Statutes of 2013

Guaranteed issue for children

AB 2244 (Feuer), Chapter 656, Statutes of 2010

Premium rate review

SB 1163 (Leno), Chapter 661, Statutes of 2010

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Abbreviations

ACA – Affordable Care Act

CCR – California Code of Regulations

CIC – California Insurance Code

CFR – Code of Federal Regulations

GIP – Guaranteed Issue Pilot

GOV – California Government Code

HSC – California Health and Safety Code

MRMIP – Major Risk Medical Insurance Program

PHSA – Public Health Service Act

QHP – Qualified Health Plan

USC – United States Code

Endnotes

1. California issuers include health care service plans licensed by the California Department of Managed Health Care (DMHC) and health insurers subject to the jurisdiction of the California Department of Insurance (CDI), which are also sometimes referred to collectively in California law as "carriers."

2. This wording in California law predates the ACA and was used to impose guaranteed availability requirements on issuers ("carriers" in California law) selling coverage to small employers pursuant to AB 1672, Chapter 1128, Statutes of 1992. The 1992 language was intended to require that issuers *actively market* to all small employer groups regardless of the group health status or claims history, in addition to guaranteeing availability to applicant groups. Separate provisions prohibited using health status or claims experience as eligibility factors for small employer groups. California maintained a similar structure in enacting ACA individual market reforms, continuing the higher legal standard in California law.

3. Unless otherwise stated, the requirements outlined in this chart *do not apply* to grandfathered plans. Individual and small group coverage in effect as of March 23, 2010, that continues to meet specific federal requirements limiting benefit and coverage changes are considered "grandfathered plans" and are exempt from many of the ACA requirements that generally apply to issuers and coverage in the individual and small group markets.

4. Pre-existing state law requires issuers to maintain continuity of care with terminated individuals in treatment for an acute or serious chronic condition, pregnancy, terminal illness, care of a newborn, or performance of a surgery, as defined. [HSC §1373.96; CIC §10133.56]

5. California Department of Insurance (health insurers) or Department of Managed Health Care (health plans), depending on which agency licenses or certifies the product sold by an issuer.

6. In late November 2013, the California Health Benefit Exchange (Covered California) and the federal Center for Consumer Information and Insurance Oversight (CCIIO) took administrative action to extend the deadlines for coverage to be effective January 1, 2014. Enrollment must occur by December 23, 2013 and, in California, payment must be received by January 5, 2014. CCIIO left it to states to set the payment deadlines.

7. Age rating curves are outlined in federal guidance from the Center for Consumer Information and Insurance Oversight (CCIIO) dated February 25, 2013, which is available at www.cms.gov/CCIIO/Resources/Files/Downloads/market-reforms-guidance-2-25-2013.pdf.

8. Federal rules require issuers who participate in exchanges to make a market-wide adjustment to the index rate for exchange fees they pay. California implementing law omits that requirement, but issuers would still be required to comply with the federal rule.

9. In comments on the final federal health insurance market rules issued February 27, 2013, CCIIO noted (in response to requests for clarification of whether the single risk pool is to be maintained at the holding company level or the individual licensee level) that the single risk pool is to be maintained at the licensed entity level (78 Federal Register 39, p. 13422). California law includes language that could reflect legislative intent to impose one single risk pool for issuers with enrollees in individual coverage under both DMHC and CDI, but because the California changes are in two separate codes with different terminology, further interpretation by state and federal regulators or legislative clarification may be needed.

About the Author

This table was prepared by the Kelch Policy Group, which administers the CHCF-funded Health Insurance Alignment Project.

About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

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