Rules for Individual Health Insurance Coverage Comparison of California Law and Selected Federal 2014 Reforms			
Issue	**Existing California Law (As of January 2013)**	**Federal Affordable Care Act Requirements (2014)**	**Grandfathered Plans[1]**
Guaranteed availability (also known as Guaranteed issue) Issuer (carrier in California law) must accept all applicants regardless of health status or claims history	• Carriers can deny coverage for an individual applicant, except as below, including denials because of health status or claims experience. Carriers must provide applicants the reason(s) for the denial in writing and file with regulators their policies and procedures for making the decisions. • Since 2010, coverage is guaranteed available for children under 19 and dependents who stay on parents' policy until age 26 • Coverage is guaranteed available for eligible individuals under HIPAA, COBRA, Cal-COBRA, and conversion coverage[2] (overview on page 4)	• Guaranteed for children under 19 and dependents up to age 26 starting in 2010 • Guaranteed for adults in 2014 • Carriers may limit guaranteed availability to open and special enrollment periods (see below)	Guaranteed availability only applies to eligible dependents who add on to an individual's grandfathered coverage
		Prohibited factors in determining eligibility or continued eligibility: • Health status; • Medical condition (physical or mental illness); • Claims experience; • Receipt of health care; • Medical history; • Genetic information; • Evidence of insurability (i.e., domestic violence); • Disability; or • Any other health status related factor.	Guaranteed eligibility is

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Pre-existing condition exclusions Limits or excludes benefits or coverage for conditions present before coverage begins	• Prohibited for children as of 2010 • Generally allowable in individual coverage for up to 12 months with credit for prior coverage	• Prohibited for children in 2010 and for adults in 2014	Prohibition does not apply to grandfathered plans but the limits in California law apply
Open enrollment Limited period of guaranteed availability when individuals can enroll in or change health coverage, typically once per year	Children's coverage is guaranteed available beginning January 1, 2011 Carriers may not limit availability for children to open enrollment periods but during open and late enrollments must offer coverage with specified rate limits	• Open enrollment periods are authorized but not required for individual coverage, if the carrier offers special enrollment opportunities as below. • Qualified health plans in the Exchange must accept eligible persons during specified open enrollment periods and defined special enrollment periods	Not applicable to grandfathered plans
Special enrollment periods Events or circumstances, sometimes referred to as "qualifying events" that trigger a fixed period of guaranteed availability (typically 30 or 60 days) for individuals who did not enroll during open enrollment	Existing guaranteed availability programs for individuals in state and federal law (HIPAA, COBRA, etc.) are based on specific qualifying circumstances and events for individuals moving from job-based coverage, depending on the program rules, and include specific opportunities for individuals and/or dependents to sign up later as "late enrollees" if specific conditions are met	• Carriers that limit guaranteed availability to open enrollment periods must offer special enrollment to individuals who qualify based on specific triggering events as for COBRA coverage, such as loss of minimum coverage, changes in dependent status (marriage, birth, adoption, etc.) termination of employment, reduction in hours, or the death or divorce of the covered person. • Qualified health plans in the Exchange are subject to specific special enrollment periods as in COBRA. Federal Exchange rules also include as special enrollment qualifying events inadvertent or unintentional errors or mistakes of the Exchange, as specified, changes in eligibility for Exchange programs and subsidies, or a demonstration that the carrier violated a material provision of the contract or policy	Not applicable to grandfathered plans

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Guaranteed renewal Requirement for carrier to renew or continue coverage at the option of the individual	Individual coverage cannot be cancelled or not renewed other than exceptions specifically outlined, such as fraud or intentional misrepresentation, and nonpayment of premium (30-day grace period)	Carrier must renew or continue coverage in force at the option of the individual, other than exceptions specifically outlined, including fraud, nonpayment, or the individual moves out of the carrier's service area	Requirement does not apply to grandfathered plans but California law does apply
Exceptions to guaranteed issue and renewal Instances where carriers will be exempt from the requirements	Guaranteed availability is limited to specific programs as above with the following additional exceptions to guaranteed renewal: • The individual does not or no longer lives, works or resides in the carrier's service area • Carrier withdraws a product from the market (90 day notice applies and must offer and guarantee all products offered to new individuals in that area) • If a carrier stops offering all individual coverage (180 day notice applies and carrier is barred from offering coverage in the market for five years) • Uniform application of exemptions without regard to health status	• For network plans, exemption if individual is not in service area • Lack of sufficient delivery system (180 day bar to market) • Lack of adequate financial capacity (180 day bar or until regulator approves, whichever is later) • Carrier discontinues a specific product (90 days notice and must offer and guarantee all products offered in that area) • Carrier stops selling all individual coverage (180 day notice and five-year bar) • Uniform application of exemptions without regard to health status	Requirement does not apply to grandfathered plans but California law does apply
Rating Factors			
General rating provisions	Carriers are permitted to vary rates for health status or claims experience and by other factors they identify and define including geographic region, age, and family size There are state and federal rating limits and restrictions that apply specifically to HIPAA, COBRA, Cal-COBRA and conversion coverage	Premiums may vary only by whether the plan covers an individual or a family, age variation limited to 3:1, by geographic rating regions developed by the state, and for tobacco use	Rating factors do not apply to grandfathered plans

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Issue	**Existing California Law (As of January 2013)**	**Federal Affordable Care Act Requirements (2014)**	**Grandfathered Plans[1]**
Age	No state limits or restrictions in the individual market Requirements imposed on carriers in the small group market define age categories (under 30, 40-49, 50-54, etc.) but do not set age ranges or limits	Age can be a rating factor but rates must not vary by more than 3:1 (sometimes referred to as an age band) Proposed federal rules apply the 3:1 age limit to individuals 21 and older, in one year increments, and propose a standard federal age curve. Proposed age bands would be 0-20, 21-63 and 64 and older.	
Family size	No state limits or restrictions in the individual market	Individual or family	
Geographic region	No state limits or restrictions in the individual market	States establish one or more rating regions and must do so for both individual and small employer coverage. Proposed federal rules would require either one region for the entire state or up to seven using counties, zip codes, or metropolitan statistical areas. States can propose and seek federal approval for more than seven rating regions.	
Tobacco	No state limits or restrictions in the individual market	Allowable factor but rates cannot vary by more than 1.5:1.	

Notes

[1] Policies of individual and small group coverage in effect as of March 23, 2010, which continues to meet specific federal requirements limiting benefit and coverage changes, are considered "grandfathered plans" and are exempt from some of the Affordable Care Act requirements that generally apply in the individual and small group markets.

[2] Overview of Existing Guaranteed Availability programs. Each of these programs ensures guaranteed availability of health insurance for individuals regardless of their health status if they meet specific requirements, outlined here in basic summary form. The federal Health Insurance Portability and Accountability Act (HIPAA) requires carriers to cover eligible individuals (and dependents in some cases) who have been covered under a group policy for at least 18 months when they lose coverage or change jobs, if specific requirements are met. Carriers must guarantee availability of the two most popular individual products they offer. California law exceeds federal law by placing limits on the rates carriers can charge for HIPAA coverage. COBRA (Consolidated Omnibus Reconciliation Act of 1985) and Cal-COBRA allow individuals to continue job-based coverage in specific circumstances such as termination of employment, reduced hours or loss of dependent status because of divorce or death of an insured person. COBRA applies to employer groups of more than 20 employees and Cal-COBRA extends the protection to California employers of 2-19 employees. COBRA allows carriers to charge no more than 2% above the group rate and Cal-COBRA

limits rates to no more than 10% above the group rate. Conversion coverage is a California-specific program available for individuals who exhaust COBRA, whose employer terminates coverage for all employees or goes out of business. The same benefit requirements and rate limits as in HIPAA apply to conversion coverage.

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