

AMENDED IN SENATE AUGUST 31, 2011
AMENDED IN SENATE AUGUST 15, 2011
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AMENDED IN SENATE JUNE 27, 2011
AMENDED IN ASSEMBLY MAY 24, 2011
AMENDED IN ASSEMBLY MAY 10, 2011
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CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 1083

**Introduced by Assembly Member Monning
(Principal coauthor: Assembly Member Feuer)**

February 18, 2011

An act to amend Sections 1357, 1357.03, 1357.05, 1357.06, 1357.07, ~~1357.12~~, and 1357.14 of, ~~and~~ to amend, repeal, and add Sections ~~1357.15, 1357.50, 1357.51, and 1357.52~~ of, *1357.12 and 1357.15 of, and to add Section 1348.95 to*, the Health and Safety Code, and to amend Sections ~~106~~, 10700, 10705, 10706, 10707, 10708, 10709, ~~10714~~, and 10716 of, ~~and~~ to amend, repeal, and add Sections ~~10198.6, 10198.7, 10198.9, 10714~~ and 10717 of, *and to add Sections 106.5 and 10127.19 to*, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1083, as amended, Monning. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, imposes various requirements, some of which take effect on January

1, 2014, on states, health plans, employers, and individuals regarding health care coverage. Pursuant to the requirements of that act, existing state law establishes the California Health Benefit Exchange for the purpose of, among other things, making available qualified health plans to qualified individuals and employers, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health carriers by the Department of Insurance. Existing law provides for the regulation of health care service plans and health carriers that offer plan contracts or health benefit plans, respectively, to small employers with regard to eligible employees, as defined. Existing law prohibits a plan or solicitor or a carrier or agent or broker from encouraging or directing small employers to seek coverage from another plan or carrier or the Voluntary Alliance Uniting Employers Purchasing Program. Existing law also regulates provisions related to preexisting conditions and late enrollees, as defined.

For purposes of that coverage, this bill would change the definitions and criteria related to eligible employees and rating periods, and, for plan years commencing on or after January 1, 2014, risk adjustment factors, age categories, and health status-related factors, as specified. *The bill would prohibit the use of risk adjustment factors and preexisting condition provisions on and after January 1, 2014. With regard to premium rates charged by a health plan on and after January 1, 2014, the bill would only allow rates to be varied with respect to family rating, rating area, and age, as specified.* The bill would change the definition of small-employers for plan years commencing on or after January 1, 2014, and would change the definition again for plan years commencing on or after January 1, 2017, as specified. ~~The bill~~ *employer and* would require employer contribution requirements to be consistent with the federal Patient Protection and Affordable Care Act. With regard to the sale of plan contracts or health benefit plans, the bill would prohibit specified persons or entities from encouraging or directing small employers to seek coverage from another plan or the voluntary purchasing pool established under the California Health Benefit Exchange. ~~The bill would make other conforming changes to implement the federal act with regard to preexisting conditions, to become effective for plan years commencing on or after January 1, 2014, and would make other changes to preexisting condition provisions, notices, and provisions~~

~~related to late enrollees.~~ *The bill would authorize the director and commissioner to issue emergency regulations to carry out provisions related to the categories of age, family size, and geographic region to make them consistent with the federal Patient Protection and Affordable Care Act. The bill would require health care service plans and health insurers to report to the departments the number of enrollees and covered lives that receive health care coverage under specified contracts or policies, and would require the departments to post that information on their Internet Web sites.*

The bill would also require all policies of individual health insurance that are offered, sold, renewed, or delivered on or after January 1, 2014, to provide coverage for essential health benefits, as defined, except as specified.

Because a willful violation of the bill’s provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1348.95 is added to the Health and Safety
2 Code, to read:
3 1348.95. Commencing March 1, 2012, and at least annually
4 thereafter, every health care service plan, not including a health
5 care service plan offering specialized health care service plan
6 contracts, shall provide to the department, in a form and manner
7 determined by the department in consultation with the Department
8 of Insurance, the number of enrollees as of December 31 of the
9 prior year, that receive health care coverage under a health care
10 service plan contract that covers individuals, small groups, groups
11 of 51-100, groups of 101 or more, or administrative services only
12 business lines. Health care service plans shall include the
13 unduplicated enrollment data in specific product lines as
14 determined by the department, including, but not limited to, HMO,

1 *point-of-service, PPO, Medicare excluding Medicare supplement,*
2 *Medi-Cal managed care, and traditional indemnity non-PPO*
3 *health insurance. The department shall publicly report the data*
4 *provided by each health care service plan pursuant to this section,*
5 *including, but not limited to, posting the data on the department's*
6 *Internet Web site. The department shall consult with the*
7 *Department of Insurance to ensure that the data reported is*
8 *comparable and consistent.*

9 **SECTION 1.**

10 *SEC. 2.* Section 1357 of the Health and Safety Code is amended
11 to read:

12 1357. As used in this article:

13 (a) "Dependent" means the spouse or child of an eligible
14 employee, subject to applicable terms of the health care plan
15 contract covering the employee, and includes dependents of
16 guaranteed association members if the association elects to include
17 dependents under its health coverage at the same time it determines
18 its membership composition pursuant to subdivision (o).

19 (b) "Eligible employee" means either of the following:

20 (1) Any permanent employee who is actively engaged on a
21 full-time basis in the conduct of the business of the small employer
22 with a normal workweek of an average of 30 hours per week over
23 the course of a month, at the small employer's regular places of
24 business, who has met any statutorily authorized applicable waiting
25 period requirements. The term includes sole proprietors or partners
26 of a partnership, if they are actively engaged on a full-time basis
27 in the small employer's business and included as employees under
28 a health care plan contract of a small employer, but does not
29 include employees who work on a part-time, temporary, or
30 substitute basis. It includes any eligible employee, as defined in
31 this paragraph, who obtains coverage through a guaranteed
32 association. Employees of employers purchasing through a
33 guaranteed association shall be deemed to be eligible employees
34 if they would otherwise meet the definition except for the number
35 of persons employed by the employer. Permanent employees who
36 work at least 20 hours but not more than 29 hours are deemed to
37 be eligible employees if all four of the following apply:

38 (A) They otherwise meet the definition of an eligible employee
39 except for the number of hours worked.

1 (B) The employer offers the employees health coverage under
2 a health benefit plan.

3 (C) All similarly situated individuals are offered coverage under
4 the health benefit plan.

5 (D) The employee must have worked at least 20 hours per
6 normal workweek for at least 50 percent of the weeks in the
7 previous calendar quarter. The health care service plan may request
8 any necessary information to document the hours and time period
9 in question, including, but not limited to, payroll records and
10 employee wage and tax filings.

11 (2) Any member of a guaranteed association as defined in
12 subdivision (o).

13 (c) “In force business” means an existing health benefit plan
14 contract issued by the plan to a small employer.

15 (d) “Late enrollee” means an eligible employee or dependent
16 who has declined enrollment in a health benefit plan offered by a
17 small employer at the time of the initial enrollment period provided
18 under the terms of the health benefit plan and who subsequently
19 requests enrollment in a health benefit plan of that small employer,
20 provided that the initial enrollment period shall be a period of at
21 least 30 days. It also means any member of an association that is
22 a guaranteed association as well as any other person eligible to
23 purchase through the guaranteed association when that person has
24 failed to purchase coverage during the initial enrollment period
25 provided under the terms of the guaranteed association’s plan
26 contract and who subsequently requests enrollment in the plan,
27 provided that the initial enrollment period shall be a period of at
28 least 30 days. However, an eligible employee, any other person
29 eligible for coverage through a guaranteed association pursuant to
30 subdivision (o), or an eligible dependent shall not be considered
31 a late enrollee if any of the following is applicable:

32 (1) The individual meets all of the following requirements:

33 (A) He or she was covered under another employer health
34 benefit plan, the Healthy Families Program, the Access for Infants
35 and Mothers (AIM) Program, the Medi-Cal program, or the
36 California Health Benefit Exchange at the time the individual was
37 eligible to enroll.

38 (B) He or she certified at the time of the initial enrollment that
39 coverage under another employer health benefit plan, the Healthy
40 Families Program, the AIM Program, the Medi-Cal program, or

1 the California Health Benefit Exchange was the reason for
2 declining enrollment, provided that, if the individual was covered
3 under another employer health plan, the individual was given the
4 opportunity to make the certification required by this subdivision
5 and was notified that failure to do so could result in later treatment
6 as a late enrollee.

7 (C) He or she has lost or will lose coverage under another
8 employer health benefit plan as a result of termination of
9 employment of the individual or of a person through whom the
10 individual was covered as a dependent, change in employment
11 status of the individual or of a person through whom the individual
12 was covered as a dependent, termination of the other plan's
13 coverage, cessation of an employer's contribution toward an
14 employee's or dependent's coverage, death of the person through
15 whom the individual was covered as a dependent, legal separation,
16 or divorce; or he or she has lost or will lose coverage under the
17 Healthy Families Program, the AIM Program, the Medi-Cal
18 program, or the California Health Benefit Exchange.

19 (D) He or she requests enrollment within 30 days after
20 termination of coverage or employer contribution toward coverage
21 provided under another employer health benefit plan, or requests
22 enrollment within 60 days after termination of Medi-Cal program
23 coverage, AIM Program coverage, Healthy Families Program
24 coverage, or coverage through the California Health Benefit
25 Exchange.

26 (2) The employer offers multiple health benefit plans and the
27 employee elects a different plan during an open enrollment period.

28 (3) A court has ordered that coverage be provided for a spouse
29 or minor child under a covered employee's health benefit plan.

30 (4) (A) Until December 31, 2013, in the case of an eligible
31 employee, as defined in paragraph (1) of subdivision (b), the plan
32 cannot produce a written statement from the employer stating that
33 the individual or the person through whom the individual was
34 eligible to be covered as a dependent, prior to declining coverage,
35 was provided with, and signed, acknowledgment of an explicit
36 written notice in boldface type specifying that failure to elect
37 coverage during the initial enrollment period permits the plan to
38 impose, at the time of the individual's later decision to elect
39 coverage, an exclusion from coverage for a period of 12 months
40 as well as a six-month preexisting condition exclusion, unless the

1 individual meets the criteria specified in paragraph (1), (2), or (3).
2 *For plan years commencing on or after January 1, 2014, a waiting*
3 *period of no longer than 90 days is permitted, unless the individual*
4 *meets the criteria specified in paragraph (1), (2), or (3).*

5 (B) Until December 31, 2013, in the case of an association
6 member who did not purchase coverage through a guaranteed
7 association, the plan cannot produce a written statement from the
8 association stating that the association sent a written notice in
9 boldface type to all potentially eligible association members at
10 their last known address prior to the initial enrollment period
11 informing members that failure to elect coverage during the initial
12 enrollment period permits the plan to impose, at the time of the
13 member's later decision to elect coverage, an exclusion from
14 coverage for a period of 12 months as well as a six-month
15 preexisting condition exclusion unless the member can demonstrate
16 that he or she meets the requirements of subparagraphs (A), (C),
17 and (D) of paragraph (1) or meets the requirements of paragraph
18 (2) or (3). *For plan years commencing on or after January 1, 2014,*
19 *a waiting period of no longer than 90 days is permitted, unless the*
20 *individual meets the criteria specified in paragraph (1), (2), or*
21 *(3).*

22 (C) In the case of an employer or person who is not a member
23 of an association, was eligible to purchase coverage through a
24 guaranteed association, and did not do so, and would not be eligible
25 to purchase guaranteed coverage unless purchased through a
26 guaranteed association, the employer or person can demonstrate
27 that he or she meets the requirements of subparagraphs (A), (C),
28 and (D) of paragraph (1), or meets the requirements of paragraph
29 (2) or (3), or that he or she recently had a change in status that
30 would make him or her eligible and that application for enrollment
31 was made within 30 days of the change.

32 (5) The individual is an employee or dependent who meets the
33 criteria described in paragraph (1) and was under a COBRA
34 continuation provision and the coverage under that provision has
35 been exhausted. For purposes of this section, the definition of
36 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
37 apply.

38 (6) The individual is a dependent of an enrolled eligible
39 employee who has lost or will lose his or her coverage under the
40 Healthy Families Program, the AIM Program, the Medi-Cal

1 program, or the California Health Benefit Exchange, and requests
2 enrollment within 60 days after termination of that coverage.

3 (7) The individual is an eligible employee who previously
4 declined coverage under an employer health benefit plan and who
5 has subsequently acquired a dependent who would be eligible for
6 coverage as a dependent of the employee through marriage, birth,
7 adoption, or placement for adoption, and who enrolls for coverage
8 under that employer health benefit plan on his or her behalf and
9 on behalf of his or her dependent within 30 days following the
10 date of marriage, birth, adoption, or placement for adoption, in
11 which case the effective date of coverage shall be the first day of
12 the month following the date the completed request for enrollment
13 is received in the case of marriage, or the date of birth, or the date
14 of adoption or placement for adoption, whichever applies. Notice
15 of the special enrollment rights contained in this paragraph shall
16 be provided by the employer to an employee at or before the time
17 the employee is offered an opportunity to enroll in plan coverage.

18 (8) The individual is an eligible employee who has declined
19 coverage for himself or herself or his or her dependents during a
20 previous enrollment period because his or her dependents were
21 covered by another employer health benefit plan at the time of the
22 previous enrollment period. That individual may enroll himself or
23 herself or his or her dependents for plan coverage during a special
24 open enrollment opportunity if his or her dependents have lost or
25 will lose coverage under that other employer health benefit plan.
26 The special open enrollment opportunity shall be requested by the
27 employee not more than 30 days after the date that the other health
28 coverage is exhausted or terminated. Upon enrollment, coverage
29 shall be effective not later than the first day of the first calendar
30 month beginning after the date the request for enrollment is
31 received. Notice of the special enrollment rights contained in this
32 paragraph shall be provided by the employer to an employee at or
33 before the time the employee is offered an opportunity to enroll
34 in plan coverage.

35 (e) “New business” means a health care service plan contract
36 issued to a small employer that is not the plan’s in force business.

37 (f) (1) For plan years commencing on or before December 31,
38 2013, “preexisting condition provision” means a contract provision
39 that excludes coverage for charges or expenses incurred during a
40 specified period following the employee’s effective date of

1 coverage, as to a condition for which medical advice, diagnosis,
2 care, or treatment was recommended or received during a specified
3 period immediately preceding the effective date of coverage.

4 (2) For plan years commencing on or after January 1, 2014, no
5 health care service plan shall limit or exclude coverage for any
6 individual based on a preexisting condition whether or not any
7 medical advice, diagnosis, care, or treatment was recommended
8 or received before that date. A preexisting condition provision
9 includes any limitation or exclusion of benefits, including a denial
10 of coverage, applicable to an individual as a result of information
11 relating to an individual's health status before the individual's
12 effective date of coverage under a group health plan, such as a
13 condition identified as a result of a preenrollment questionnaire
14 or physical examination given to the individual, or review of
15 medical records relating to the preenrollment period.

16 (g) "Creditable coverage" means:

17 (1) Any individual or group policy, contract, or program that is
18 written or administered by a disability insurer, health care service
19 plan, fraternal benefits society, self-insured employer plan, or any
20 other entity, in this state or elsewhere, and that arranges or provides
21 medical, hospital, and surgical coverage not designed to supplement
22 other private or governmental plans. The term includes continuation
23 or conversion coverage but does not include accident only, credit,
24 coverage for onsite medical clinics, disability income, Medicare
25 supplement, long-term care, dental, vision, coverage issued as a
26 supplement to liability insurance, insurance arising out of a
27 workers' compensation or similar law, automobile medical payment
28 insurance, or insurance under which benefits are payable with or
29 without regard to fault and that is statutorily required to be
30 contained in any liability insurance policy or equivalent
31 self-insurance.

32 (2) The Medicare Program pursuant to Title XVIII of the federal
33 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

34 (3) The Medicaid Program pursuant to Title XIX of the federal
35 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

36 (4) Any other publicly sponsored program, provided in this state
37 or elsewhere, of medical, hospital, and surgical care.

38 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
39 (Civilian Health and Medical Program of the Uniformed Services
40 (CHAMPUS)).

- 1 (6) A medical care program of the Indian Health Service or of
2 a tribal organization.
- 3 (7) A state health benefits risk pool.
- 4 (8) A health plan offered under 5 U.S.C. Chapter 89
5 (commencing with Section 8901) (Federal Employees Health
6 Benefits Program (FEHBP)).
- 7 (9) A public health plan as defined in federal regulations
8 authorized by Section 2701(c)(1)(I) of the Public Health Service
9 Act, as amended by Public Law 104-191, the Health Insurance
10 Portability and Accountability Act of 1996.
- 11 (10) A health benefit plan under Section 5(e) of the Peace Corps
12 Act (22 U.S.C. Sec. 2504(e)).
- 13 (11) Any other creditable coverage as defined by subdivision
14 (c) of Section 2704 of Title XXVII of the federal Public Health
15 Service Act (42 U.S.C. Sec. 300gg-3(c)).
- 16 (h) “Rating period” means the period for which premium rates
17 established by a plan are in effect and shall be no less than 12
18 months. This subdivision shall be implemented to the extent
19 permitted under the federal Patient Protection and Affordable Care
20 Act (Public Law 111-148) and any rules, regulations, or guidance
21 issued consistent with that law.
- 22 (i) “Risk adjusted employee risk rate” means the rate determined
23 for an eligible employee of a small employer in a particular risk
24 category after applying the risk adjustment factor. *For plan years*
25 *commencing on or after January 1, 2014, no risk adjustment factor*
26 *shall be used in the determination of rates.*
- 27 (j) “Risk adjustment factor” means the percentage adjustment
28 to be applied equally to each standard employee risk rate for a
29 particular small employer, based upon any expected deviations
30 from standard cost of services. This factor may not be more than
31 120 percent or less than 80 percent until July 1, 1996. Effective
32 July 1, 1996, this factor may not be more than 110 percent or less
33 than 90 percent. For plan years commencing on or after January
34 1, 2014, no risk adjustment factor shall be used in the determination
35 of rates.
- 36 (k) “Risk category” means the following characteristics of an
37 eligible employee: age, geographic region, and family composition
38 of the employee, plus the health benefit plan selected by the small
39 employer to the extent permitted under the federal Patient

1 Protection and Affordable Care Act (Public Law 111-148) and
2 any rules, regulations, or guidance issued consistent with that law.

3 (1) No more than the following age categories may be used in
4 determining premium rates:

5 Under 30

6 30–39

7 40–49

8 50–54

9 55–59

10 60–64

11 65 and over

12 However, for the 65 and over age category, separate premium
13 rates may be specified depending upon whether coverage under
14 the plan contract will be primary or secondary to benefits provided
15 by the Medicare Program pursuant to Title XVIII of the federal
16 Social Security Act (42 U.S.C. Sec. 1395 et seq.). For plan years
17 commencing on or after January 1, 2014, the rate for age shall not
18 vary by more than three to one for adults.

19 (2) Small employer health care service plans shall base rates to
20 small employers using no more than the following family size
21 categories:

22 (A) Single.

23 ~~(B) Two-adult families.~~

24 ~~(C) One adult and child or children.~~

25 ~~(D) Two-adult families and child or children.~~

26 (B) *Married couple or registered domestic partners. “Domestic
27 partner” shall have the same meaning as that term is used in
28 Section 297 of the Family Code.*

29 (C) *One adult and child or children.*

30 (D) *Married couple and child or children or registered domestic
31 partners and child or children.*

32 (3) *The director may issue regulations developed in
33 collaboration with the Insurance Commissioner that are necessary
34 to carry out the purpose of this subdivision to make the categories
35 of age, family size, and geographic region consistent with the
36 federal Patient Protection and Affordable Care Act (Public Law
37 111-148), and any rules, regulations, or guidance issued consistent
38 with that law. Any rules and regulations adopted pursuant to this
39 subdivision may be adopted as emergency regulations in
40 accordance with the Administrative Procedure Act (Chapter 3.5*

1 (commencing with Section 11340) of Part 1 of Division 3 of Title
2 2 of the Government Code). Until December 31, 2015, the adoption
3 of these regulations shall be deemed an emergency and necessary
4 for the immediate preservation of the public peace, health and
5 safety, or general welfare.

6 (3)

7 (4) (A) In determining rates for small employers, a plan that
8 operates statewide shall use no more than nine geographic regions
9 in the state, have no region smaller than an area in which the first
10 three digits of all its ZIP Codes are in common within a county,
11 and divide no county into more than two regions. Plans shall be
12 deemed to be operating statewide if their coverage area includes
13 90 percent or more of the state’s population. Geographic regions
14 established pursuant to this section shall, as a group, cover the
15 entire state, and the area encompassed in a geographic region shall
16 be separate and distinct from areas encompassed in other
17 geographic regions. Geographic regions may be noncontiguous.

18 (B) (i) In determining rates for small employers, a plan that
19 does not operate statewide shall use no more than the number of
20 geographic regions in the state that is determined by the following
21 formula: the population, as determined in the last federal census,
22 of all counties that are included in their entirety in a plan’s service
23 area divided by the total population of the state, as determined in
24 the last federal census, multiplied by nine. The resulting number
25 shall be rounded to the nearest whole integer. No region may be
26 smaller than an area in which the first three digits of all its ZIP
27 Codes are in common within a county and no county may be
28 divided into more than two regions. The area encompassed in a
29 geographic region shall be separate and distinct from areas
30 encompassed in other geographic regions. Geographic regions
31 may be noncontiguous. No plan shall have less than one geographic
32 area.

33 (ii) If the formula in clause (i) results in a plan that operates in
34 more than one county having only one geographic region, then the
35 formula in clause (i) shall not apply and the plan may have two
36 geographic regions, provided that no county is divided into more
37 than one region.

38 Nothing in this section shall be construed to require a plan to
39 establish a new service area or to offer health coverage on a
40 statewide basis, outside of the plan’s existing service area.

1 (l) “Small employer” means any of the following:

2 (1) For plan years commencing on or before December 31,
3 2013, any person, firm, proprietary or nonprofit corporation,
4 partnership, public agency, or association that is actively engaged
5 in business or service, that, on at least 50 percent of its working
6 days during the preceding calendar quarter or preceding calendar
7 year, employed at least two, but no more than 50, eligible
8 employees, the majority of whom were employed within this state,
9 that was not formed primarily for purposes of buying health care
10 service plan contracts, and in which a bona fide employer-employee
11 relationship exists. For plan years commencing on or after January
12 1, 2014, and on or before December 31, 2015, any person, firm,
13 proprietary or nonprofit corporation, partnership, public agency,
14 or association that is actively engaged in business or service, that,
15 on at least 50 percent of its working days during the preceding
16 calendar quarter or preceding calendar year, employed at least one,
17 but no more than 50, eligible employees, the majority of whom
18 were employed within this state, that was not formed primarily for
19 purposes of buying health care service plan contracts, and in which
20 a bona fide employer-employee relationship exists. For plan years
21 commencing on or after January 1, 2016, any person, firm,
22 proprietary or nonprofit corporation, partnership, public agency,
23 or association that is actively engaged in business or service, that,
24 on at least 50 percent of its working days during the preceding
25 calendar quarter or preceding calendar year, employed at least one,
26 but no more than 100, eligible employees, the majority of whom
27 were employed within this state, that was not formed primarily for
28 purposes of buying health care service plan contracts, and in which
29 a bona fide employer-employee relationship exists. In determining
30 whether to apply the calendar quarter or calendar year test, a health
31 care service plan shall use the test that ensures eligibility if only
32 one test would establish eligibility. In determining the number of
33 eligible employees, companies that are affiliated companies and
34 that are eligible to file a combined tax return for purposes of state
35 taxation shall be considered one employer. Subsequent to the
36 issuance of a health care service plan contract to a small employer
37 pursuant to this article, and for the purpose of determining
38 eligibility, the size of a small employer shall be determined
39 annually. Except as otherwise specifically provided in this article,
40 provisions of this article that apply to a small employer shall

1 continue to apply until the plan contract anniversary following the
2 date the employer no longer meets the requirements of this
3 definition. It includes any small employer as defined in this
4 paragraph who purchases coverage through a guaranteed
5 association, and any employer purchasing coverage for employees
6 through a guaranteed association. This paragraph shall be
7 implemented to the extent consistent with the federal Patient
8 Protection and Affordable Care Act (Public Law ~~111-148~~) *111-148*;
9 *PPACA*) and any rules, regulations, or guidance issued consistent
10 with that ~~law~~ *law*, *except that the minimum requirement of one*
11 *employee shall be implemented only to the extent required by*
12 *PPACA*.

13 (2) Any guaranteed association, as defined in subdivision (n),
14 that purchases health coverage for members of the association.

15 ~~(3) For plan years commencing on or after January 1, 2014, a~~
16 ~~self-employed individual who obtains at least 50 percent of annual~~
17 ~~income from self-employment as demonstrated through personal~~
18 ~~income tax filings for the current or prior year. To the extent~~
19 ~~permitted under the federal Patient Protection and Affordable Care~~
20 ~~Act (Public Law 111-148) and any rules, regulations, or guidance~~
21 ~~issued consistent with that law, a self-employed individual may~~
22 ~~at his or her discretion seek to enroll as an individual rather than~~
23 ~~a small employer through the California Health Benefit Exchange~~
24 ~~to the extent permitted under the federal Patient Protection and~~
25 ~~Affordable Care Act (Public Law 111-148) and any rules,~~
26 ~~regulations, or guidance issued consistent with that law.~~

27 (4)

28 (3) For plan years commencing on or after January 1, 2014, the
29 definition of an employer, for purposes of determining whether
30 an employer with one employee shall include sole proprietors,
31 certain owners of “S” corporations, or other individuals, shall be
32 consistent with Section 1304 of the federal Patient Protection and
33 Affordable Care Act (Public Law 111-148) and any federal rules,
34 regulations, or guidance issued consistent with that law.

35 (m) “Standard employee risk rate” means the rate applicable to
36 an eligible employee in a particular risk category in a small
37 employer group.

38 (n) “Guaranteed association” means a nonprofit organization
39 comprised of a group of individuals or employers who associate
40 based solely on participation in a specified profession or industry,

1 accepting for membership any individual or employer meeting its
2 membership criteria, and that (1) includes one or more small
3 employers as defined in paragraph (1) of subdivision (l), (2) does
4 not condition membership directly or indirectly on the health or
5 claims history of any person, (3) uses membership dues solely for
6 and in consideration of the membership and membership benefits,
7 except that the amount of the dues shall not depend on whether
8 the member applies for or purchases insurance offered to the
9 association, (4) is organized and maintained in good faith for
10 purposes unrelated to insurance, (5) has been in active existence
11 on January 1, 1992, and for at least five years prior to that date,
12 (6) has included health insurance as a membership benefit for at
13 least five years prior to January 1, 1992, (7) has a constitution and
14 bylaws, or other analogous governing documents that provide for
15 election of the governing board of the association by its members,
16 (8) offers any plan contract that is purchased to all individual
17 members and employer members in this state, (9) includes any
18 member choosing to enroll in the plan contracts offered to the
19 association provided that the member has agreed to make the
20 required premium payments, and (10) covers at least 1,000 persons
21 with the health care service plan with which it contracts. The
22 requirement of 1,000 persons may be met if component chapters
23 of a statewide association contracting separately with the same
24 carrier cover at least 1,000 persons in the aggregate.

25 This subdivision applies regardless of whether a contract issued
26 by a plan is with an association, or a trust formed for or sponsored
27 by an association, to administer benefits for association members.

28 For purposes of this subdivision, an association formed by a
29 merger of two or more associations after January 1, 1992, and
30 otherwise meeting the criteria of this subdivision shall be deemed
31 to have been in active existence on January 1, 1992, if its
32 predecessor organizations had been in active existence on January
33 1, 1992, and for at least five years prior to that date and otherwise
34 met the criteria of this subdivision.

35 (o) "Members of a guaranteed association" means any individual
36 or employer meeting the association's membership criteria if that
37 person is a member of the association and chooses to purchase
38 health coverage through the association. At the association's
39 discretion, it also may include employees of association members,
40 association staff, retired members, retired employees of members,

1 and surviving spouses and dependents of deceased members.
 2 However, if an association chooses to include these persons as
 3 members of the guaranteed association, the association shall make
 4 that election in advance of purchasing a plan contract. Health care
 5 service plans may require an association to adhere to the
 6 membership composition it selects for up to 12 months.

7 (p) “Affiliation period” means a period that, under the terms of
 8 the health care service plan contract, must expire before health
 9 care services under the contract become effective. ~~On or after~~
 10 ~~January 1, 2014, affiliation periods are prohibited. An affiliation~~
 11 *period under a health care service plan contract shall run*
 12 *concurrently with any waiting period under that plan contract. An*
 13 *affiliation period may not exceed 60 days or, in the case of a late*
 14 *enrollee, 90 days.*

15 (q) “Waiting period” means the period that is required to pass
 16 with respect to the employee before the employee is eligible to be
 17 covered for benefits under the terms of the policy. However, such
 18 periods shall not be based upon the health status of the employee
 19 or dependent. For plan years commencing on or after January 1,
 20 2014, a health plan may ~~permit~~ *apply* a waiting period of up to 90
 21 days as a condition of ~~enrollment~~ *employment* if applied equally
 22 to all full-time employees, consistent with the federal Patient
 23 Protection and Affordable Care Act (Public Law 111-148) and
 24 any rules, regulations, or guidance issued consistent with that law.

25 (r) ~~“Plan year” means a consecutive 12-month period during~~
 26 ~~which a health plan provides coverage for health benefits. A plan~~
 27 ~~year may be a calendar year or otherwise. This definition shall~~
 28 ~~apply to the extent it is consistent with the federal Patient~~
 29 ~~Protection and Affordable Care Act (Public Law 111-148) and~~
 30 ~~any federal rules, regulations, or guidance issued consistent with~~
 31 ~~that law.~~

32 (r) *“Plan year” has the meaning set forth in Section 144.103*
 33 *of Title 45 of the Code of Federal Regulations.*

34 (s) *“PPACA” means the federal Patient Protection and*
 35 *Affordable Care Act (Public Law 111-148), as amended by the*
 36 *federal Health Care and Education Reconciliation Act of 2010*
 37 *(Public Law 111-152), and any rules, regulations, or guidance*
 38 *issued thereunder.*

39 (t) *“Grandfathered health plan” has the meaning set forth in*
 40 *Section 1251 of PPACA.*

1 ~~SEC. 2.~~

2 *SEC. 3.* Section 1357.03 of the Health and Safety Code is
3 amended to read:

4 1357.03. (a) (1) Upon the effective date of this article, a plan
5 shall fairly and affirmatively offer, market, and sell all of the plan's
6 health care service plan contracts that are sold to small employers
7 or to associations that include small employers to all small
8 employers in each service area in which the plan provides or
9 arranges for the provision of health care services.

10 (2) Each plan shall make available to each small employer all
11 small employer health care service plan contracts that the plan
12 offers and sells to small employers or to associations that include
13 small employers in this state.

14 (3) No plan or solicitor shall induce or otherwise encourage a
15 small employer to separate or otherwise exclude an eligible
16 employee from a health care service plan contract that is provided
17 in connection with the employee's employment or membership in
18 a guaranteed association.

19 (4) A plan contracting to participate in the voluntary purchasing
20 pool for small employers offered through the California Health
21 Benefit Exchange shall be deemed in compliance with the
22 requirements of paragraph (1) for a contract offered through the
23 California Health Benefit Exchange in those geographic regions
24 in which plans participate in the California Health Benefit
25 Exchange.

26 (5) (A) A plan shall be deemed to meet the requirements of
27 paragraphs (1) and (2) with respect to a plan contract that qualifies
28 as a grandfathered health plan under Section 1251 of PPACA if
29 all of the following requirements are met:

30 (i) The plan offers to renew the plan contract, unless the plan
31 withdraws the plan contract from the small employer market
32 pursuant to subdivision (e) of Section 1357.11.

33 (ii) The plan provides appropriate notice of the grandfathered
34 status of the contract in any materials provided to an enrollee of
35 the contract describing the benefits provided under the contract,
36 as required under PPACA.

37 (iii) The plan makes no changes to the benefits covered under
38 the plan contract other than those required by a state or federal
39 law, regulation, rule, or guidance and those permitted to be made
40 to a grandfathered health plan under PPACA.

1 (B) For purposes of this paragraph, “PPACA” means the federal
2 Patient Protection and Affordable Care Act (Public Law 111-148),
3 as amended by the federal Health Care and Education
4 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
5 regulations, or guidance issued thereunder. For purposes of this
6 paragraph, a “grandfathered health plan” shall have the meaning
7 set forth in Section 1251 of PPACA.

8 (b) Every plan shall file with the director the reasonable
9 employee participation requirements and employer contribution
10 requirements that will be applied in offering its plan contracts.
11 Participation requirements shall be applied uniformly among all
12 small employer groups, except that a plan may vary application
13 of minimum employee participation requirements by the size of
14 the small employer group and whether the employer contributes
15 100 percent of the eligible employee’s premium. Employer
16 contribution requirements shall not vary by employer size.
17 Employer contribution requirements shall be consistent with the
18 federal Patient Protection and Affordable Care Act (Public Law
19 111-148). A health care service plan shall not establish a
20 participation requirement that (1) requires a person who meets the
21 definition of a dependent in subdivision (a) of Section 1357 to
22 enroll as a dependent if he or she is otherwise eligible for coverage
23 and wishes to enroll as an eligible employee and (2) allows a plan
24 to reject an otherwise eligible small employer because of the
25 number of persons that waive coverage due to coverage through
26 another employer. Members of an association eligible for health
27 coverage under subdivision (o) of Section 1357, but not electing
28 any health coverage through the association, shall not be counted
29 as eligible employees for purposes of determining whether the
30 guaranteed association meets a plan’s reasonable participation
31 standards.

32 (c) The plan shall not reject an application from a small
33 employer for a health care service plan contract if all of the
34 following are met:

35 (1) The small employer, as defined by paragraph (1) of
36 subdivision (l) of Section 1357, offers health benefits to 100
37 percent of its eligible employees, as defined by paragraph (1) of
38 subdivision (b) of Section 1357. Employees who waive coverage
39 on the grounds that they have other group coverage shall not be
40 counted as eligible employees.

1 (2) The small employer agrees to make the required premium
2 payments.

3 (3) The small employer agrees to inform the small employers'
4 employees of the availability of coverage and the provision that
5 those not electing coverage must wait one year to obtain coverage
6 through the group if they later decide they would like to have
7 coverage.

8 (4) The employees and their dependents who are to be covered
9 by the plan contract work or reside in the service area in which
10 the plan provides or otherwise arranges for the provision of health
11 care services.

12 (d) No plan or solicitor shall, directly or indirectly, engage in
13 the following activities:

14 (1) Encourage or direct small employers to refrain from filing
15 an application for coverage with a plan because of the health status,
16 claims experience, industry, occupation of the small employer, or
17 geographic location provided that it is within the plan's approved
18 service area.

19 (2) Encourage or direct small employers to seek coverage from
20 another plan or the voluntary purchasing pool established under
21 the California Health Benefit Exchange because of the health
22 status, claims experience, industry, occupation of the small
23 employer, or geographic location provided that it is within the
24 plan's approved service area.

25 (e) A plan shall not, directly or indirectly, enter into any contract,
26 agreement, or arrangement with a solicitor that provides for or
27 results in the compensation paid to a solicitor for the sale of a
28 health care service plan contract to be varied because of the health
29 status, claims experience, industry, occupation, or geographic
30 location of the small employer or small employer's employees.
31 This subdivision does not apply to a compensation arrangement
32 that provides compensation to a solicitor on the basis of percentage
33 of premium, provided that the percentage shall not vary because
34 of the health status, claims experience, industry, occupation, or
35 geographic area of the small employer.

36 (f) A policy or contract that covers ~~one or more employees a~~
37 *small employer, as defined in Section 1304(b) of PPACA and in*
38 *subdivision (l) of Section 1357*, shall not establish rules for
39 eligibility, including continued eligibility, of an individual, or

1 dependent of an individual, to enroll under the terms of the plan
2 based on any of the following health status-related factors:

- 3 (1) Health status.
- 4 (2) Medical condition, including physical and mental illnesses.
- 5 (3) Claims experience.
- 6 (4) Receipt of health care.
- 7 (5) Medical history.
- 8 (6) Genetic information.
- 9 (7) Evidence of insurability, including conditions arising out of
10 acts of domestic violence.
- 11 (8) Disability.
- 12 (9) Any other health status-related factor as determined by the
13 department.

14 (g) A plan shall comply with the requirements of Section 1374.3.

15 ~~SEC. 3.~~

16 *SEC. 4.* Section 1357.05 of the Health and Safety Code is
17 amended to read:

18 1357.05. (a) For plan years commencing on or before
19 December 31, 2013, except in the case of a late enrollee, or for
20 satisfaction of a preexisting condition clause in the case of initial
21 coverage of an eligible employee, a plan may not exclude any
22 eligible employee or dependent who would otherwise be entitled
23 to health care services on the basis of an actual or expected health
24 condition of that employee or dependent. No plan contract may
25 limit or exclude coverage for a specific eligible employee or
26 dependent by type of illness, treatment, medical condition, or
27 accident, except for preexisting conditions as permitted by Section
28 1357.06.

29 (b) For plan years commencing on or after January 1, 2014, a
30 plan may not exclude any eligible employee or dependent who
31 would otherwise be entitled to health care services on the basis of
32 an actual or expected health condition of that employee or
33 dependent. No plan contract may limit or exclude coverage for a
34 specific eligible employee or dependent by type of illness,
35 treatment, medical condition, or accident, except for preexisting
36 conditions as permitted by Section 1357.06.

37 ~~SEC. 4.~~

38 *SEC. 5.* Section 1357.06 of the Health and Safety Code is
39 amended to read:

1 1357.06. (a) (1) For plan years commencing on or before
2 December 31, 2013, preexisting condition provisions of a plan
3 contract shall not exclude coverage for a period beyond six months
4 following the individual's effective date of coverage and may only
5 relate to conditions for which medical advice, diagnosis, care, or
6 treatment, including prescription drugs, was recommended or
7 received from a licensed health practitioner during the six months
8 immediately preceding the effective date of coverage.

9 (2) Notwithstanding paragraph (1), a plan contract offered to a
10 small employer shall not impose any preexisting condition
11 provision upon any child under 19 years of age.

12 (3) For plan years commencing on or after January 1, 2014, a
13 health plan *offered to a small employer* shall not impose a
14 preexisting condition provision upon any individual.

15 (b) (1) For plan years commencing on or before December 31,
16 2013, a plan that does not utilize a preexisting condition provision
17 may impose a waiting or affiliation period, not to exceed 60 days,
18 before the coverage issued subject to this article shall become
19 effective. During the waiting or affiliation period no premiums
20 shall be charged to the enrollee or the subscriber.

21 (2) For plan years commencing on or after January 1, 2014, no
22 waiting or affiliation period based on a preexisting condition, health
23 status, or any other factor prohibited under subdivision (f) of
24 Section 1357.03 shall be imposed.

25 (3) A plan contract may ~~permit~~ *apply* a waiting period of up to
26 90 days as a condition of ~~enrollment~~ *employment* if applied equally
27 to all full-time employees and if consistent with the federal Patient
28 Protection and Affordable Care Act (Public Law 111-148) and
29 any rules, regulations, or guidance issued consistent with that law.
30 *A waiting period under a plan contract shall run concurrently with*
31 *any affiliation period under the plan. During the waiting period,*
32 *no plan premiums shall be charged to the enrollee or subscriber.*

33 (4) *A plan may impose an affiliation period, not to exceed 60*
34 *days or, in the case of a late enrollee, 90 days before the coverage*
35 *issued subject to this article shall become effective. During the*
36 *affiliation period, no premiums shall be charged to the enrollee*
37 *or the subscriber. An affiliation period under a plan contract shall*
38 *run concurrently with any waiting period under that contract.*

39 (c) For plan years commencing on or before December 31, 2013,
40 in determining whether a preexisting condition provision or a

1 waiting or affiliation period applies to any person, a plan shall
2 credit the time the person was covered under creditable coverage,
3 provided the person becomes eligible for coverage under the
4 succeeding plan contract within 62 days of termination of prior
5 coverage, exclusive of any waiting or affiliation period, and applies
6 for coverage with the succeeding plan contract within the applicable
7 enrollment period. A plan shall also credit any time an eligible
8 employee must wait before enrolling in the plan, including any
9 affiliation or employer-imposed waiting or affiliation period.
10 However, if a person's employment has ended, the availability of
11 health coverage offered through employment or sponsored by an
12 employer has terminated, or an employer's contribution toward
13 health coverage has terminated, a plan shall credit the time the
14 person was covered under creditable coverage if the person
15 becomes eligible for health coverage offered through employment
16 or sponsored by an employer within 180 days, exclusive of any
17 waiting or affiliation period, and applies for coverage under the
18 succeeding plan contract within the applicable enrollment period.

19 *(d) For plan years commencing on or after January 1, 2014, in*
20 *determining whether a waiting or affiliation period applies to any*
21 *person, a plan shall credit the time the person was covered under*
22 *creditable coverage, provided the person becomes eligible for*
23 *coverage under the succeeding plan contract within 62 days of*
24 *termination of prior coverage, exclusive of any waiting or*
25 *affiliation period, and applies for coverage with the succeeding*
26 *plan contract within the applicable enrollment period. A plan shall*
27 *also credit any time an eligible employee must wait before enrolling*
28 *in the plan, including any affiliation or employer-imposed waiting*
29 *or affiliation period. However, if a person's employment has ended,*
30 *the availability of health coverage offered through employment or*
31 *sponsored by an employer has terminated, or an employer's*
32 *contribution toward health coverage has terminated, a plan shall*
33 *credit the time the person was covered under creditable coverage*
34 *if the person becomes eligible for health coverage offered through*
35 *employment or sponsored by an employer within 180 days,*
36 *exclusive of any waiting or affiliation period, and applies for*
37 *coverage under the succeeding plan contract within the applicable*
38 *enrollment period.*

39 (e)

1 (e) For plan years commencing on or before December 31, 2013,
2 in addition to the preexisting condition exclusions authorized by
3 subdivision (a) and the waiting or affiliation period authorized by
4 subdivision (b), health plans providing coverage to a guaranteed
5 association may impose on employers or individuals purchasing
6 coverage who would not be eligible for guaranteed coverage if
7 they were not purchasing through the association a waiting or
8 affiliation period, not to exceed 60 days, before the coverage issued
9 subject to this article shall become effective. During the waiting
10 or affiliation period, no premiums shall be charged to the enrollee
11 or the subscriber.

12 (e)

13 (f) An individual's period of creditable coverage shall be
14 certified pursuant to subdivision (e) of Section 2704 of Title XXVII
15 of the federal Public Health Service Act (42 U.S.C. Sec.
16 300gg-3(e)).

17 (f)

18 (g) A health care service plan issuing group coverage may not
19 impose a preexisting condition exclusion to a condition relating
20 to benefits for pregnancy or maternity care. For plan years
21 commencing on or after January 1, 2014, a health care service plan
22 issuing group coverage may not impose any preexisting condition
23 exclusion on any individual.

24 ~~SEC. 5.~~

25 *SEC. 6.* Section 1357.07 of the Health and Safety Code is
26 amended to read:

27 1357.07. (a) For plan years commencing on or before
28 December 31, 2013, no plan contract may exclude a late enrollee
29 from coverage for more than 12 months from the date of the late
30 enrollee's application for coverage. No premium shall be charged
31 to the late enrollee until the exclusion period has ended.

32 (b) For plan years commencing on or after January 1, 2014, no
33 plan contract may exclude a late enrollee from coverage for more
34 than 90 days from the date of the late enrollee's application for
35 coverage to the extent consistent with the federal Patient Protection
36 and Affordable Care Act (Public Law 111-148) and any rules,
37 regulations, or guidance issued consistent with that law. No
38 premium shall be charged to the late enrollee until the exclusion
39 period has ended. Nothing in this subdivision shall be construed
40 as prohibiting a health care service plan from restricting enrollment

1 of late enrollees to open enrollment periods as authorized under
2 Section ~~2701~~ 2702 of the federal Patient Protection and Affordable
3 Care Act (Public Law 111-148) and any rules, regulations, or
4 guidance issued consistent with that law.

5 ~~SEC. 6.~~

6 *SEC. 7.* Section 1357.12 of the Health and Safety Code is
7 amended to read:

8 1357.12. Premiums for contracts offered or delivered by plans
9 on or after the effective date of this article shall be subject to the
10 following requirements:

11 (a) (1) The premium for new business shall be determined for
12 an eligible employee in a particular risk category after applying a
13 risk adjustment factor to the plan's standard employee risk rates.
14 The risk adjusted employee risk rate may not be more than 120
15 percent or less than 80 percent of the plan's applicable standard
16 employee risk rate until July 1, 1996. Effective July 1, 1996, this
17 factor may not be more than 110 percent or less than 90 percent.
18 For plan years commencing on or ~~before~~ *after* January 1, 2014,
19 no risk adjustment factor shall be used in the determination of
20 rates.

21 (2) The premium charged a small employer for new business
22 shall be equal to the sum of the risk adjusted employee risk rates.

23 (3) The standard employee risk rates applied to a small employer
24 for new business shall be in effect for no less than 12 months. This
25 subdivision shall be implemented to the extent permitted under
26 the federal Patient Protection and Affordable Care Act (Public
27 Law 111-148) and any rules, regulations, or guidance issued
28 consistent with that law.

29 (b) (1) The premium for in force business shall be determined
30 for an eligible employee in a particular risk category after applying
31 a risk adjustment factor to the plan's standard employee risk rates.
32 The risk adjusted employee risk rates may not be more than 120
33 percent or less than 80 percent of the plan's applicable standard
34 employee risk rate until July 1, 1996. Effective July 1, 1996, this
35 factor may not be more than 110 percent or less than 90 percent.
36 The factor effective July 1, 1996, shall apply to in force business
37 at the earlier of either the time of renewal or July 1, 1997. For plan
38 years commencing on or before December 31, 2013, the risk
39 adjustment factor applied to a small employer may not increase
40 by more than 10 percentage points from the risk adjustment factor

1 applied in the prior rating period. ~~For plan years commencing on~~
2 ~~or after January 1, 2014, no risk adjustment factor shall be used~~
3 ~~in the determination of rates.~~ The risk adjustment factor for a small
4 employer may not be modified more frequently than every 12
5 months. *For plan years commencing on or after January 1, 2014,*
6 *no risk adjustment factor shall be used in the determination of*
7 *rates.*

8 (2) The premium charged a small employer for in force business
9 shall be equal to the sum of the risk adjusted employee risk rates.
10 The standard employee risk rates shall be in effect for no less than
11 six months.

12 (3) For a contract that a plan has discontinued offering, the risk
13 adjustment factor applied to the standard employee risk rates for
14 the first rating period of the new contract that the small employer
15 elects to purchase shall be no greater than the risk adjustment factor
16 applied in the prior rating period to the discontinued contract.
17 However, the risk adjusted employee risk rate may not be more
18 than 120 percent or less than 80 percent of the plan's applicable
19 standard employee risk rate until July 1, 1996. Effective July 1,
20 1996, this factor may not be more than 110 percent or less than 90
21 percent. The factor effective July 1, 1996, shall apply to in force
22 business at the earlier of either the time of renewal or July 1, 1997.
23 ~~For plan years commencing on or after January 1, 2014, no risk~~
24 ~~adjustment factor shall be used in the determination of rates.~~ The
25 risk adjustment factor for a small employer may not be modified
26 more frequently than every 12 months. *For plan years commencing*
27 *on or after January 1, 2014, no risk adjustment factor shall be*
28 *used in the determination of rates.*

29 (c) (1) For any small employer, a plan may, with the consent
30 of the small employer, establish composite employee and
31 dependent rates for either new business or renewal of in force
32 business. The composite rates shall be determined as the average
33 of the risk adjusted employee risk rates for the small employer, as
34 determined in accordance with the requirements of subdivisions
35 (a) and (b). The sum of the composite rates so determined shall be
36 equal to the sum of the risk adjusted employee risk rates for the
37 small employer.

38 (2) The composite rates shall be used for all employees and
39 dependents covered throughout a rating period of no less than six
40 months nor more than 12 months, except that a plan may reserve

1 the right to redetermine the composite rates if the enrollment under
 2 the contract changes by more than a specified percentage during
 3 the rating period. Any redetermination of the composite rates shall
 4 be based on the same risk adjusted employee risk rates used to
 5 determine the initial composite rates for the rating period. If a plan
 6 reserves the right to redetermine the rates and the enrollment
 7 changes more than the specified percentage, the plan shall
 8 redetermine the composite rates if the redetermined rates would
 9 result in a lower premium for the small employer. A plan reserving
 10 the right to redetermine the composite rates based upon a change
 11 in enrollment shall use the same specified percentage to measure
 12 that change with respect to all small employers electing composite
 13 rates.

14 *(d) This section shall remain in effect only until January 1, 2014,*
 15 *and as of that date is repealed, unless a later enacted statute, that*
 16 *is enacted before January 1, 2014, deletes or extends that date.*

17 *SEC. 8. Section 1357.12 is added to the Health and Safety*
 18 *Code, to read:*

19 *1357.12. (a) Premium rates for contracts offered or delivered*
 20 *by plans on or after January 1, 2014, shall be subject to the*
 21 *following requirements:*

22 *(1) With respect to the premium rate charged by a health plan,*
 23 *such rate shall vary with respect to the particular plan or coverage*
 24 *involved only by any of the following:*

25 *(A) Whether such plan or coverage covers an individual or*
 26 *family.*

27 *(B) Rating area.*

28 *(C) Age, except that such rate shall not vary by more than 3 to*
 29 *1 for adults.*

30 *(2) Such rate shall not vary with respect to the particular plan*
 31 *or coverage involved by any other factor not described in*
 32 *paragraph (1).*

33 *(b) This section shall become operative on January 1, 2014.*

34 ~~SEC. 7.~~

35 *SEC. 9. Section 1357.14 of the Health and Safety Code is*
 36 *amended to read:*

37 *1357.14. In connection with the offering for sale of any plan*
 38 *contract to a small employer, each plan shall make a reasonable*
 39 *disclosure, as part of its solicitation and sales materials, of the*
 40 *following:*

1 (a) For plan years commencing on or before December 31, 2013,
2 the extent to which premium rates for a specified small employer
3 are established or adjusted in part based upon the actual or expected
4 variation in service costs or actual or expected variation in health
5 condition of the employees and dependents of the small employer.

6 (b) The provisions concerning the plan's right to change
7 premium rates and the factors other than provision of services
8 experience that affect changes in premium rates.

9 (c) Provisions relating to the guaranteed issue and renewal of
10 contracts.

11 (d) For plan years commencing on or before December 31,
12 2013, provisions relating to the effect of any preexisting condition
13 provision.

14 (e) Provisions relating to the small employer's right to apply
15 for any contract written, issued, or administered by the plan at the
16 time of application for a new health care service plan contract, or
17 at the time of renewal of a health care service plan contract,
18 *consistent with the requirements of PPACA.*

19 (f) The availability, upon request, of a listing of all the plan's
20 contracts and benefit plan designs offered, *both inside and outside*
21 *the California Health Benefit Exchange*, to small employers,
22 including the rates for each contract.

23 (g) At the time it offers a contract to a small employer, each
24 plan shall provide the small employer with a statement of all of
25 its plan contracts offered to small employers, including the rates
26 for each plan contract, in the service area in which the employer's
27 employees and eligible dependents who are to be covered by the
28 plan contract work or reside. For purposes of this subdivision,
29 plans that are affiliated plans or that are eligible to file a
30 consolidated income tax return shall be treated as one health plan.

31 (h) Each plan shall do all of the following:

32 (1) Prepare a brochure that summarizes all of its plan contracts
33 offered to small employers and to make this summary available
34 to any small employer and to solicitors upon request. The summary
35 shall include for each contract information on benefits provided,
36 a generic description of the manner in which services are provided,
37 such as how access to providers is limited, benefit limitations,
38 required copayments and deductibles, *for plan years commencing*
39 *on or before December 31, 2013*, standard employee risk rates,
40 and, for plan years commencing on or before December 31, 2013,

1 an explanation of the manner in which creditable coverage is
2 calculated if a preexisting condition or affiliation period is imposed.
3 The summary shall also include a telephone number that can be
4 called for more detailed benefit information. Plans are required to
5 keep the information contained in the brochure accurate and up to
6 date and, upon updating the brochure, send copies to solicitors and
7 solicitor firms with whom the plan contracts to solicit enrollments
8 or subscriptions. For plan years commencing on or after January
9 1, 2014, a health benefit plan offered to a small employer shall not
10 impose any preexisting condition provision upon any individual.
11 Nothing in this paragraph shall be construed as prohibiting a health
12 benefit plan from restricting enrollment of enrollees to open
13 enrollment periods as authorized under Section 2702 of the federal
14 Patient Protection and Affordable Care Act (Public Law 111-148)
15 and any rules, regulations, or guidance issued consistent with that
16 law.

17 (2) For each contract, prepare a more detailed evidence of
18 coverage and make it available to small employers, solicitors, and
19 solicitor firms upon request. The evidence of coverage shall contain
20 all information that a prudent buyer would need to be aware of in
21 making contract selections.

22 (3) ~~Provide~~ *For plan years commencing on or before December*
23 *31, 2013, provide* to small employers and solicitors, upon request,
24 for any given small employer the sum of the standard employee
25 risk rates and the sum of the risk adjusted employee risk rates.
26 When requesting this information, small employers, solicitors, and
27 solicitor firms shall provide the plan with the information the plan
28 needs to determine the small employer's risk adjusted employee
29 risk rate. For plan years commencing on or after January 1, 2014,
30 no risk adjustment factor may be used in the determination of rates.

31 (4) Provide copies of the current summary brochure to all
32 solicitors and solicitor firms contracting with the plan to solicit
33 enrollments or subscriptions from small employers.

34 For purposes of this subdivision, plans that are affiliated plans
35 or that are eligible to file a consolidated income tax return shall
36 be treated as one health plan.

37 (i) Every solicitor or solicitor firm contracting with one or more
38 plans to solicit enrollments or subscriptions from small employers
39 shall do all of the following:

1 (1) When providing information on contracts to a small
2 employer but making no specific recommendations on particular
3 plan contracts:

4 (A) Advise the small employer of the plan's obligation to sell
5 to any small employer any plan contract it offers to small
6 employers and provide them, upon request, with the actual rates
7 that would be charged to that employer for a given contract.

8 (B) Notify the small employer that the solicitor or solicitor firm
9 will procure rate and benefit information for the small employer
10 on any plan contract offered by a plan whose contract the solicitor
11 sells.

12 (C) Notify the small employer that upon request the solicitor or
13 solicitor firm will provide the small employer with the summary
14 brochure required under paragraph (1) of subdivision (h) for any
15 plan contract offered by a plan with whom the solicitor or solicitor
16 firm has contracted with to solicit enrollments or subscriptions.

17 (D) Notify the small employer of the availability of coverage
18 through the California Health Benefit Exchange and the availability
19 of tax credits for certain employers, and ~~effective January 1, 2014,~~
20 ~~the availability of tax credits through the Exchange.~~

21 (2) When recommending a particular benefit plan design or
22 designs, advise the small employer that, upon request, the agent
23 will provide the small employer with the brochure required by
24 paragraph (1) of subdivision (h) containing the benefit plan design
25 or designs being recommended by the agent or broker.

26 (3) Prior to filing an application for a small employer for a
27 particular contract:

28 (A) For each of the plan contracts offered by the plan whose
29 contract the solicitor or solicitor firm is offering, provide the small
30 employer with the benefit summary required in paragraph (1) of
31 subdivision (h) and, *for plan years commencing on or before*
32 *December 31, 2013*, the sum of the standard employee risk rates
33 for that particular employer.

34 (B) Notify the small employer that, upon request, the solicitor
35 or solicitor firm will provide the small employer with an evidence
36 of coverage brochure for each contract the plan offers.

37 (C) For plan years commencing on or before December 31,
38 2013, notify the small employer that actual rates may be 10 percent
39 higher or lower than the sum of the standard employee risk rates,
40 depending on how the plan assesses the risk of the small

1 employer’s group. For plan years commencing on or after January
2 1, 2014, no risk adjustment factor may be used in the determination
3 of rates.

4 (D) For plan years commencing on or before December 31,
5 2013, notify the small employer that, upon request, the solicitor
6 or solicitor firm will submit information to the plan to ascertain
7 the small employer’s sum of the risk adjusted employee risk rate
8 for any contract the plan offers. On or after November 1, 2013,
9 notify the small employer of the employee rate effective January
10 1, 2014. For plan years commencing on or after January 1, 2014,
11 no risk adjustment factor may be used in the determination of rates.

12 (E) Obtain a signed statement from the small employer
13 acknowledging that the small employer has received the disclosures
14 required by this section.

15 ~~SEC. 8.~~

16 *SEC. 10.* Section 1357.15 of the Health and Safety Code is
17 amended to read:

18 1357.15. (a) At least 60 calendar days prior to renewing or
19 amending a plan contract subject to this article which will be in
20 force on the operative date of this article, a plan shall file a notice
21 of material modification with the director in accordance with the
22 provisions of Section 1352. The notice of material modification
23 shall include a statement certifying that the plan is in compliance
24 with subdivision (j) of Section 1357 and Section 1357.12. For rates
25 in effect until January 1, 2014, the certified statement shall set
26 forth the standard employee risk rate for each risk category and
27 the highest and lowest risk adjustment factors that will be used in
28 setting the rates at which the contract will be renewed or amended.
29 Any action by the director, as permitted under Section 1352, to
30 disapprove, suspend, or postpone the plan’s use of a plan contract
31 shall be in writing, specifying the reasons that the plan contract
32 does not comply with the requirements of this chapter.

33 (b) At least 60 calendar days prior to offering a plan contract
34 subject to this article, all plans shall file a notice of material
35 modification with the director in accordance with the provisions
36 of Section 1352. The notice of material modification shall include
37 a statement certifying that the plan is in compliance with
38 subdivision (j) of Section 1357 and Section 1357.12. For rates in
39 effect until January 1, 2014, the certified statement shall set forth
40 the standard employee risk rate for each risk category and the

1 highest and lowest risk adjustment factors that will be used in
2 setting the rates at which the contract will be offered. Plans that
3 will be offering to a small employer plan contracts approved by
4 the director prior to the effective date of this article shall file a
5 notice of material modification in accordance with this subdivision.
6 Any action by the director, as permitted under Section 1352, to
7 disapprove, suspend, or postpone the plan's use of a plan contract
8 shall be in writing, specifying the reasons that the plan contract
9 does not comply with the requirements of this chapter.

10 (c) ~~Prior~~ *For plan years commencing on or before December*
11 *31, 2013, prior to making any changes in the risk categories or*
12 *standard employee risk rates filed with the director pursuant to*
13 *subdivision (a) or (b), the plan shall file as an amendment a*
14 *statement setting forth the changes and certifying that the plan is*
15 *in compliance with subdivision (j) of Section 1357 and Section*
16 *1357.12. A plan may commence offering plan contracts utilizing*
17 *the changed risk categories set forth in the certified statement on*
18 *the 31st day from the date of the filing, or at an earlier time*
19 *determined by the director, unless the director disapproves the*
20 *amendment by written notice, stating the reasons therefor. If only*
21 *the standard employee risk rate is being changed, and not the risk*
22 *categories, a plan may commence offering plan contracts utilizing*
23 *the changed standard employee risk rate upon filing the certified*
24 *statement unless the director disapproves the amendment by written*
25 *notice.*

26 (d) Periodic changes to the standard employee risk rate that a
27 plan proposes to implement over the course of up to 12 consecutive
28 months may be filed in conjunction with the certified statement
29 filed under subdivision (a), (b), or (c).

30 (e) Each plan shall maintain at its principal place of business
31 all of the information required to be filed with the director pursuant
32 to this section.

33 (f) ~~Each~~ *For plan years commencing on or before December*
34 *31, 2013, each plan shall make available to the director, on request,*
35 *the risk adjustment factor used in determining the rate for any*
36 *particular small employer.*

37 (g) Nothing in this section shall be construed to limit the
38 director's authority to enforce the rating practices set forth in this
39 article.

1 (h) This section shall remain in effect only until January 1, 2014,
 2 and as of that date is repealed, unless a later enacted statute, that
 3 is enacted before January 1, 2014, deletes or extends that date.

4 ~~SEC. 9.~~

5 *SEC. 11.* Section 1357.15 is added to the Health and Safety
 6 Code, to read:

7 1357.15. (a) At least 60 calendar days prior to renewing or
 8 amending a plan contract subject to this article which will be in
 9 force on the operative date of this article, a plan shall file a notice
 10 of material modification with the director in accordance with the
 11 provisions of Section 1352. The notice of material modification
 12 shall include a statement certifying that the plan is in compliance
 13 with subdivision (j) of Section 1357 and Section 1357.12. Any
 14 action by the director, as permitted under Section 1352, to
 15 disapprove, suspend, or postpone the plan’s use of a plan contract
 16 shall be in writing, specifying the reasons that the plan contract
 17 does not comply with the requirements of this chapter.

18 (b) At least 60 calendar days prior to offering a plan contract
 19 subject to this article, all plans shall file a notice of material
 20 modification with the director in accordance with the provisions
 21 of Section 1352. The notice of material modification shall include
 22 a statement certifying that the plan is in compliance with
 23 subdivision (j) of Section 1357 and Section 1357.12. Plans that
 24 will be offering to a small employer plan contracts approved by
 25 the director prior to the effective date of this article shall file a
 26 notice of material modification in accordance with this subdivision.
 27 Any action by the director, as permitted under Section 1352, to
 28 disapprove, suspend, or postpone the plan’s use of a plan contract
 29 shall be in writing, specifying the reasons that the plan contract
 30 does not comply with the requirements of this chapter.

31 ~~(c) Prior to making any changes in the risk categories or standard~~
 32 ~~employee risk rates filed with the director pursuant to subdivision~~
 33 ~~(a) or (b), the plan shall file as an amendment a statement setting~~
 34 ~~forth the changes and certifying that the plan is in compliance with~~
 35 ~~subdivision (j) of Section 1357 and Section 1357.12. A plan may~~
 36 ~~commence offering plan contracts utilizing the changed risk~~
 37 ~~categories set forth in the certified statement on the 31st day from~~
 38 ~~the date of the filing, or at an earlier time determined by the~~
 39 ~~director, unless the director disapproves the amendment by written~~
 40 ~~notice, stating the reasons therefor. If only the standard employee~~

1 risk rate is being changed, and not the risk categories, a plan may
2 commence offering plan contracts utilizing the changed standard
3 employee risk rate upon filing the certified statement unless the
4 director disapproves the amendment by written notice. For plan
5 years commencing on or after January 1, 2014, no risk adjustment
6 factor may be used in the determination of rates.

7 (d)

8 (c) Each plan shall maintain at its principal place of business
9 all of the information required to be filed with the director pursuant
10 to this section.

11 (e)

12 (d) Nothing in this section shall be construed to limit the
13 director's authority to enforce the rating practices set forth in this
14 article.

15 (f)

16 (e) This section shall become operative on January 1, 2014.

17 ~~SEC. 10. Section 1357.50 of the Health and Safety Code is~~
18 ~~amended to read:~~

19 ~~1357.50. For purposes of this article:~~

20 (a) ~~“Health benefit plan” means any individual or group~~
21 ~~insurance policy or health care service plan contract that provides~~
22 ~~medical, hospital, and surgical benefits. The term does not include~~
23 ~~accident only, credit, disability income, coverage of Medicare~~
24 ~~services pursuant to contracts with the United States government,~~
25 ~~Medicare supplement, long-term care insurance, dental, vision,~~
26 ~~coverage issued as a supplement to liability insurance, insurance~~
27 ~~arising out of a workers' compensation or similar law, automobile~~
28 ~~medical payment insurance, or insurance under which benefits are~~
29 ~~payable with or without regard to fault and that is statutorily~~
30 ~~required to be contained in any liability insurance policy or~~
31 ~~equivalent self-insurance.~~

32 (b) ~~“Late enrollee” means an eligible employee or dependent~~
33 ~~who has declined health coverage under a health benefit plan~~
34 ~~offered through employment or sponsored by an employer at the~~
35 ~~time of the initial enrollment period provided under the terms of~~
36 ~~the health benefit plan, and who subsequently requests enrollment~~
37 ~~in a health benefit plan of that employer, provided that the initial~~
38 ~~enrollment period shall be a period of at least 30 days. However,~~
39 ~~an eligible employee or dependent shall not be considered a late~~
40 ~~enrollee if any of the following is applicable:~~

- 1 ~~(1) The individual meets all of the following requirements:~~
- 2 ~~(A) The individual was covered under another employer health~~
- 3 ~~benefit plan, the Healthy Families Program, the Access for Infants~~
- 4 ~~and Mothers (AIM) Program, or the Medi-Cal program, at the time~~
- 5 ~~the individual was eligible to enroll.~~
- 6 ~~(B) The individual certified, at the time of the initial enrollment,~~
- 7 ~~that coverage under another employer health benefit plan, the~~
- 8 ~~Healthy Families Program, the AIM Program, or the Medi-Cal~~
- 9 ~~program was the reason for declining enrollment provided that, if~~
- 10 ~~the individual was covered under another employer health benefit~~
- 11 ~~plan, the individual was given the opportunity to make the~~
- 12 ~~certification required by this subdivision and was notified that~~
- 13 ~~failure to do so could result in later treatment as a late enrollee.~~
- 14 ~~(C) The individual has lost or will lose coverage under another~~
- 15 ~~employer health benefit plan as a result of termination of~~
- 16 ~~employment of the individual or of a person through whom the~~
- 17 ~~individual was covered as a dependent, change in employment~~
- 18 ~~status of the individual or of a person through whom the individual~~
- 19 ~~was covered as a dependent, termination of the other plan's~~
- 20 ~~coverage, cessation of an employer's contribution toward an~~
- 21 ~~employee's or dependent's coverage, death of a person through~~
- 22 ~~whom the individual was covered as a dependent, legal separation,~~
- 23 ~~or divorce; or the individual has lost or will lose coverage under~~
- 24 ~~the Healthy Families Program, the AIM Program, or the Medi-Cal~~
- 25 ~~program.~~
- 26 ~~(D) The individual requests enrollment within 30 days after~~
- 27 ~~termination of coverage, or cessation of employer contribution~~
- 28 ~~toward coverage provided under another employer health benefit~~
- 29 ~~plan, or requests enrollment within 60 days after termination of~~
- 30 ~~Medi-Cal program coverage, AIM Program coverage, or Healthy~~
- 31 ~~Families Program coverage.~~
- 32 ~~(2) The individual is employed by an employer that offers~~
- 33 ~~multiple health benefit plans and the individual elects a different~~
- 34 ~~plan during an open enrollment period.~~
- 35 ~~(3) A court has ordered that coverage be provided for a spouse~~
- 36 ~~or minor child under a covered employee's health benefit plan.~~
- 37 ~~The health benefit plan shall enroll a dependent child within 30~~
- 38 ~~days after receipt of a court order or request from the district~~
- 39 ~~attorney, either parent or the person having custody of the child~~
- 40 ~~as defined in Section 3751.5 of the Family Code, the employer,~~

1 or the group administrator. In the case of children who are eligible
2 for Medicaid, the State Department of Health Care Services may
3 also make the request.

4 ~~(4) The plan cannot produce a written statement from the~~
5 ~~employer stating that, prior to declining coverage, the individual~~
6 ~~or the person through whom the individual was eligible to be~~
7 ~~covered as a dependent was provided with, and signed~~
8 ~~acknowledgment of, explicit written notice in boldface type~~
9 ~~specifying that failure to elect coverage during the initial~~
10 ~~enrollment period permits the plan to impose, at the time of the~~
11 ~~individual's later decision to elect coverage, an exclusion from~~
12 ~~coverage for a period of 12 months as well as a six-month~~
13 ~~preexisting condition exclusion, unless the individual meets the~~
14 ~~criteria specified in paragraph (1), (2), or (3).~~

15 ~~(5) The individual is an employee or dependent who meets the~~
16 ~~criteria described in paragraph (1) and was under a COBRA~~
17 ~~continuation provision, and the coverage under that provision has~~
18 ~~been exhausted. For purposes of this section, the definition of~~
19 ~~“COBRA” set forth in subdivision (e) of Section 1373.621 shall~~
20 ~~apply.~~

21 ~~(6) The individual is a dependent of an enrolled eligible~~
22 ~~employee who has lost or will lose his or her coverage under the~~
23 ~~Healthy Families Program, the AIM Program, or the Medi-Cal~~
24 ~~program, and requests enrollment within 60 days of termination~~
25 ~~of that coverage.~~

26 ~~(7) The individual is an eligible employee who previously~~
27 ~~declined coverage under an employer health benefit plan and who~~
28 ~~has subsequently acquired a dependent who would be eligible for~~
29 ~~coverage as a dependent of the employee through marriage, birth,~~
30 ~~adoption, or placement for adoption, and who enrolls for coverage~~
31 ~~under that employer health benefit plan on his or her behalf, and~~
32 ~~on behalf of his or her dependent within 30 days following the~~
33 ~~date of marriage, birth, adoption, or placement for adoption, in~~
34 ~~which case the effective date of coverage shall be the first day of~~
35 ~~the month following the date the completed request for enrollment~~
36 ~~is received in the case of marriage, or the date of birth, or the date~~
37 ~~of adoption or placement for adoption, whichever applies. Notice~~
38 ~~of the special enrollment rights contained in this paragraph shall~~
39 ~~be provided by the employer to an employee at or before the time~~
40 ~~the employee is offered an opportunity to enroll in plan coverage.~~

1 ~~(8) The individual is an eligible employee who has declined~~
2 ~~coverage for himself or herself or his or her dependents during a~~
3 ~~previous enrollment period because his or her dependents were~~
4 ~~covered by another employer health benefit plan at the time of the~~
5 ~~previous enrollment period. That individual may enroll himself or~~
6 ~~herself or his or her dependents for plan coverage during a special~~
7 ~~open enrollment opportunity if his or her dependents have lost or~~
8 ~~will lose coverage under that other employer health benefit plan.~~
9 ~~The special open enrollment opportunity shall be requested by the~~
10 ~~employee not more than 30 days after the date that the other health~~
11 ~~coverage is exhausted or terminated. Upon enrollment, coverage~~
12 ~~shall be effective not later than the first day of the first calendar~~
13 ~~month beginning after the date the request for enrollment is~~
14 ~~received. Notice of the special enrollment rights contained in this~~
15 ~~paragraph shall be provided by the employer to an employee at or~~
16 ~~before the time the employee is offered an opportunity to enroll~~
17 ~~in plan coverage.~~

18 ~~(e) Until December 31, 2013, “preexisting condition provision”~~
19 ~~means a contract provision that excludes coverage for charges or~~
20 ~~expenses incurred during a specified period following the enrollee’s~~
21 ~~effective date of coverage, as to a condition for which medical~~
22 ~~advice, diagnosis, care, or treatment was recommended or received~~
23 ~~during a specified period immediately preceding the effective date~~
24 ~~of coverage.~~

25 ~~(d) “Creditable coverage” means:~~

26 ~~(1) Any individual or group policy, contract, or program that is~~
27 ~~written or administered by a disability insurance company,~~
28 ~~nonprofit hospital service plan, health care service plan, fraternal~~
29 ~~benefits society, self-insured employer plan, or any other entity,~~
30 ~~in this state or elsewhere, and that arranges or provides medical,~~
31 ~~hospital, and surgical coverage not designed to supplement other~~
32 ~~private or governmental plans. The term includes continuation or~~
33 ~~conversion coverage but does not include accident only, credit,~~
34 ~~coverage for onsite medical clinics, disability income, Medicare~~
35 ~~supplement, long-term care insurance, dental, vision, coverage~~
36 ~~issued as a supplement to liability insurance, insurance arising out~~
37 ~~of a workers’ compensation or similar law, automobile medical~~
38 ~~payment insurance, or insurance under which benefits are payable~~
39 ~~with or without regard to fault and that is statutorily required to~~

1 ~~be contained in any liability insurance policy or equivalent~~
2 ~~self-insurance.~~

3 ~~(2) The Medicare Program pursuant to Title XVIII of the federal~~
4 ~~Social Security Act (42 U.S.C. Sec. 1395 et seq.).~~

5 ~~(3) The Medicaid Program pursuant to Title XIX of the federal~~
6 ~~Social Security Act (42 U.S.C. Sec. 1396 et seq.).~~

7 ~~(4) Any other publicly sponsored program, provided in this state~~
8 ~~or elsewhere, of medical, hospital, and surgical care.~~

9 ~~(5) 10 U.S.C. Chapter 55 (commencing with Section 1071)~~
10 ~~(Civilian Health and Medical Program of the Uniformed Services~~
11 ~~(CHAMPUS)).~~

12 ~~(6) A medical care program of the Indian Health Service or of~~
13 ~~a tribal organization.~~

14 ~~(7) A state health benefits risk pool.~~

15 ~~(8) A health plan offered under 5 U.S.C. Chapter 89~~
16 ~~(commencing with Section 8901) (Federal Employees Health~~
17 ~~Benefits Program (FEHBP)).~~

18 ~~(9) A public health plan as defined in federal regulations~~
19 ~~authorized by Section 2701(e)(1)(I) of the Public Health Service~~
20 ~~Act, as amended by Public Law 104-191, the Health Insurance~~
21 ~~Portability and Accountability Act of 1996.~~

22 ~~(10) A health benefit plan under Section 5(e) of the Peace Corps~~
23 ~~Act (22 U.S.C. Sec. 2504(e)).~~

24 ~~(11) Any other creditable coverage as defined by subdivision~~
25 ~~(c) of Section 2704 of Title XXVII of the federal Public Health~~
26 ~~Service Act (42 U.S.C. Sec. 300gg-3(c)).~~

27 ~~(e) "Waivered condition" means a contract provision that~~
28 ~~excludes coverage for charges or expenses incurred during a~~
29 ~~specified period of time for one or more specific, identified,~~
30 ~~medical conditions.~~

31 ~~(f) "Affiliation period" means a period that, under the terms of~~
32 ~~the health benefit plan, must expire before health care services~~
33 ~~under the plan become effective.~~

34 ~~(g) This section shall remain in effect only until January 1, 2014,~~
35 ~~and as of that date is repealed, unless a later enacted statute, that~~
36 ~~is enacted before January 1, 2014, deletes or extends that date.~~

37 ~~SEC. 11. Section 1357.50 is added to the Health and Safety~~
38 ~~Code, to read:~~

39 ~~1357.50. For purposes of this article:~~

1 (a) ~~“Health benefit plan” means any individual or group~~
2 ~~insurance policy or health care service plan contract that provides~~
3 ~~essential health benefits as defined consistent with Section 1302~~
4 ~~of the federal Patient Protection and Affordable Care Act (Public~~
5 ~~Law 111-148). The term does not include accident only, credit,~~
6 ~~disability income, coverage of Medicare services pursuant to~~
7 ~~contracts with the United States government, Medicare supplement,~~
8 ~~long-term care insurance, dental, vision, coverage issued as a~~
9 ~~supplement to liability insurance, insurance arising out of a~~
10 ~~workers’ compensation or similar law, automobile medical payment~~
11 ~~insurance, or insurance under which benefits are payable with or~~
12 ~~without regard to fault and that is statutorily required to be~~
13 ~~contained in any liability insurance policy or equivalent~~
14 ~~self-insurance. The term does not include a grandfathered plan as~~
15 ~~defined in Section 1251 of the federal Patient Protection and~~
16 ~~Affordable Care Act (Public Law 111-148).~~

17 (b) ~~“Late enrollee” means an eligible employee or dependent~~
18 ~~who has declined health coverage under a health benefit plan~~
19 ~~offered through employment or sponsored by an employer at the~~
20 ~~time of the initial enrollment period provided under the terms of~~
21 ~~the health benefit plan, and who subsequently requests enrollment~~
22 ~~in a health benefit plan of that employer, provided that the initial~~
23 ~~enrollment period shall be a period of at least 30 days. However,~~
24 ~~an eligible employee or dependent shall not be considered a late~~
25 ~~enrollee if any of the following is applicable:~~

26 (1) ~~The individual meets all of the following requirements:~~

27 (A) ~~The individual was covered under another employer health~~
28 ~~benefit plan, the Healthy Families Program, the Access for Infants~~
29 ~~and Mothers (AIM) Program, the Medi-Cal program, or the~~
30 ~~California Health Benefit Exchange, at the time the individual was~~
31 ~~eligible to enroll.~~

32 (B) ~~The individual certified, at the time of the initial enrollment,~~
33 ~~that coverage under another employer health benefit plan, the~~
34 ~~Healthy Families Program, the AIM Program, the Medi-Cal~~
35 ~~program, or the California Health Benefit Exchange was the reason~~
36 ~~for declining enrollment provided that, if the individual was~~
37 ~~covered under another employer health benefit plan, the individual~~
38 ~~was given the opportunity to make the certification required by~~
39 ~~this subdivision and was notified that failure to do so could result~~
40 ~~in later treatment as a late enrollee.~~

1 ~~(C) The individual has lost or will lose coverage under another~~
2 ~~employer health benefit plan as a result of termination of~~
3 ~~employment of the individual or of a person through whom the~~
4 ~~individual was covered as a dependent, change in employment~~
5 ~~status of the individual or of a person through whom the individual~~
6 ~~was covered as a dependent, termination of the other plan's~~
7 ~~coverage, cessation of an employer's contribution toward an~~
8 ~~employee's or dependent's coverage, death of a person through~~
9 ~~whom the individual was covered as a dependent, legal separation,~~
10 ~~or divorce; or the individual has lost or will lose coverage under~~
11 ~~the Healthy Families Program, the AIM Program, the Medi-Cal~~
12 ~~program, or the California Health Benefit Exchange.~~

13 ~~(D) The individual requests enrollment within 30 days after~~
14 ~~termination of coverage, or cessation of employer contribution~~
15 ~~toward coverage provided under another employer health benefit~~
16 ~~plan, or requests enrollment within 60 days after termination of~~
17 ~~Medi-Cal program coverage, AIM Program coverage, Healthy~~
18 ~~Families Program coverage, or coverage through the California~~
19 ~~Health Benefit Exchange.~~

20 ~~(2) The individual is employed by an employer that offers~~
21 ~~multiple health benefit plans and the individual elects a different~~
22 ~~plan during an open enrollment period.~~

23 ~~(3) A court has ordered that coverage be provided for a spouse~~
24 ~~or minor child under a covered employee's health benefit plan.~~
25 ~~The health benefit plan shall enroll a dependent child within 30~~
26 ~~days after receipt of a court order or request from the district~~
27 ~~attorney, either parent or the person having custody of the child~~
28 ~~as defined in Section 3751.5 of the Family Code, the employer,~~
29 ~~or the group administrator. In the case of children who are eligible~~
30 ~~for Medicaid, the State Department of Health Care Services may~~
31 ~~also make the request.~~

32 ~~(4) The plan cannot produce a written statement from the~~
33 ~~employer stating that, prior to declining coverage, the individual~~
34 ~~or the person through whom the individual was eligible to be~~
35 ~~covered as a dependent was provided with, and signed~~
36 ~~acknowledgment of, explicit written notice in boldface type~~
37 ~~specifying that failure to elect coverage during the initial~~
38 ~~enrollment period permits the plan to impose, at the time of the~~
39 ~~individual's later decision to elect coverage, an exclusion from~~
40 ~~coverage for a period of 12 months as well as a six-month~~

1 preexisting condition exclusion, unless the individual meets the
2 criteria specified in paragraph (1), (2), or (3).

3 (5) The individual is an employee or dependent who meets the
4 criteria described in paragraph (1) and was under a COBRA
5 continuation provision, and the coverage under that provision has
6 been exhausted. For purposes of this section, the definition of
7 “COBRA” set forth in subdivision (e) of Section 1373.621 shall
8 apply.

9 (6) The individual is a dependent of an enrolled eligible
10 employee who has lost or will lose his or her coverage under the
11 Healthy Families Program, the AIM Program, the Medi-Cal
12 program, or the California Health Benefit Exchange, and requests
13 enrollment within 60 days of termination of that coverage.

14 (7) The individual is an eligible employee who previously
15 declined coverage under an employer health benefit plan and who
16 has subsequently acquired a dependent who would be eligible for
17 coverage as a dependent of the employee through marriage, birth,
18 adoption, or placement for adoption, and who enrolls for coverage
19 under that employer health benefit plan on his or her behalf, and
20 on behalf of his or her dependent within 30 days following the
21 date of marriage, birth, adoption, or placement for adoption, in
22 which case the effective date of coverage shall be the first day of
23 the month following the date the completed request for enrollment
24 is received in the case of marriage, or the date of birth, or the date
25 of adoption or placement for adoption, whichever applies. Notice
26 of the special enrollment rights contained in this paragraph shall
27 be provided by the employer to an employee at or before the time
28 the employee is offered an opportunity to enroll in plan coverage.

29 (8) The individual is an eligible employee who has declined
30 coverage for himself or herself or his or her dependents during a
31 previous enrollment period because his or her dependents were
32 covered by another employer health benefit plan at the time of the
33 previous enrollment period. That individual may enroll himself or
34 herself or his or her dependents for plan coverage during a special
35 open enrollment opportunity if his or her dependents have lost or
36 will lose coverage under that other employer health benefit plan.
37 The special open enrollment opportunity shall be requested by the
38 employee not more than 30 days after the date that the other health
39 coverage is exhausted or terminated. Upon enrollment, coverage
40 shall be effective not later than the first day of the first calendar

1 month beginning after the date the request for enrollment is
2 received. Notice of the special enrollment rights contained in this
3 paragraph shall be provided by the employer to an employee at or
4 before the time the employee is offered an opportunity to enroll
5 in plan coverage.

6 (e) ~~On or after January 1, 2014, a plan contract shall not establish~~
7 ~~any preexisting condition exclusion or limitation for any individual~~
8 ~~or dependent of an individual, whether or not any medical advice,~~
9 ~~diagnosis, care, or treatment was recommended or received before~~
10 ~~that date. A preexisting condition exclusion includes any limitation~~
11 ~~or exclusion of benefits, including a denial of coverage, applicable~~
12 ~~to an individual as a result of information relating to an individual's~~
13 ~~health status before the individual's effective date of coverage~~
14 ~~under a group health plan, or group or individual health insurance~~
15 ~~coverage, such as a condition identified as a result of a~~
16 ~~preenrollment questionnaire or physical examination given to the~~
17 ~~individual, or review of medical records relating to the~~
18 ~~preenrollment period.~~

19 (d) “Creditable coverage” means:

20 (1) ~~Any individual or group policy, contract, or program that is~~
21 ~~written or administered by a disability insurance company,~~
22 ~~nonprofit hospital service plan, health care service plan, fraternal~~
23 ~~benefits society, self-insured employer plan, or any other entity,~~
24 ~~in this state or elsewhere, and that arranges or provides medical,~~
25 ~~hospital, and surgical coverage not designed to supplement other~~
26 ~~private or governmental plans. The term includes continuation or~~
27 ~~conversion coverage but does not include accident only, credit,~~
28 ~~coverage for onsite medical clinics, disability income, Medicare~~
29 ~~supplement, long-term care insurance, dental, vision, coverage~~
30 ~~issued as a supplement to liability insurance, insurance arising out~~
31 ~~of a workers' compensation or similar law, automobile medical~~
32 ~~payment insurance, or insurance under which benefits are payable~~
33 ~~with or without regard to fault and that is statutorily required to~~
34 ~~be contained in any liability insurance policy or equivalent~~
35 ~~self-insurance.~~

36 (2) ~~The Medicare Program pursuant to Title XVIII of the federal~~
37 ~~Social Security Act (42 U.S.C. Sec. 1395 et seq.).~~

38 (3) ~~The Medicaid Program pursuant to Title XIX of the federal~~
39 ~~Social Security Act (42 U.S.C. Sec. 1396 et seq.).~~

- 1 ~~(4) Any other publicly sponsored program, provided in this state~~
2 ~~or elsewhere, of medical, hospital, and surgical care.~~
3 ~~(5) 10 U.S.C. Chapter 55 (commencing with Section 1071)~~
4 ~~(Civilian Health and Medical Program of the Uniformed Services~~
5 ~~(CHAMPUS)).~~
6 ~~(6) A medical care program of the Indian Health Service or of~~
7 ~~a tribal organization.~~
8 ~~(7) A state health benefits risk pool.~~
9 ~~(8) A health plan offered under 5 U.S.C. Chapter 89~~
10 ~~(commencing with Section 8901) (Federal Employees Health~~
11 ~~Benefits Program (FEHBP)).~~
12 ~~(9) A public health plan as defined in federal regulations~~
13 ~~authorized by Section 2701(e)(1)(I) of the Public Health Service~~
14 ~~Act, as amended by Public Law 104-191, the Health Insurance~~
15 ~~Portability and Accountability Act of 1996.~~
16 ~~(10) A health benefit plan under Section 5(e) of the Peace Corps~~
17 ~~Act (22 U.S.C. Sec. 2504(e)).~~
18 ~~(11) Any other creditable coverage as defined by subdivision~~
19 ~~(e) of Section 2704 of Title XXVII of the federal Public Health~~
20 ~~Service Act (42 U.S.C. Sec. 300gg-3(c)).~~
21 ~~(e) “Waiting period” means the period that is required to pass~~
22 ~~with respect to the employee before the employee is eligible to be~~
23 ~~covered for benefits under the terms of the policy. However, such~~
24 ~~periods shall not be based upon health status of the employee or~~
25 ~~dependent. For plan years commencing on or after January 1, 2014,~~
26 ~~a health benefit plan may permit a waiting period of up to 90 days~~
27 ~~as a condition of enrollment if applied equally to all full-time~~
28 ~~employees, consistent with the federal Patient Protection and~~
29 ~~Affordable Care Act (Public Law 111-148) and any rules,~~
30 ~~regulations, or guidance issued consistent with that law.~~
31 ~~(f) “Plan year” means a consecutive 12-month period during~~
32 ~~which a health benefit plan provides coverage for health benefits.~~
33 ~~A plan year may be a calendar year or otherwise. This definition~~
34 ~~shall apply to the extent it is consistent with the federal Patient~~
35 ~~Protection and Affordable Care Act (Public Law 111-148) and~~
36 ~~any federal rules, regulations, or guidance issued consistent with~~
37 ~~that law.~~
38 ~~(g) This section shall become operative on January 1, 2014.~~
39 ~~SEC. 12. Section 1357.51 of the Health and Safety Code is~~
40 ~~amended to read:~~

1 1357.51. ~~(a) For plan years commencing on or before~~
2 ~~December 31, 2013, no plan contract that covers three or more~~
3 ~~enrollees shall exclude coverage for any individual on the basis~~
4 ~~of a preexisting condition provision for a period greater than six~~
5 ~~months following the individual's effective date of coverage.~~
6 ~~Preexisting condition provisions contained in plan contracts may~~
7 ~~relate only to conditions for which medical advice, diagnosis, care,~~
8 ~~or treatment, including use of prescription drugs, was recommended~~
9 ~~or received from a licensed health practitioner during the six~~
10 ~~months immediately preceding the effective date of coverage.~~

11 ~~(b) For plan years commencing on or before December 31,~~
12 ~~2013, no plan contract that covers one or two individuals shall~~
13 ~~exclude coverage on the basis of a preexisting condition provision~~
14 ~~for a period greater than 12 months following the individual's~~
15 ~~effective date of coverage, nor shall the plan limit or exclude~~
16 ~~coverage for a specific enrollee by type of illness, treatment,~~
17 ~~medical condition, or accident, except for satisfaction of a~~
18 ~~preexisting condition clause pursuant to this article. Preexisting~~
19 ~~condition provisions contained in plan contracts may relate only~~
20 ~~to conditions for which medical advice, diagnosis, care, or~~
21 ~~treatment, including use of prescription drugs, was recommended~~
22 ~~or received from a licensed health practitioner during the 12 months~~
23 ~~immediately preceding the effective date of coverage.~~

24 ~~(c) (1) Notwithstanding subdivision (a), a plan contract for~~
25 ~~group coverage shall not impose any preexisting condition~~
26 ~~provision upon any child under 19 years of age.~~

27 ~~(2) Notwithstanding subdivision (b), a plan contract for~~
28 ~~individual coverage that is not a grandfathered health plan within~~
29 ~~the meaning of Section 1251 of the federal Patient Protection and~~
30 ~~Affordable Care Act (Public Law 111-148) shall not impose any~~
31 ~~preexisting condition provision upon any child under 19 years of~~
32 ~~age.~~

33 ~~(d) For plan years commencing on or before December 31,~~
34 ~~2013, a plan that does not utilize a preexisting condition provision~~
35 ~~may impose a waiting period or affiliation period not to exceed~~
36 ~~60 days, before the coverage issued subject to this article shall~~
37 ~~become effective. During the waiting or affiliation period, the plan~~
38 ~~is not required to provide health care services and no premium~~
39 ~~shall be charged to the subscriber or enrollee.~~

1 ~~(e) For plan years commencing on or before December 31, 2013,~~
2 ~~a plan that does not utilize a preexisting condition provision in~~
3 ~~plan contracts that cover one or two individuals may impose a~~
4 ~~contract provision excluding coverage for waived conditions.~~
5 ~~No plan may exclude coverage on the basis of a waived condition~~
6 ~~for a period greater than 12 months following the individual's~~
7 ~~effective date of coverage. A waived condition provision~~
8 ~~contained in plan contracts may relate only to conditions for which~~
9 ~~medical advice, diagnosis, care, or treatment, including use of~~
10 ~~prescription drugs, was recommended or received from a licensed~~
11 ~~health practitioner during the 12 months immediately preceding~~
12 ~~the effective date of coverage.~~

13 ~~(f) For plan years commencing on or before December 31, 2013,~~
14 ~~in determining whether a preexisting condition provision, a~~
15 ~~waived condition provision, or a waiting or affiliation period~~
16 ~~applies to any enrollee, a plan shall credit the time the enrollee~~
17 ~~was covered under creditable coverage, provided that the enrollee~~
18 ~~becomes eligible for coverage under the succeeding plan contract~~
19 ~~within 62 days of termination of prior coverage, exclusive of any~~
20 ~~waiting or affiliation period, and applies for coverage under the~~
21 ~~succeeding plan within the applicable enrollment period. A plan~~
22 ~~shall also credit any time that an eligible employee must wait~~
23 ~~before enrolling in the plan, including any postenrollment or~~
24 ~~employer-imposed waiting or affiliation period.~~

25 ~~However, if a person's employment has ended, the availability~~
26 ~~of health coverage offered through employment or sponsored by~~
27 ~~an employer has terminated, or an employer's contribution toward~~
28 ~~health coverage has terminated, a plan shall credit the time the~~
29 ~~person was covered under creditable coverage if the person~~
30 ~~becomes eligible for health coverage offered through employment~~
31 ~~or sponsored by an employer within 180 days, exclusive of any~~
32 ~~waiting or affiliation period, and applies for coverage under the~~
33 ~~succeeding plan contract within the applicable enrollment period.~~

34 ~~(g) For plan years commencing on or before December 31,~~
35 ~~2013, no plan shall exclude late enrollees from coverage for more~~
36 ~~than 12 months from the date of the late enrollee's application for~~
37 ~~coverage. No plan shall require any premium or other periodic~~
38 ~~charge to be paid by or on behalf of a late enrollee during the period~~
39 ~~of exclusion from coverage permitted by this subdivision.~~

1 ~~(h) A health care service plan issuing group coverage may not~~
2 ~~impose a preexisting condition exclusion upon a condition relating~~
3 ~~to benefits for pregnancy or maternity care.~~

4 ~~(i) An individual's period of creditable coverage shall be~~
5 ~~certified pursuant to subsection (e) of Section 2704 of Title XXVII~~
6 ~~of the federal Public Health Service Act (42 U.S.C. Sec.~~
7 ~~300gg-3(e)).~~

8 ~~(j) This section shall remain in effect only until January 1, 2014,~~
9 ~~and as of that date is repealed, unless a later enacted statute, that~~
10 ~~is enacted before January 1, 2014, deletes or extends that date.~~

11 ~~SEC. 13. Section 1357.51 is added to the Health and Safety~~
12 ~~Code, to read:~~

13 ~~1357.51. (a) No plan contract that covers one or more enrollees~~
14 ~~shall exclude coverage for any individual on the basis of a~~
15 ~~preexisting condition.~~

16 ~~(b) (1) A plan contract for group coverage shall not impose any~~
17 ~~preexisting condition provision upon any individual. A preexisting~~
18 ~~condition provision includes any limitation or exclusion of benefits,~~
19 ~~including a denial of coverage, applicable to an individual as a~~
20 ~~result of information relating to an individual's health status before~~
21 ~~the individual's effective date of coverage under a group or~~
22 ~~individual health plan such as a condition identified as a result of~~
23 ~~a preenrollment questionnaire or physical examination given to~~
24 ~~the individual, or review of medical records relating to the~~
25 ~~preenrollment period.~~

26 ~~(2) A plan contract for individual coverage that is not a~~
27 ~~grandfathered health plan within the meaning of Section 1251 of~~
28 ~~the federal Patient Protection and Affordable Care Act (Public~~
29 ~~Law 111-148) shall not impose any preexisting condition provision~~
30 ~~upon any individual.~~

31 ~~(c) For plan years commencing on or after January 1, 2014, a~~
32 ~~plan may impose a 90-day waiting period from the date of the late~~
33 ~~enrollee's application for coverage. A plan contract may permit a~~
34 ~~waiting period of up to 90 days as a condition of enrollment if~~
35 ~~applied equally to all full-time employees and if consistent with~~
36 ~~the federal Patient Protection and Affordable Care Act (Public~~
37 ~~Law 111-148) and any rules, regulations, or guidance issued~~
38 ~~consistent with that law.~~

- 1 ~~(d) A health care service plan issuing group coverage may not~~
2 ~~impose a preexisting condition exclusion based on health~~
3 ~~status-related factors, including, but not limited to, the following:~~
4 ~~(1) Health status.~~
5 ~~(2) Medical condition, including both physical and mental~~
6 ~~illnesses.~~
7 ~~(3) Claims experience.~~
8 ~~(4) Receipt of medical care.~~
9 ~~(5) Medical history.~~
10 ~~(6) Genetic information.~~
11 ~~(7) Evidence of insurability, including conditions arising from~~
12 ~~domestic violence.~~
13 ~~(8) Disability.~~
14 ~~(9) Any other health status-related factor determined appropriate~~
15 ~~by the federal government.~~
16 ~~(10) Any other health status-related factor determined~~
17 ~~appropriate by the director.~~
18 ~~(e) An individual's period of creditable coverage shall be~~
19 ~~certified pursuant to subsection (e) of Section 2704 of Title XXVII~~
20 ~~of the federal Public Health Service Act (42 U.S.C. Sec.~~
21 ~~300gg-3(e)).~~
22 ~~(f) This section shall become operative on January 1, 2014.~~
23 ~~SEC. 14. Section 1357.52 of the Health and Safety Code is~~
24 ~~amended to read:~~
25 ~~1357.52. (a) For plan years commencing on or before~~
26 ~~December 31, 2013, except in the case of a late enrollee, or for~~
27 ~~satisfaction of a preexisting condition clause in the case of initial~~
28 ~~coverage of an eligible employee, a plan may not exclude any~~
29 ~~eligible employee or dependent who would otherwise be entitled~~
30 ~~to health care services on the basis of any of the following: the~~
31 ~~health status, the medical condition, including both physical and~~
32 ~~mental illnesses, the claims experience, the medical history, the~~
33 ~~genetic information, or the disability or evidence of insurability~~
34 ~~including conditions arising out of acts of domestic violence of~~
35 ~~that employee or dependent. No plan contract may limit or exclude~~
36 ~~coverage for a specific eligible employee or dependent by type of~~
37 ~~illness, treatment, medical condition, or accident, except for~~
38 ~~preexisting conditions as permitted by Section 1357.06.~~
39 ~~(b) For plan years commencing on or after January 1, 2014, a~~
40 ~~plan may not exclude any eligible employee or dependent who~~

1 ~~would otherwise be entitled to health care services on the basis of~~
2 ~~any of the following: the health status, the medical condition,~~
3 ~~including both physical and mental illnesses, the claims experience,~~
4 ~~the medical history, the genetic information, or the disability or~~
5 ~~evidence of insurability, including conditions arising out of acts~~
6 ~~of domestic violence, of that employee or dependent. No plan~~
7 ~~contract may limit or exclude coverage for a specific eligible~~
8 ~~employee or dependent by type of illness, treatment, medical~~
9 ~~condition, or accident.~~

10 ~~(e) This section shall remain in effect only until January 1, 2014,~~
11 ~~and as of that date is repealed, unless a later enacted statute, that~~
12 ~~is enacted before January 1, 2014, deletes or extends that date.~~

13 ~~SEC. 15. Section 1357.52 is added to the Health and Safety~~
14 ~~Code, to read:~~

15 ~~1357.52. For plan years commencing on or after January 1,~~
16 ~~2014, a plan may not exclude any eligible employee or dependent~~
17 ~~who would otherwise be entitled to health care services on the~~
18 ~~basis of any of the following: the health status, the medical~~
19 ~~condition, including both physical and mental illnesses, the claims~~
20 ~~experience, the medical history, the genetic information, or the~~
21 ~~disability or evidence of insurability including conditions arising~~
22 ~~out of acts of domestic violence of that employee or dependent.~~
23 ~~No plan contract may limit or exclude coverage for a specific~~
24 ~~eligible employee or dependent by type of illness, treatment,~~
25 ~~medical condition, or accident.~~

26 ~~This section shall become operative on January 1, 2014.~~

27 ~~SEC. 15.5. Section 106 of the Insurance Code is amended to~~
28 ~~read:~~

29 ~~106. (a) Disability insurance includes insurance appertaining~~
30 ~~to injury, disablement or death resulting to the insured from~~
31 ~~accidents, and appertaining to disablements resulting to the insured~~
32 ~~from sickness.~~

33 ~~(b) In statutes that become effective on or after January 1, 2002,~~
34 ~~the term "health insurance" for purposes of this code shall mean~~
35 ~~an individual or group disability insurance policy that provides~~
36 ~~coverage for hospital, medical, or surgical benefits. The term~~
37 ~~"health insurance" shall not include any of the following kinds of~~
38 ~~insurance:~~

39 ~~(1) Accidental death and accidental death and dismemberment.~~

1 ~~(2) Disability insurance, including hospital indemnity, accident~~
2 ~~only, and specified disease insurance that pays benefits on a fixed~~
3 ~~benefit, cash payment only basis.~~

4 ~~(3) Credit disability, as defined in subdivision (2) of Section~~
5 ~~779.2.~~

6 ~~(4) Coverage issued as a supplement to liability insurance.~~

7 ~~(5) Disability income, as defined in subdivision (i) of Section~~
8 ~~799.01.~~

9 ~~(6) Insurance under which benefits are payable with or without~~
10 ~~regard to fault and that is statutorily required to be contained in~~
11 ~~any liability insurance policy or equivalent self-insurance.~~

12 ~~(7) Insurance arising out of a workers' compensation or similar~~
13 ~~law.~~

14 ~~(8) Long-term care.~~

15 ~~(e) In a statute that becomes effective on or after January 1,~~
16 ~~2008, the term "specialized health insurance policy" as used in~~
17 ~~this code shall mean a policy of health insurance for covered~~
18 ~~benefits in a single specialized area of health care, including~~
19 ~~dental-only, vision-only, and behavioral health-only policies.~~

20 ~~(d) (1) In a statute that becomes effective on or after January~~
21 ~~1, 2014, the term "health insurance" for purposes of this code shall~~
22 ~~include an individual or small group disability insurance policy~~
23 ~~that provides essential health benefits consistent with Section 1302~~
24 ~~of the federal Patient Protection and Affordable Care Act (Public~~
25 ~~Law 111-148) and regulations adopted pursuant thereto.~~

26 ~~(2) This shall not apply to coverage that is grandfathered~~
27 ~~coverage consistent with Section 1251 of the federal Patient~~
28 ~~Protection and Affordable Care Act (Public Law 111-148). The~~
29 ~~term "health insurance" shall not include a specialized health~~
30 ~~insurance policy, Medicare supplement, or coverage of Medicare~~
31 ~~services pursuant to contracts with the United States government.~~

32 ~~(e) In statutes effective on or after January 1, 2012, the term~~
33 ~~"health insurer" shall mean a disability insurer that sells "health~~
34 ~~insurance" within the meaning of this section.~~

35 ~~SEC. 16. Section 10198.6 of the Insurance Code is amended~~
36 ~~to read:~~

37 ~~10198.6. For purposes of this article:~~

38 ~~(a) "Health benefit plan" means any group or individual policy~~
39 ~~or contract that provides medical, hospital, or surgical benefits.~~

40 ~~The term does not include accident only, credit, disability income,~~

1 coverage of Medicare services pursuant to contracts with the United
2 States government, Medicare supplement, long-term care insurance,
3 dental, vision, coverage issued as a supplement to liability
4 insurance, insurance arising out of a workers' compensation or
5 similar law, automobile medical payment insurance, or insurance
6 under which benefits are payable with or without regard to fault
7 and that is statutorily required to be contained in any liability
8 insurance policy or equivalent self-insurance.

9 (b) "Late enrollee" means an eligible employee or dependent
10 who has declined health coverage under a health benefit plan
11 offered through employment or sponsored by an employer at the
12 time of the initial enrollment period provided under the terms of
13 the health benefit plan, and who subsequently requests enrollment
14 in a health benefit plan of that employer, provided that the initial
15 enrollment period shall be a period of at least 30 days. However,
16 an eligible employee or dependent shall not be considered a late
17 enrollee if any of the following is applicable:

18 (1) The individual meets all of the following requirements:

19 (A) The individual was covered under another employer health
20 benefit plan, the Healthy Families Program, the Access for Infants
21 and Mothers (AIM) Program, or the Medi-Cal program, at the time
22 the individual was eligible to enroll.

23 (B) The individual certified, at the time of the initial enrollment,
24 that coverage under another employer health benefit plan, the
25 Healthy Families Program, the AIM Program, or the Medi-Cal
26 program was the reason for declining enrollment provided that, if
27 the individual was covered under another employer health benefit
28 plan, the individual was given the opportunity to make the
29 certification required by this subdivision and was notified that
30 failure to do so could result in later treatment as a late enrollee.

31 (C) The individual has lost or will lose coverage under another
32 employer health benefit plan as a result of termination of
33 employment of the individual or of a person through whom the
34 individual was covered as a dependent, change in employment
35 status of the individual or of a person through whom the individual
36 was covered as a dependent, termination of the other plan's
37 coverage, cessation of an employer's contribution toward an
38 employee's or dependent's coverage, death of a person through
39 whom the individual was covered as a dependent, legal separation,
40 or divorce; or the individual has lost or will lose coverage under

1 the Healthy Families Program, the AIM Program, or the Medi-Cal
2 program:

3 ~~(D) The individual requests enrollment within 30 days after~~
4 ~~termination of coverage, or cessation of employer contribution~~
5 ~~toward coverage provided under another employer health benefit~~
6 ~~plan, or requests enrollment within 60 days after termination of~~
7 ~~Medi-Cal program coverage, AIM Program coverage, or Healthy~~
8 ~~Families Program coverage:~~

9 (2) ~~The individual is employed by an employer that offers~~
10 ~~multiple health benefit plans and the individual elects a different~~
11 ~~plan during an open enrollment period.~~

12 (3) ~~A court has ordered that coverage be provided for a spouse~~
13 ~~or minor child under a covered employee’s health benefit plan.~~

14 (4) ~~The carrier cannot produce a written statement from the~~
15 ~~employer stating that, prior to declining coverage, the individual~~
16 ~~or the person through whom the individual was eligible to be~~
17 ~~covered as a dependent was provided with, and signed~~
18 ~~acknowledgment of, explicit written notice in boldface type~~
19 ~~specifying that failure to elect coverage during the initial~~
20 ~~enrollment period permits the carrier to impose, at the time of the~~
21 ~~individual’s later decision to elect coverage, an exclusion from~~
22 ~~coverage for a period of 12 months as well as a six-month~~
23 ~~preexisting condition exclusion, unless the individual meets the~~
24 ~~criteria specified in paragraph (1), (2), or (3).~~

25 (5) ~~The individual is an employee or dependent who meets the~~
26 ~~criteria described in paragraph (1) and was under a COBRA~~
27 ~~continuation provision and the coverage under that provision has~~
28 ~~been exhausted. For purposes of this section, the definition of~~
29 ~~“COBRA” set forth in subdivision (e) of Section 10116.5 shall~~
30 ~~apply.~~

31 (6) ~~The individual is a dependent of an enrolled eligible~~
32 ~~employee who has lost or will lose his or her coverage under the~~
33 ~~Healthy Families Program, the AIM Program, or the Medi-Cal~~
34 ~~program, and requests enrollment within 60 days of termination~~
35 ~~of that coverage.~~

36 (e) ~~Until December 31, 2013, “preexisting condition provision”~~
37 ~~means a policy provision that excludes coverage for charges or~~
38 ~~expenses incurred during a specified period following the insured’s~~
39 ~~effective date of coverage, as to a condition for which medical~~
40 ~~advice, diagnosis, care, or treatment was recommended or received~~

1 during a specified period immediately preceding the effective date
2 of coverage.

3 (d) “Creditable coverage” means:

4 (1) Any individual or group policy, contract, or program, that
5 is written or administered by a disability insurance company, health
6 care service plan, fraternal benefits society, self-insured employer
7 plan, or any other entity, in this state or elsewhere, and that
8 arranges or provides medical, hospital, and surgical coverage not
9 designed to supplement other private or governmental plans. The
10 term includes continuation or conversion coverage but does not
11 include accident only, credit, coverage for onsite medical clinics,
12 disability income, Medicare supplement, long-term care insurance,
13 dental, vision, coverage issued as a supplement to liability
14 insurance, insurance arising out of a workers’ compensation or
15 similar law, automobile medical payment insurance, or insurance
16 under which benefits are payable with or without regard to fault
17 and that is statutorily required to be contained in any liability
18 insurance policy or equivalent self-insurance.

19 (2) The federal Medicare Program pursuant to Title XVIII of
20 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

21 (3) The Medicaid Program pursuant to Title XIX of the federal
22 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

23 (4) Any other publicly sponsored program, provided in this state
24 or elsewhere, of medical, hospital, and surgical care.

25 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
26 (Civilian Health and Medical Program of the Uniformed Services
27 (CHAMPUS)).

28 (6) A medical care program of the Indian Health Service or of
29 a tribal organization.

30 (7) A state health benefits risk pool.

31 (8) A health plan offered under 5 U.S.C. Chapter 89
32 (commencing with Section 8901) (Federal Employees Health
33 Benefits Program (FEHBP)).

34 (9) A public health plan as defined in federal regulations
35 authorized by Section 2704(e)(1)(I) of the federal Public Health
36 Service Act, as amended by Public Law 104-191, the federal Health
37 Insurance Portability and Accountability Act of 1996.

38 (10) A health benefit plan under Section 5(e) of the federal
39 Peace Corps Act (22 U.S.C. Sec. 2504(e)).

1 ~~(11) Any other creditable coverage as defined by subsection (e)~~
2 ~~of Section 2701 of Title XXVII of the federal Public Health Service~~
3 ~~Act (42 U.S.C. Sec. 300gg-3(e)).~~

4 ~~(e) “Affiliation period” means a period that, under the terms of~~
5 ~~the health benefit plan, must expire before health care services~~
6 ~~under the plan become effective.~~

7 ~~(f) “Waivered condition” means a contract provision that~~
8 ~~excludes coverage for charges or expenses incurred during a~~
9 ~~specified period of time for one or more specific, identified,~~
10 ~~medical conditions.~~

11 ~~(g) This section shall remain in effect only until January 1, 2014,~~
12 ~~and as of that date is repealed, unless a later enacted statute, that~~
13 ~~is enacted before January 1, 2014, deletes or extends that date.~~

14 ~~SEC. 17.— Section 10198.6 is added to the Insurance Code, to~~
15 ~~read:~~

16 ~~10198.6.— For purposes of this article:~~

17 ~~(a) “Health benefit plan” means any group or individual policy~~
18 ~~or contract that provides health insurance, as defined in Section~~
19 ~~106, and that is issued, renewed, or written by any insurer,~~
20 ~~self-insured employee welfare benefit plan, fraternal benefits~~
21 ~~society, or any other entity. The term does not include accident~~
22 ~~only, credit, disability income, coverage of Medicare services~~
23 ~~pursuant to contracts with the United States government, Medicare~~
24 ~~supplement, long-term care insurance, dental, vision, coverage~~
25 ~~issued as a supplement to liability insurance, insurance arising out~~
26 ~~of a workers’ compensation or similar law, automobile medical~~
27 ~~payment insurance, or insurance under which benefits are payable~~
28 ~~with or without regard to fault and that is statutorily required to~~
29 ~~be contained in any liability insurance policy or equivalent~~
30 ~~self-insurance.~~

31 ~~(b) “Late enrollee” means an eligible employee or dependent~~
32 ~~who has declined health coverage under a health benefit plan~~
33 ~~offered through employment or sponsored by an employer at the~~
34 ~~time of the initial enrollment period provided under the terms of~~
35 ~~the health benefit plan, and who subsequently requests enrollment~~
36 ~~in a health benefit plan of that employer, provided that the initial~~
37 ~~enrollment period shall be a period of at least 30 days. However,~~
38 ~~an eligible employee or dependent shall not be considered a late~~
39 ~~enrollee if any of the following is applicable:~~

40 ~~(1) The individual meets all of the following requirements:~~

1 (A) The individual was covered under another employer health
2 benefit plan, the Healthy Families Program, the Access for Infants
3 and Mothers (AIM) Program, the Medi-Cal program, or the
4 California Health Benefit Exchange, at the time the individual was
5 eligible to enroll.

6 (B) The individual certified, at the time of the initial enrollment,
7 that coverage under another employer health benefit plan, the
8 Healthy Families Program, the AIM Program, the Medi-Cal
9 program, or the California Health Benefit Exchange was the reason
10 for declining enrollment provided that, if the individual was
11 covered under another employer health benefit plan, the individual
12 was given the opportunity to make the certification required by
13 this subdivision and was notified that failure to do so could result
14 in later treatment as a late enrollee.

15 (C) The individual has lost or will lose coverage under another
16 employer health benefit plan as a result of termination of
17 employment of the individual or of a person through whom the
18 individual was covered as a dependent, change in employment
19 status of the individual or of a person through whom the individual
20 was covered as a dependent, termination of the other plan's
21 coverage, cessation of an employer's contribution toward an
22 employee's or dependent's coverage, death of a person through
23 whom the individual was covered as a dependent, legal separation,
24 or divorce; or the individual has lost or will lose coverage under
25 the Healthy Families Program, the AIM Program, the Medi-Cal
26 program, or the California Health Benefit Exchange.

27 (D) The individual requests enrollment within 30 days after
28 termination of coverage, or cessation of employer contribution
29 toward coverage provided under another employer health benefit
30 plan, or requests enrollment within 60 days after termination of
31 Medi-Cal program coverage, AIM Program coverage, Healthy
32 Families Program coverage, or coverage through the California
33 Health Benefit Exchange.

34 (2) The individual is employed by an employer that offers
35 multiple health benefit plans and the individual elects a different
36 plan during an open enrollment period.

37 (3) A court has ordered that coverage be provided for a spouse
38 or minor child under a covered employee's health benefit plan.

39 (4) The carrier cannot produce a written statement from the
40 employer stating that, prior to declining coverage, the individual

1 or the person through whom the individual was eligible to be
2 covered as a dependent was provided with, and signed
3 acknowledgment of, explicit written notice in boldface type
4 specifying that failure to elect coverage during the initial
5 enrollment period permits the carrier to impose, at the time of the
6 individual's later decision to elect coverage, an exclusion from
7 coverage for a period of 12 months as well as a six-month
8 preexisting condition exclusion, unless the individual meets the
9 criteria specified in paragraph (1), (2), or (3).

10 (5) The individual is an employee or dependent who meets the
11 criteria described in paragraph (1) and was under a COBRA
12 continuation provision and the coverage under that provision has
13 been exhausted. For purposes of this section, the definition of
14 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
15 apply.

16 (6) The individual is a dependent of an enrolled eligible
17 employee who has lost or will lose his or her coverage under the
18 Healthy Families Program, the AIM Program, the Medi-Cal
19 program, or the California Health Benefit Exchange, and requests
20 enrollment within 60 days of termination of that coverage.

21 (e) For plan years commencing on or after January 1, 2014, a
22 policy shall not establish any preexisting condition exclusion or
23 limitation for any individual or dependent of an individual, whether
24 or not any medical advice, diagnosis, care, or treatment was
25 recommended or received before that date. A preexisting condition
26 exclusion includes any limitation or exclusion of benefits, including
27 a denial of coverage, applicable to an individual as a result of
28 information relating to an individual's health status before the
29 individual's effective date of coverage under a group health plan,
30 or group or individual health insurance coverage, such as a
31 condition identified as a result of a preenrollment questionnaire
32 or physical examination given to the individual, or review of
33 medical records relating to the preenrollment period.

34 (d) "Creditable coverage" means:

35 (1) Any individual or group policy, contract, or program, that
36 is written or administered by a disability insurance company, health
37 care service plan, fraternal benefits society, self-insured employer
38 plan, or any other entity, in this state or elsewhere, and that
39 arranges or provides medical, hospital, and surgical coverage not
40 designed to supplement other private or governmental plans. The

1 term includes continuation or conversion coverage but does not
2 include accident only, credit, coverage for onsite medical clinics,
3 disability income, Medicare supplement, long-term care insurance,
4 dental, vision, coverage issued as a supplement to liability
5 insurance, insurance arising out of a workers' compensation or
6 similar law, automobile medical payment insurance, or insurance
7 under which benefits are payable with or without regard to fault
8 and that is statutorily required to be contained in any liability
9 insurance policy or equivalent self-insurance.

10 (2) The federal Medicare Program pursuant to Title XVIII of
11 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

12 (3) The Medicaid Program pursuant to Title XIX of the federal
13 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

14 (4) Any other publicly sponsored program, provided in this state
15 or elsewhere, of medical, hospital, and surgical care.

16 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
17 (Civilian Health and Medical Program of the Uniformed Services
18 (CHAMPUS)).

19 (6) A medical care program of the Indian Health Service or of
20 a tribal organization.

21 (7) A state health benefits risk pool.

22 (8) A health plan offered under 5 U.S.C. Chapter 89
23 (commencing with Section 8901) (Federal Employees Health
24 Benefits Program (FEHBP)).

25 (9) A public health plan as defined in federal regulations
26 authorized by Section 2704(c)(1)(I) of the federal Public Health
27 Service Act, as amended by Public Law 104-191, the federal Health
28 Insurance Portability and Accountability Act of 1996.

29 (10) A health benefit plan under Section 5(e) of the federal
30 Peace Corps Act (22 U.S.C. Sec. 2504(e)).

31 (11) Any other creditable coverage as defined by subsection (e)
32 of Section 2701 of Title XXVII of the federal Public Health Service
33 Act (42 U.S.C. Sec. 300gg-3(e)).

34 (e) "Waiting period" means the period that is required to pass
35 with respect to the employee before the employee is eligible to be
36 covered for benefits under the terms of the policy. However, such
37 periods shall not be based upon health status of the employee or
38 dependent. For plan years commencing on or after January 1, 2014,
39 a health benefit plan may permit a waiting period of up to 90 days
40 as a condition of enrollment if applied equally to all full-time

1 employees, consistent with the federal Patient Protection and
2 Affordable Care Act (Public Law 111-148) and any rules,
3 regulations, or guidance issued consistent with that law.

4 (f) “Plan year” means a consecutive 12-month period during
5 which a health benefit plan provides coverage for health benefits.
6 A plan year may be a calendar year or otherwise. This definition
7 shall apply to the extent it is consistent with the federal Patient
8 Protection and Affordable Care Act (Public Law 111-148) and
9 any federal rules, regulations, or guidance issued consistent with
10 that law.

11 (g) This section shall become operative on January 1, 2014.

12 SEC. 18. Section 10198.7 of the Insurance Code is amended
13 to read:

14 10198.7. (a) For plan years commencing on or before
15 December 31, 2013, no health benefit plan that covers three or
16 more persons and that is issued, renewed, or written by any insurer,
17 nonprofit hospital service plan, self-insured employee welfare
18 benefit plan, fraternal benefits society, or any other entity shall
19 exclude coverage for any individual on the basis of a preexisting
20 condition provision for a period greater than six months following
21 the individual’s effective date of coverage, nor shall limit or
22 exclude coverage for a specific insured person by type of illness,
23 treatment, medical condition, or accident except for satisfaction
24 of a preexisting clause pursuant to this article. Preexisting condition
25 provisions contained in health benefit plans may relate only to
26 conditions for which medical advice, diagnosis, care, or treatment,
27 including use of prescription drugs, was recommended or received
28 from a licensed health practitioner during the six months
29 immediately preceding the effective date of coverage.

30 (b) For plan years commencing on or before December 31,
31 2013, no health benefit plan that covers one or two individuals and
32 that is issued, renewed, or written by any insurer, self-insured
33 employee welfare benefit plan, fraternal benefits society, or any
34 other entity shall exclude coverage on the basis of a preexisting
35 condition provision for a period greater than 12 months following
36 the individual’s effective date of coverage, nor shall limit or
37 exclude coverage for a specific insured person by type of illness,
38 treatment, medical condition, or accident, except for satisfaction
39 of a preexisting condition clause pursuant to this article. Preexisting
40 condition provisions contained in health benefit plans may relate

1 only to conditions for which medical advice, diagnosis, care, or
2 treatment, including use of prescription drugs, was recommended
3 or received from a licensed health practitioner during the 12 months
4 immediately preceding the effective date of coverage.

5 (e) (1) Notwithstanding subdivision (a), a health benefit plan
6 for group coverage shall not impose any preexisting condition
7 provision upon any child under 19 years of age.

8 (2) Notwithstanding subdivision (b), a health benefit plan for
9 individual coverage that is a grandfathered plan within the meaning
10 of Section 1251 of the federal Patient Protection and Affordable
11 Care Act (Public Law 111-148) shall not impose any preexisting
12 condition provision upon any child under 19 years of age.

13 (d) For plan years commencing on or before December 31,
14 2013, a carrier that does not utilize a preexisting condition
15 provision may impose a waiting or affiliation period not to exceed
16 60 days, before the coverage issued subject to this article shall
17 become effective. During the waiting or affiliation period, the
18 carrier is not required to provide health care services and no
19 premium shall be charged to the subscriber or enrollee.

20 (e) For plan years commencing on or before December 31,
21 2013, a carrier that does not utilize a preexisting condition
22 provision in health plans that cover one or two individuals may
23 impose a contract provision excluding coverage for waived
24 conditions. No carrier may exclude coverage on the basis of a
25 waived condition for a period greater than 12 months following
26 the individual's effective date of coverage. A waived condition
27 provision contained in health benefit plans may relate only to
28 conditions for which medical advice, diagnosis, care, or treatment,
29 including use of prescription drugs, was recommended or received
30 from a licensed health practitioner during the 12 months
31 immediately preceding the effective date of coverage.

32 (f) For plan years commencing on or before December 31, 2013,
33 in determining whether a preexisting condition provision, a
34 waived condition provision, or a waiting or affiliation period
35 applies to any person, all health benefit plans shall credit the time
36 the person was covered under creditable coverage, provided the
37 person becomes eligible for coverage under the succeeding health
38 benefit plan within 62 days of termination of prior coverage,
39 exclusive of any waiting or affiliation period, and applies for
40 coverage under the succeeding plan within the applicable

1 enrollment period. A health benefit plan shall also credit any time
 2 an eligible employee must wait before enrolling in the health
 3 benefit plan, including any affiliation or employer-imposed waiting
 4 period. However, if a person's employment has ended, the
 5 availability of health coverage offered through employment or
 6 sponsored by an employer has terminated, or an employer's
 7 contribution toward health coverage has terminated, a carrier shall
 8 credit the time the person was covered under creditable coverage
 9 if the person becomes eligible for health coverage offered through
 10 employment or sponsored by an employer within 180 days,
 11 exclusive of any waiting or affiliation period, and applies for
 12 coverage under the succeeding plan within the applicable
 13 enrollment period.

14 (g) For plan years commencing on or before December 31,
 15 2013, no health benefit plan that covers three or more persons and
 16 that is issued, renewed, or written by any insurer, nonprofit hospital
 17 service plan, self-insured employee welfare benefit plan, fraternal
 18 benefits society, or any other entity may exclude late enrollees
 19 from coverage for more than 12 months from the date of the late
 20 enrollee's application for coverage. No insurer, nonprofit hospital
 21 service plan, self-insured employee welfare benefit plan, fraternal
 22 benefits society, or any other entity shall require any premium or
 23 other periodic charge to be paid by or on behalf of a late enrollee
 24 during the period of exclusion from coverage permitted by this
 25 subdivision.

26 (h) An individual's period of creditable coverage shall be
 27 certified pursuant to subsection (e) of Section 2704 of Title XXVII
 28 of the federal Public Health Service Act (42 U.S.C. See.
 29 300gg-3(e)).

30 (i) A group health benefit plan may not impose a preexisting
 31 condition exclusion to a condition relating to benefits for pregnancy
 32 or maternity care.

33 (j) Any entity providing aggregate or specific stop loss coverage
 34 or any other assumption of risk with reference to a health benefit
 35 plan shall provide that the plan meets all requirements of this article
 36 concerning waiting periods, preexisting condition provisions, and
 37 late enrollees.

38 (k) This section shall remain in effect only until January 1, 2014,
 39 and as of that date is repealed, unless a later enacted statute, that
 40 is enacted before January 1, 2014, deletes or extends that date.

1 ~~SEC. 19.~~ Section 10198.7 is added to the Insurance Code, to
2 read:

3 ~~10198.7. (a) For plan years commencing on or after January~~
4 ~~1, 2014, no health benefit plan that covers one or more persons~~
5 ~~and that is issued, renewed, or written by any insurer, self-insured~~
6 ~~employee welfare benefit plan, fraternal benefits society, or any~~
7 ~~other entity shall exclude coverage for any individual on the basis~~
8 ~~of a preexisting condition.~~

9 ~~(b) (1) For plan years commencing on or after January 1, 2014,~~
10 ~~a health benefit plan for group coverage that is issued, renewed,~~
11 ~~or written by any insurer, self-insured employee welfare benefit~~
12 ~~plan, fraternal benefits society, or any other entity shall not impose~~
13 ~~any preexisting condition provision upon any individual.~~

14 ~~(2) A health benefit plan for individual coverage that is a~~
15 ~~grandfathered plan within the meaning of Section 1251 of the~~
16 ~~federal Patient Protection and Affordable Care Act (Public Law~~
17 ~~111-148) shall not impose any preexisting condition provision~~
18 ~~upon any individual.~~

19 ~~(c) For plan years commencing on or after January 1, 2014, a~~
20 ~~health benefit plan may impose a 90-day waiting period from the~~
21 ~~date of the late enrollee's application for coverage. A group health~~
22 ~~benefit plan may permit a waiting period of up to 90 days as a~~
23 ~~condition of enrollment if applied equally to all full-time employees~~
24 ~~and if consistent with the federal Patient Protection and Affordable~~
25 ~~Care Act (Public Law 111-148) and any rules, regulations, or~~
26 ~~guidance issued consistent with that law.~~

27 ~~(d) An individual's period of creditable coverage shall be~~
28 ~~certified pursuant to subsection (c) of Section 2704 of Title XXVII~~
29 ~~of the federal Public Health Service Act (42 U.S.C. Sec.~~
30 ~~300gg-3(e)).~~

31 ~~(e) For plan years commencing on or after January 1, 2014, a~~
32 ~~health benefit plan may not impose a preexisting condition~~
33 ~~exclusion or establish rules for eligibility, including continued~~
34 ~~eligibility, of any individual to enroll under the terms of that plan~~
35 ~~or coverage based on health status-related factors, in relation to~~
36 ~~the individual or a dependent of the individual, including, but not~~
37 ~~limited to, the following:~~

38 ~~(1) Health status.~~

39 ~~(2) Medical condition, including both physical and mental~~
40 ~~illnesses.~~

- 1 ~~(3) Claims experience.~~
2 ~~(4) Receipt of medical care.~~
3 ~~(5) Medical history.~~
4 ~~(6) Genetic information.~~
5 ~~(7) Evidence of insurability, including conditions arising from~~
6 ~~domestic violence.~~
7 ~~(8) Disability.~~
8 ~~(9) Any other health status-related factor determined appropriate~~
9 ~~by the federal government.~~
10 ~~(10) Any other health status-related factor determined~~
11 ~~appropriate by the commissioner.~~
12 ~~(f) Any entity providing aggregate or specific stop-loss coverage~~
13 ~~or any other assumption of risk with reference to a health benefit~~
14 ~~plan shall provide that the plan meets all requirements of this article~~
15 ~~concerning waiting periods, preexisting condition provisions, and~~
16 ~~late enrollees.~~
17 ~~(g) “Plan year” means a consecutive 12-month period during~~
18 ~~which a health benefit plan provides coverage for health benefits.~~
19 ~~A plan year may be a calendar year or otherwise. This definition~~
20 ~~shall apply to the extent it is consistent with the federal Patient~~
21 ~~Protection and Affordable Care Act (Public Law 111-148) and~~
22 ~~any federal rules, regulations, or guidance issued consistent with~~
23 ~~that law.~~
24 ~~(h) This section shall become operative on January 1, 2014.~~
25 ~~SEC. 20. Section 10198.9 of the Insurance Code is amended~~
26 ~~to read:~~
27 ~~10198.9. (a) (1) For plan years commencing on or before~~
28 ~~December 31, 2013, except in the case of a late enrollee, or for~~
29 ~~satisfaction of a preexisting condition clause in the case of initial~~
30 ~~coverage of an eligible employee, a disability insurer may not~~
31 ~~exclude any eligible employee or dependent who would otherwise~~
32 ~~be entitled to health care services on the basis of any of the~~
33 ~~following: the health status, the medical condition, including both~~
34 ~~physical and mental illnesses, the claims experience, the medical~~
35 ~~history, the genetic information, or the disability or evidence of~~
36 ~~insurability, including conditions arising out of acts of domestic~~
37 ~~violence of that employee or dependent. No health benefit plan~~
38 ~~may limit or exclude coverage for a specific eligible employee or~~
39 ~~dependent by type of illness, treatment, medical condition, or~~

1 accident, except for preexisting conditions as permitted by Section
2 10198.7.

3 (2) For plan years commencing on or after January 1, 2014, a
4 health insurer may not exclude any eligible employee or dependent
5 who would otherwise be entitled to health care services on the
6 basis of any of the following: the health status, the medical
7 condition, including both physical and mental illnesses, the claims
8 experience, the medical history, the genetic information, or the
9 disability or evidence of insurability including conditions arising
10 out of acts of domestic violence of that employee or dependent.
11 No health benefit plan may limit or exclude coverage for a specific
12 eligible employee or dependent by type of illness, treatment,
13 medical condition, or accident.

14 (b) For purposes of this section, “health benefit plan” shall have
15 the same meaning as in Section 10198.6 and subdivision (a) of
16 Section 10198.61.

17 (c) For purposes of this section, “eligible employee” shall have
18 the same meaning as in Section 10700 except that it shall apply to
19 any health benefit plan covering one or more eligible employees.

20 (d) This section shall remain in effect only until January 1, 2014,
21 and as of that date is repealed, unless a later enacted statute, that
22 is enacted before January 1, 2014, deletes or extends that date.

23 SEC. 21. Section 10198.9 is added to the Insurance Code, to
24 read:

25 10198.9. (a) For plan years commencing on or after January
26 1, 2014, a policy of health insurance, as defined in Section 106,
27 that is issued, renewed, or written by any insurer, self-insured
28 employee welfare benefit plan, fraternal benefits society, or any
29 other entity shall not exclude any eligible employee or dependent
30 who would otherwise be entitled to health care services on the
31 basis of any of the following: the health status, the medical
32 condition, including both physical and mental illnesses, the claims
33 experience, the medical history, the genetic information, or the
34 disability or evidence of insurability including conditions arising
35 out of acts of domestic violence of that employee or dependent.
36 No health benefit plan may limit or exclude coverage for a specific
37 eligible employee or dependent by type of illness, treatment,
38 medical condition, or accident.

1 ~~(b) For purposes of this section, “health benefit plan” shall have~~
 2 ~~the same meaning as in Section 10198.6 and subdivision (a) of~~
 3 ~~Section 10198.61.~~

4 ~~(e) For purposes of this section, “eligible employee” shall have~~
 5 ~~the same meaning as in Section 10700 except that it shall apply to~~
 6 ~~any health benefit plan covering one or more eligible employees.~~

7 ~~(d) This section shall become operative on January 1, 2014.~~

8 *SEC. 12. Section 106.5 is added to the Insurance Code, to*
 9 *read:*

10 *106.5. (a) All nongrandfathered policies of individual health*
 11 *insurance, except Medicare supplement policies, as defined in*
 12 *Article 6 (commencing with Section 10192.05) of Chapter 1 of*
 13 *Part 2, or small employer health insurance, as defined in Chapter*
 14 *8 (commencing with Section 10700) of Part 2, that are offered,*
 15 *sold, renewed, or delivered on or after January 1, 2014, shall*
 16 *provide coverage for essential health benefits, as described in*
 17 *Section 2707 of the federal Patient Protection and Affordable Care*
 18 *Act (Public Law 111-148).*

19 *(b) A nongrandfathered policy is a policy that is not*
 20 *grandfathered, as defined in Section 147.140 of Title 45 of the*
 21 *Code of Federal Regulations.*

22 *SEC. 13. Section 10127.19 is added to the Insurance Code, to*
 23 *read:*

24 *10127.19. Commencing March 1, 2012, and at least annually*
 25 *thereafter, every health insurer, not including a health insurer*
 26 *offering specialized health insurance policies, shall provide to the*
 27 *department, in a form and manner determined by the department*
 28 *in consultation with the Department of Managed Health Care, the*
 29 *number of covered lives, as of December 31 of the prior year, that*
 30 *receive health care coverage under a health insurance policy that*
 31 *covers individuals, small groups, groups of 51-100, groups of 101*
 32 *or more, or administrative services only business lines. Health*
 33 *insurers shall include the unduplicated enrollment data in specific*
 34 *product lines as determined by the department, including, but not*
 35 *limited to HMO, point-of-service, PPO, Medicare excluding*
 36 *Medicare supplement, Medi-Cal managed care, and traditional*
 37 *indemnity non-PPO health insurance. The department shall*
 38 *publicly report the data provided by each health insurer pursuant*
 39 *to this section, including, but not limited to, posting the data on*
 40 *the department’s Internet Web site. The department shall consult*

1 *with the Department of Managed Health Care to ensure that the*
2 *data reported is comparable and consistent.*

3 ~~SEC. 22.~~

4 *SEC. 14.* Section 10700 of the Insurance Code is amended to
5 read:

6 10700. As used in this chapter:

7 (a) “Agent or broker” means a person or entity licensed under
8 Chapter 5 (commencing with Section 1621) of Part 2 of Division
9 1.

10 (b) “Benefit plan design” means a specific health coverage
11 product issued by a carrier to small employers, to trustees of
12 associations that include small employers, or to individuals if the
13 coverage is offered through employment or sponsored by an
14 employer. It includes services covered and the levels of copayment
15 and deductibles, and it may include the professional providers who
16 are to provide those services and the sites where those services are
17 to be provided. A benefit plan design may also be an integrated
18 system for the financing and delivery of quality health care services
19 which has significant incentives for the covered individuals to use
20 the system.

21 (c) “Board” means the Major Risk Medical Insurance Board.

22 (d) “Carrier” means any disability insurance company or any
23 other entity that writes, issues, or administers health benefit plans
24 that cover the employees of small employers, regardless of the
25 situs of the contract or master policyholder. For the purposes of
26 Articles 3 (commencing with Section 10719) and 4 (commencing
27 with Section 10730), “carrier” also includes health care service
28 plans.

29 (e) “Dependent” means the spouse or child of an eligible
30 employee, subject to applicable terms of the health benefit plan
31 covering the employee, and includes dependents of guaranteed
32 association members if the association elects to include dependents
33 under its health coverage at the same time it determines its
34 membership composition pursuant to subdivision (z).

35 (f) “Eligible employee” means either of the following:

36 (1) Any permanent employee who is actively engaged on a
37 full-time basis in the conduct of the business of the small employer
38 with a normal workweek of an average of 30 hours per week over
39 the course of a month, in the small employer’s regular place of
40 business, who has met any statutorily authorized applicable waiting

1 period requirements. The term includes sole proprietors or partners
2 of a partnership, if they are actively engaged on a full-time basis
3 in the small employer's business, and they are included as
4 employees under a health benefit plan of a small employer, but
5 does not include employees who work on a part-time, temporary,
6 or substitute basis. It includes any eligible employee, as defined
7 in this paragraph, who obtains coverage through a guaranteed
8 association. Employees of employers purchasing through a
9 guaranteed association shall be deemed to be eligible employees
10 if they would otherwise meet the definition except for the number
11 of persons employed by the employer. A permanent employee
12 who works at least 20 hours but not more than 29 hours is deemed
13 to be an eligible employee if all four of the following apply:

14 (A) The employee otherwise meets the definition of an eligible
15 employee except for the number of hours worked.

16 (B) The employer offers the employee health coverage under a
17 health benefit plan.

18 (C) All similarly situated individuals are offered coverage under
19 the health benefit plan.

20 (D) The employee must have worked at least 20 hours per
21 normal workweek for at least 50 percent of the weeks in the
22 previous calendar quarter. The insurer may request any necessary
23 information to document the hours and time period in question,
24 including, but not limited to, payroll records and employee wage
25 and tax filings.

26 (2) Any member of a guaranteed association as defined in
27 subdivision (z).

28 (g) "Enrollee" means an eligible employee or dependent who
29 receives health coverage through the program from a participating
30 carrier.

31 (h) "Financially impaired" means, for the purposes of this
32 chapter, a carrier that, on or after the effective date of this chapter,
33 is not insolvent and is either:

34 (1) Deemed by the commissioner to be potentially unable to
35 fulfill its contractual obligations.

36 (2) Placed under an order of rehabilitation or conservation by
37 a court of competent jurisdiction.

38 (i) "Fund" means the California Small Group Reinsurance Fund.

39 (j) "Health benefit plan" means a policy or contract written or
40 administered by a carrier that arranges or provides health care

1 benefits for the covered eligible employees of a small employer
2 and their dependents. The term does not include accident only,
3 credit, disability income, coverage of Medicare services pursuant
4 to contracts with the United States government, Medicare
5 supplement, long-term care insurance, dental, vision, coverage
6 issued as a supplement to liability insurance, automobile medical
7 payment insurance, or insurance under which benefits are payable
8 with or without regard to fault and that is statutorily required to
9 be contained in any liability insurance policy or equivalent
10 self-insurance.

11 (k) “In force business” means an existing health benefit plan
12 issued by the carrier to a small employer.

13 (l) “Late enrollee” means an eligible employee or dependent
14 who has declined health coverage under a health benefit plan
15 offered by a small employer at the time of the initial enrollment
16 period provided under the terms of the health benefit plan and who
17 subsequently requests enrollment in a health benefit plan of that
18 small employer, provided that the initial enrollment period shall
19 be a period of at least 30 days. It also means any member of an
20 association that is a guaranteed association as well as any other
21 person eligible to purchase through the guaranteed association
22 when that person has failed to purchase coverage during the initial
23 enrollment period provided under the terms of the guaranteed
24 association’s health benefit plan and who subsequently requests
25 enrollment in the plan, provided that the initial enrollment period
26 shall be a period of at least 30 days. However, an eligible
27 employee, another person eligible for coverage through a
28 guaranteed association pursuant to subdivision (z), or an eligible
29 dependent shall not be considered a late enrollee if any of the
30 following is applicable:

31 (1) The individual meets all of the following requirements:

32 (A) He or she was covered under another employer health
33 benefit plan, the Healthy Families Program, the Access for Infants
34 and Mothers (AIM) Program, the Medi-Cal program, or the
35 California Health Benefit Exchange, at the time the individual was
36 eligible to enroll.

37 (B) He or she certified at the time of the initial enrollment that
38 coverage under another employer health benefit plan, the Healthy
39 Families Program, the AIM Program, the Medi-Cal program, or
40 the California Health Benefit Exchange was the reason for

1 declining enrollment provided that, if the individual was covered
2 under another employer health plan, the individual was given the
3 opportunity to make the certification required by this subdivision
4 and was notified that failure to do so could result in later treatment
5 as a late enrollee.

6 (C) He or she has lost or will lose coverage under another
7 employer health benefit plan as a result of termination of
8 employment of the individual or of a person through whom the
9 individual was covered as a dependent, change in employment
10 status of the individual, or of a person through whom the individual
11 was covered as a dependent, the termination of the other plan's
12 coverage, cessation of an employer's contribution toward an
13 employee's or dependent's coverage, death of the person through
14 whom the individual was covered as a dependent, legal separation,
15 or divorce; or he or she has lost or will lose coverage under the
16 Healthy Families Program, the AIM Program, the Medi-Cal
17 program, or the California Health Benefit Exchange.

18 (D) He or she requests enrollment within 30 days after
19 termination of coverage or employer contribution toward coverage
20 provided under another employer health benefit plan, or requests
21 enrollment within 60 days after termination of Medi-Cal program
22 coverage, AIM Program coverage, Healthy Families Program
23 coverage, or coverage through the California Health Benefit
24 Exchange.

25 (2) The individual is employed by an employer who offers
26 multiple health benefit plans and the individual elects a different
27 plan during an open enrollment period.

28 (3) A court has ordered that coverage be provided for a spouse
29 or minor child under a covered employee's health benefit plan.

30 (4) (A) For plan years commencing on or before December 31,
31 2013, in the case of an eligible employee as defined in paragraph
32 (1) of subdivision (f), the carrier cannot produce a written statement
33 from the employer stating that the individual or the person through
34 whom an individual was eligible to be covered as a dependent,
35 prior to declining coverage, was provided with, and signed
36 acknowledgment of, an explicit written notice in boldface type
37 specifying that failure to elect coverage during the initial
38 enrollment period permits the carrier to impose, at the time of the
39 individual's later decision to elect coverage, an exclusion from
40 coverage for a period of 12 months as well as a six-month

1 preexisting condition exclusion unless the individual meets the
2 criteria specified in paragraph (1), (2), or (3). *For plan years*
3 *commencing on or after January 1, 2014, a waiting period of no*
4 *longer than 90 days is permitted unless the individual meets the*
5 *criteria specified in paragraph (1), (2), or (3).*

6 (B) For plan years commencing on or before December 31,
7 2013, in the case of an eligible employee who is a guaranteed
8 association member, the plan cannot produce a written statement
9 from the guaranteed association stating that the association sent a
10 written notice in boldface type to all potentially eligible association
11 members at their last known address prior to the initial enrollment
12 period informing members that failure to elect coverage during
13 the initial enrollment period permits the plan to impose, at the time
14 of the member's later decision to elect coverage, an exclusion from
15 coverage for a period of 12 months as well as a six-month
16 preexisting condition exclusion unless the member can demonstrate
17 that he or she meets the requirements of subparagraphs (A), (C),
18 and (D) of paragraph (1) or meets the requirements of paragraph
19 (2) or (3). *For plan years commencing on or after January 1, 2014,*
20 *a waiting period of no longer than 90 days is permitted unless the*
21 *individual meets the criteria specified in paragraph (1), (2), or*
22 *(3).*

23 (C) In the case of an employer or person who is not a member
24 of an association, was eligible to purchase coverage through a
25 guaranteed association, and did not do so, and would not be eligible
26 to purchase guaranteed coverage unless purchased through a
27 guaranteed association, the employer or person can demonstrate
28 that he or she meets the requirements of subparagraphs (A), (C),
29 and (D) of paragraph (1), or meets the requirements of paragraph
30 (2) or (3), or that he or she recently had a change in status that
31 would make him or her eligible and that application for coverage
32 was made within 30 days of the change.

33 (5) The individual is an employee or dependent who meets the
34 criteria described in paragraph (1) and was under a COBRA
35 continuation provision and the coverage under that provision has
36 been exhausted. For purposes of this section, the definition of
37 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
38 apply.

39 (6) The individual is a dependent of an enrolled eligible
40 employee who has lost or will lose his or her coverage under the

1 Healthy Families Program, the AIM Program, the Medi-Cal
2 program, or the California Health Benefit Exchange, and requests
3 enrollment within 60 days after termination of that coverage.

4 (7) The individual is an eligible employee who previously
5 declined coverage under an employer health benefit plan and who
6 has subsequently acquired a dependent who would be eligible for
7 coverage as a dependent of the employee through marriage, birth,
8 adoption, or placement for adoption, and who enrolls for coverage
9 under that employer health benefit plan on his or her behalf and
10 on behalf of his or her dependent within 30 days following the
11 date of marriage, birth, adoption, or placement for adoption, in
12 which case the effective date of coverage shall be the first day of
13 the month following the date the completed request for enrollment
14 is received in the case of marriage, or the date of birth, or the date
15 of adoption or placement for adoption, whichever applies. Notice
16 of the special enrollment rights contained in this paragraph shall
17 be provided by the employer to an employee at or before the time
18 the employee is offered an opportunity to enroll in plan coverage.

19 (8) The individual is an eligible employee who has declined
20 coverage for himself or herself or his or her dependents during a
21 previous enrollment period because his or her dependents were
22 covered by another employer health benefit plan at the time of the
23 previous enrollment period. That individual may enroll himself or
24 herself or his or her dependents for plan coverage during a special
25 open enrollment opportunity if his or her dependents have lost or
26 will lose coverage under that other employer health benefit plan.
27 The special open enrollment opportunity shall be requested by the
28 employee not more than 30 days after the date that the other health
29 coverage is exhausted or terminated. Upon enrollment, coverage
30 shall be effective not later than the first day of the first calendar
31 month beginning after the date the request for enrollment is
32 received. Notice of the special enrollment rights contained in this
33 paragraph shall be provided by the employer to an employee at or
34 before the time the employee is offered an opportunity to enroll
35 in plan coverage.

36 (m) “New business” means a health benefit plan issued to a
37 small employer that is not the carrier’s in force business.

38 (n) “Participating carrier” means a carrier that has entered into
39 a contract with the program to provide health benefits coverage
40 under this part.

1 (o) “Plan of operation” means the plan of operation of the fund,
2 including articles, bylaws, and operating rules adopted by the fund
3 pursuant to Article 3 (commencing with Section 10719).

4 ~~(p) “Program” means the Health Insurance Plan of California.~~

5 ~~(q)~~

6 (p) (1) For plan years commencing on or before December 31,
7 2013, “preexisting condition provision” means a policy provision
8 that excludes coverage for charges or expenses incurred during a
9 specified period following the insured’s effective date of coverage,
10 as to a condition for which medical advice, diagnosis, care, or
11 treatment was recommended or received during a specified period
12 immediately preceding the effective date of coverage.

13 (2) For plan years commencing on or after January 1, 2014, no
14 insurer shall limit or exclude coverage for any individual based
15 on a preexisting condition whether or not any medical advice,
16 diagnosis, care, or treatment was recommended or received before
17 that date. A preexisting condition exclusion includes any limitation
18 or exclusion of benefits, including a denial of coverage, applicable
19 to an individual as a result of information relating to an individual’s
20 health status before the individual’s effective date of coverage
21 under a group health plan, or group or individual health insurance
22 coverage, such as a condition identified as a result of a
23 preenrollment questionnaire or physical examination given to the
24 individual, or review of medical records relating to the
25 preenrollment period.

26 ~~(r)~~

27 (q) “Creditable coverage” means:

28 (1) Any individual or group policy, contract, or program, that
29 is written or administered by a disability insurer, health care service
30 plan, fraternal benefits society, self-insured employer plan, or any
31 other entity, in this state or elsewhere, and that arranges or provides
32 medical, hospital, and surgical coverage not designed to supplement
33 other private or governmental plans. The term includes continuation
34 or conversion coverage but does not include accident only, credit,
35 coverage for onsite medical clinics, disability income, Medicare
36 supplement, long-term care, dental, vision, coverage issued as a
37 supplement to liability insurance, insurance arising out of a
38 workers’ compensation or similar law, automobile medical payment
39 insurance, or insurance under which benefits are payable with or
40 without regard to fault and that is statutorily required to be

1 contained in any liability insurance policy or equivalent
2 self-insurance.

3 (2) The federal Medicare Program pursuant to Title XVIII of
4 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

5 (3) The Medicaid Program pursuant to Title XIX of the federal
6 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

7 (4) Any other publicly sponsored program, provided in this state
8 or elsewhere, of medical, hospital, and surgical care.

9 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
10 (Civilian Health and Medical Program of the Uniformed Services
11 (CHAMPUS)).

12 (6) A medical care program of the Indian Health Service or of
13 a tribal organization.

14 (7) A state health benefits risk pool.

15 (8) A health plan offered under 5 U.S.C. Chapter 89
16 (commencing with Section 8901) (Federal Employees Health
17 Benefits Program (FEHBP)).

18 (9) A public health plan as defined in federal regulations
19 authorized by Section 2701(c)(1)(I) of the federal Public Health
20 Service Act, as amended by Public Law 104-191, the federal Health
21 Insurance Portability and Accountability Act of 1996.

22 (10) A health benefit plan under Section 5(e) of the federal
23 Peace Corps Act (22 U.S.C. Sec. 2504(e)).

24 (11) Any other creditable coverage as defined by subsection (c)
25 of Section 2704 of Title XXVII of the federal Public Health Service
26 Act (42 U.S.C. Sec. 300gg-3(c)).

27 (~~s~~)

28 (*r*) “Rating period” means the period for which premium rates
29 established by a carrier are in effect and shall be no less than 12
30 months. This subdivision shall be implemented to the extent
31 permitted under the federal Patient Protection and Affordable Care
32 Act (Public Law 111-148) and any rules, regulations, or guidance
33 issued consistent with that law.

34 (~~t~~)

35 (*s*) “Risk adjusted employee risk rate” means the rate determined
36 for an eligible employee of a small employer in a particular risk
37 category after applying the risk adjustment factor. *For plan years*
38 *commencing on or after January 1, 2014, no risk adjustment factor*
39 *shall be used in the determination of rates.*

40 (~~tt~~)

1 (t) “Risk adjustment factor” means the percent adjustment to
2 be applied equally to each standard employee risk rate for a
3 particular small employer, based upon any expected deviations
4 from standard claims. This factor may not be more than 120 percent
5 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
6 this factor may not be more than 110 percent or less than 90
7 percent. For plan years commencing on or after January 1, 2014,
8 no risk adjustment factor shall be used in the determination of
9 rates.

10 ~~(v)~~

11 (u) “Risk category” means the following characteristics of an
12 eligible employee: age, geographic region, and family size of the
13 employee, plus the benefit plan design selected by the small
14 employer to the extent permitted under the federal Patient
15 Protection and Affordable Care Act (Public Law 111-148) and
16 any rules, regulations, or guidance issued consistent with that law.

17 (1) No more than the following age categories may be used in
18 determining premium rates:

- 19 Under 30
- 20 30–39
- 21 40–49
- 22 50–54
- 23 55–59
- 24 60–64
- 25 65 and over

26 However, for the 65 and over age category, separate premium
27 rates may be specified depending upon whether coverage under
28 the health benefit plan will be primary or secondary to benefits
29 provided by the federal Medicare Program pursuant to Title XVIII
30 of the federal Social Security Act. For plan years commencing on
31 or after January 1, 2014, the rate for age shall not vary by more
32 than three to one for adults.

33 (2) Small employer carriers shall base rates to small employers
34 using no more than the following family size categories:

- 35 (A) Single.
- 36 ~~(B) Two-adult families.~~
- 37 ~~(C) One adult and child or children.~~
- 38 ~~(D) Two-adult families and child or children.~~

1 (B) Married couple or registered domestic partners. “Domestic
 2 partner” shall have the same meaning as that term is used in
 3 Section 297 of the Family Code.

4 (C) One adult and child or children.

5 (D) Married couple and child or children or registered domestic
 6 partners and child or children.

7 (3) The commissioner may issue regulations developed in
 8 collaboration with the Director of Managed Health Care that are
 9 necessary to carry out the purpose of this subdivision to make the
 10 categories of age, family size, and geographic region consistent
 11 with the federal Patient Protection and Affordable Care Act (Public
 12 Law 111-148), and any rules, regulations, or guidance issued
 13 consistent with that law. Any rules and regulations adopted
 14 pursuant to this subdivision may be adopted as emergency
 15 regulations in accordance with the Administrative Procedure Act
 16 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
 17 Division 3 of Title 2 of the Government Code). Until December
 18 31, 2015, the adoption of these regulations shall be deemed an
 19 emergency and necessary for the immediate preservation of the
 20 public peace, health and safety, or general welfare.

21 ~~(3)~~

22 (4) (A) In determining rates for small employers, a carrier that
 23 operates statewide shall use no more than nine geographic regions
 24 in the state, have no region smaller than an area in which the first
 25 three digits of all its ZIP Codes are in common within a county,
 26 and shall divide no county into more than two regions. Carriers
 27 shall be deemed to be operating statewide if their coverage area
 28 includes 90 percent or more of the state’s population. Geographic
 29 regions established pursuant to this section shall, as a group, cover
 30 the entire state, and the area encompassed in a geographic region
 31 shall be separate and distinct from areas encompassed in other
 32 geographic regions. Geographic regions may be noncontiguous.

33 (B) In determining rates for small employers, a carrier that does
 34 not operate statewide shall use no more than the number of
 35 geographic regions in the state than is determined by the following
 36 formula: the population, as determined in the last federal census,
 37 of all counties which are included in their entirety in a carrier’s
 38 service area divided by the total population of the state, as
 39 determined in the last federal census, multiplied by nine. The
 40 resulting number shall be rounded to the nearest whole integer.

1 No region may be smaller than an area in which the first three
2 digits of all its ZIP Codes are in common within a county and no
3 county may be divided into more than two regions. The area
4 encompassed in a geographic region shall be separate and distinct
5 from areas encompassed in other geographic regions. Geographic
6 regions may be noncontiguous. No carrier shall have less than one
7 geographic area.

8 (w)

9 (v) “Small employer” means either of the following:

10 (1) For plan years commencing on or after December 31, 2013,
11 any person, proprietary or nonprofit firm, corporation, partnership,
12 public agency, or association that is actively engaged in business
13 or service that, on at least 50 percent of its working days during
14 the preceding calendar quarter, or preceding calendar year,
15 employed at least two, but not more than 50, eligible employees,
16 the majority of whom were employed within this state, that was
17 not formed primarily for purposes of buying health insurance and
18 in which a bona fide employer-employee relationship exists. For
19 plan years commencing on or after January 1, 2014, and on or
20 before December 31, 2015, any person, firm, proprietary or
21 nonprofit corporation, partnership, public agency, or association
22 that is actively engaged in business or service, that, on at least 50
23 percent of its working days during the preceding calendar quarter
24 or preceding calendar year, employed at least one, but no more
25 than 50, eligible employees, the majority of whom were employed
26 within this state, that was not formed primarily for purposes of
27 buying health insurance, and in which a bona fide
28 employer-employee relationship exists. For plan years commencing
29 on or after January 1, 2016, any person, firm, proprietary or
30 nonprofit corporation, partnership, public agency, or association
31 that is actively engaged in business or service, that, on at least 50
32 percent of its working days during the preceding calendar quarter
33 or preceding calendar year, employed at least one, but no more
34 than 100, eligible employees, the majority of whom were employed
35 within this state, that was not formed primarily for purposes of
36 buying health benefit plans, and in which a bona fide
37 employer-employee relationship exists. In determining whether
38 to apply the calendar quarter or calendar year test, the insurer shall
39 use the test that ensures eligibility if only one test would establish
40 eligibility. In determining the number of eligible employees,

1 companies that are affiliated companies and that are eligible to file
2 a combined income tax return for purposes of state taxation shall
3 be considered one employer. Subsequent to the issuance of a health
4 benefit plan to a small employer pursuant to this chapter, and for
5 the purpose of determining eligibility, the size of a small employer
6 shall be determined annually. Except as otherwise specifically
7 provided, provisions of this chapter that apply to a small employer
8 shall continue to apply until the health benefit plan anniversary
9 following the date the employer no longer meets the requirements
10 of this definition. It includes any small employer as defined in this
11 paragraph who purchases coverage through a guaranteed
12 association, and any employer purchasing coverage for employees
13 through a guaranteed association. This paragraph shall be
14 implemented to the extent consistent with the federal Patient
15 Protection and Affordable Care Act (Public Law 111-148) and
16 any rules, regulations, or guidance issued consistent with that law
17 *law, except that the minimum requirement of one employee shall*
18 *be implemented only to the extent required by PPACA.*

19 (2) Any guaranteed association, as defined in subdivision (y),
20 that purchases health coverage for members of the association.

21 ~~(3) For plan years commencing on or after January 1, 2014, a~~
22 ~~self-employed individual who obtains at least 50 percent of annual~~
23 ~~income from self-employment as demonstrated through personal~~
24 ~~income tax filings for the current or prior year. To the extent~~
25 ~~permitted under the federal Patient Protection and Affordable Care~~
26 ~~Act (Public Law 111-148) and any rules or guidance issued~~
27 ~~consistent with that law, a self-employed individual may at his or~~
28 ~~her discretion seek to enroll as an individual rather than a small~~
29 ~~employer through the California Health Benefit Exchange to the~~
30 ~~extent permitted under the federal Patient Protection and Affordable~~
31 ~~Care Act (Public Law 111-148) and any rules, regulations, or~~
32 ~~guidance issued consistent with that law.~~

33 (3) *For plan years commencing on or after January 1, 2014,*
34 *the definition of an employer, for purposes of determining whether*
35 *an employer with one employee shall include sole proprietors,*
36 *certain owners of "S" corporations, or other individuals, shall be*
37 *consistent with Section 1304 of the federal Patient Protection and*
38 *Affordable Care Act (Public Law 111-148) and any federal rules,*
39 *regulations, or guidance issued consistent with that law.*

40 (x)

1 (w) “Standard employee risk rate” means the rate applicable to
2 an eligible employee in a particular risk category in a small
3 employer group. *For plan years commencing on or after January*
4 *1, 2014, no risk adjustment factor shall be used to determine rates.*

5 ~~(y)~~

6 (x) “Guaranteed association” means a nonprofit organization
7 comprised of a group of individuals or employers who associate
8 based solely on participation in a specified profession or industry,
9 accepting for membership any individual or employer meeting its
10 membership criteria which (1) includes one or more small
11 employers as defined in paragraph (1) of subdivision (w), (2) does
12 not condition membership directly or indirectly on the health or
13 claims history of any person, (3) uses membership dues solely for
14 and in consideration of the membership and membership benefits,
15 except that the amount of the dues shall not depend on whether
16 the member applies for or purchases insurance offered by the
17 association, (4) is organized and maintained in good faith for
18 purposes unrelated to insurance, (5) has been in active existence
19 on January 1, 1992, and for at least five years prior to that date,
20 (6) has been offering health insurance to its members for at least
21 five years prior to January 1, 1992, (7) has a constitution and
22 bylaws, or other analogous governing documents that provide for
23 election of the governing board of the association by its members,
24 (8) offers any benefit plan design that is purchased to all individual
25 members and employer members in this state, (9) includes any
26 member choosing to enroll in the benefit plan design offered to
27 the association provided that the member has agreed to make the
28 required premium payments, and (10) covers at least 1,000 persons
29 with the carrier with which it contracts. The requirement of 1,000
30 persons may be met if component chapters of a statewide
31 association contracting separately with the same carrier cover at
32 least 1,000 persons in the aggregate.

33 This subdivision applies regardless of whether a master policy
34 by an admitted insurer is delivered directly to the association or a
35 trust formed for or sponsored by an association to administer
36 benefits for association members.

37 For purposes of this subdivision, an association formed by a
38 merger of two or more associations after January 1, 1992, and
39 otherwise meeting the criteria of this subdivision shall be deemed
40 to have been in active existence on January 1, 1992, if its

1 predecessor organizations had been in active existence on January
2 1, 1992, and for at least five years prior to that date and otherwise
3 met the criteria of this subdivision.

4 (z)

5 (y) “Members of a guaranteed association” means any individual
6 or employer meeting the association’s membership criteria if that
7 person is a member of the association and chooses to purchase
8 health coverage through the association. At the association’s
9 discretion, it may also include employees of association members,
10 association staff, retired members, retired employees of members,
11 and surviving spouses and dependents of deceased members.
12 However, if an association chooses to include those persons as
13 members of the guaranteed association, the association must so
14 elect in advance of purchasing coverage from a plan. Health plans
15 may require an association to adhere to the membership
16 composition it selects for up to 12 months.

17 (aa)

18 (z) “Affiliation period” means a period that, under the terms of
19 the health benefit plan, must expire before health care services
20 under the plan become effective until December 31, 2013.

21 ~~(ab) “Plan year” means a consecutive 12-month period during~~
22 ~~which a health plan provides coverage for health benefits. A plan~~
23 ~~year may be a calendar year or otherwise. This definition shall~~
24 ~~apply to the extent it is consistent with the federal Patient~~
25 ~~Protection and Affordable Care Act (Public Law 111-148) and~~
26 ~~any federal rules, regulations, or guidance issued consistent with~~
27 ~~that law. An affiliation period under a plan contract shall run~~
28 ~~concurrently with any waiting period under the plan contract. An~~
29 ~~affiliation period may not exceed 60 days or, in the case of a late~~
30 ~~enrollee, 90 days.~~

31 (aa) “Plan year” has the meaning set forth in Section 144.103
32 of Title 45 of the Code of Federal Regulations.

33 (ab) “PPACA” means the federal Patient Protection and
34 Affordable Care Act (Public Law 111-148), as amended by the
35 federal Health Care and Education Reconciliation Act of 2010
36 (Public Law 111-152), and any rules, regulations, or guidance
37 issued thereunder.

38 (ac) “Grandfathered health plan” has the meaning set forth in
39 Section 1251 of PPACA.

1 (ad) “Waiting period” means the period that is required to pass
2 with respect to the employee before the employee is eligible to be
3 covered for benefits under the terms of the policy. However, such
4 periods shall not be based upon the health status of the employee
5 or dependent. For plan years commencing on or after January 1,
6 2014, a health benefit plan may apply a waiting period of up to
7 90 days as a condition of employment if applied equally to all
8 full-time employees, consistent with the federal Patient Protection
9 and Affordable Care Act (Public Law 111-148) and any rules,
10 regulations, or guidance issued consistent with that law.

11 ~~SEC. 23.~~

12 SEC. 15. Section 10705 of the Insurance Code is amended to
13 read:

14 10705. Upon the effective date of this act:

15 (a) No group or individual policy or contract or certificate of
16 group insurance or statement of group coverage providing benefits
17 to employees of small employers as defined in this chapter shall
18 be issued or delivered by a carrier subject to the jurisdiction of the
19 commissioner regardless of the situs of the contract or master
20 policyholder or of the domicile of the carrier nor, except as
21 otherwise provided in Sections 10270.91 and 10270.92, shall a
22 carrier provide coverage subject to this chapter until a copy of the
23 form of the policy, contract, certificate, or statement of coverage
24 is filed with and approved by the commissioner in accordance with
25 Sections 10290 and 10291, and the carrier has complied with the
26 requirements of Section 10717.

27 (b) (1) Each carrier, except a self-funded employer, shall fairly
28 and affirmatively offer, market, and sell all of the carrier’s benefit
29 plan designs that are sold to, offered through, or sponsored by,
30 small employers or associations that include small employers to
31 all small employers in each geographic region in which the carrier
32 makes coverage available or provides benefits.

33 (2) A carrier contracting to participate in the California Health
34 Benefit Exchange shall be deemed to be in compliance with
35 paragraph (1) for a benefit plan design offered in those geographic
36 regions in which the carrier participates in the California Health
37 Benefit Exchange.

38 (3) (A) A carrier shall be deemed to meet the requirements of
39 paragraph (1) and subdivision (c) with respect to a benefit plan

1 design that qualifies as a grandfathered health plan under Section
2 1251 of PPACA if all of the following requirements are met:

3 (i) The carrier offers to renew the benefit plan design, unless
4 the carrier withdraws the benefit plan design from the small
5 employer market pursuant to subdivision (e) of Section 10713.

6 (ii) The carrier provides appropriate notice of the grandfathered
7 status of the benefit plan design in any materials provided to an
8 insured of the design describing the benefits provided under the
9 design, as required under PPACA.

10 (iii) The carrier makes no changes to the benefits covered under
11 the benefit plan design other than those required by a state or
12 federal law, regulation, rule, or guidance and those permitted to
13 be made to a grandfathered health plan under PPACA.

14 (B) For purposes of this paragraph, “PPACA” means the federal
15 Patient Protection and Affordable Care Act (Public Law 111-148),
16 as amended by the federal Health Care and Education
17 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
18 regulations, or guidance issued thereunder. For purposes of this
19 paragraph, a “grandfathered health plan” shall have the meaning
20 set forth in Section 1251 of PPACA.

21 (4) Nothing in this section shall be construed to require an
22 association, or a trust established and maintained by an association
23 to receive a master insurance policy issued by an admitted insurer
24 and to administer the benefits thereof solely for association
25 members, to offer, market, or sell a benefit plan design to those
26 who are not members of the association. However, if the
27 association markets, offers, or sells a benefit plan design to those
28 who are not members of the association it is subject to the
29 requirements of this section. This shall apply to an association that
30 otherwise meets the requirements of paragraph (8) formed by
31 merger of two or more associations after January 1, 1992, if the
32 predecessor organizations had been in active existence on January
33 1, 1992, and for at least five years prior to that date and met the
34 requirements of paragraph (5).

35 (5) A carrier which (A) effective January 1, 1992, and at least
36 20 years prior to that date, markets, offers, or sells benefit plan
37 designs only to all members of one association and (B) does not
38 market, offer, or sell any other individual, selected group, or group
39 policy or contract providing medical, hospital, and surgical benefits
40 shall not be required to market, offer, or sell to those who are not

1 members of the association. However, if the carrier markets, offers,
2 or sells any benefit plan design or any other individual, selected
3 group, or group policy or contract providing medical, hospital, and
4 surgical benefits to those who are not members of the association
5 it is subject to the requirements of this section.

6 (6) Each carrier that sells health benefit plans to members of
7 one association pursuant to paragraph (5) shall submit an annual
8 statement to the commissioner which states that the carrier is selling
9 health benefit plans pursuant to paragraph (5) and which, for the
10 one association, lists all the information required by paragraph (7).

11 (7) Each carrier that sells health benefit plans to members of
12 any association shall submit an annual statement to the
13 commissioner which lists each association to which the carrier
14 sells health benefit plans, the industry or profession which is served
15 by the association, the association's membership criteria, a list of
16 officers, the state in which the association is organized, and the
17 site of its principal office.

18 (8) For purposes of paragraphs (4) and (5), an association is a
19 nonprofit organization comprised of a group of individuals or
20 employers who associate based solely on participation in a
21 specified profession or industry, accepting for membership any
22 individual or small employer meeting its membership criteria,
23 which do not condition membership directly or indirectly on the
24 health or claims history of any person, which uses membership
25 dues solely for and in consideration of the membership and
26 membership benefits, except that the amount of the dues shall not
27 depend on whether the member applies for or purchases insurance
28 offered by the association, which is organized and maintained in
29 good faith for purposes unrelated to insurance, which has been in
30 active existence on January 1, 1992, and at least five years prior
31 to that date, which has a constitution and bylaws, or other
32 analogous governing documents which provide for election of the
33 governing board of the association by its members, which has
34 contracted with one or more carriers to offer one or more health
35 benefit plans to all individual members and small employer
36 members in this state.

37 (c) Each carrier shall make available to each small employer
38 all benefit plan designs that the carrier offers or sells to small
39 employers or to associations that include small employers.
40 Notwithstanding subdivision (d) of Section 10700, for purposes

1 of this subdivision, companies that are affiliated companies or that
2 are eligible to file a consolidated income tax return shall be treated
3 as one carrier.

4 (d) Each carrier shall do all of the following:

5 (1) Prepare a brochure that summarizes all of its benefit plan
6 designs and make this summary available to small employers,
7 agents, and brokers upon request. The summary shall include for
8 each benefit plan design information on benefits provided, a generic
9 description of the manner in which services are provided, such as
10 how access to providers is limited, benefit limitations, required
11 copayments and deductibles, standard employee risk rates, and,
12 until January 1, 2014, an explanation of how creditable coverage
13 is calculated if a preexisting condition or affiliation period is
14 imposed. The summary shall also include a telephone number that
15 can be called for more detailed benefit information. Carriers are
16 required to keep the information contained in the brochure accurate
17 and up to date, and, upon updating the brochure, send copies to
18 agents and brokers representing the carrier. Any entity that provides
19 administrative services only with regard to a benefit plan design
20 written or issued by another carrier shall not be required to prepare
21 a summary brochure which includes that benefit plan design. For
22 plan years commencing on or after January 1, 2014, a health benefit
23 plan offered to a small employer shall not impose any preexisting
24 condition provision upon any individual. Nothing in this paragraph
25 shall be construed as prohibiting a health benefit plan from
26 restricting enrollment of enrollees to open enrollment periods as
27 authorized under Section 2702 of the federal Patient Protection
28 and Affordable Care Act (Public Law 111-148) and any rules,
29 regulations, or guidance issued consistent with that law.

30 (2) For each benefit plan design, prepare a more detailed
31 evidence of coverage and make it available to small employers,
32 agents and brokers upon request. The evidence of coverage shall
33 contain all information that a prudent buyer would need to be aware
34 of in making selections of benefit plan designs. An entity that
35 provides administrative services only with regard to a benefit plan
36 design written or issued by another carrier shall not be required to
37 prepare an evidence of coverage for that benefit plan design.

38 (3) Provide to small employers, agents, and brokers, upon
39 request, for any given small employer the sum of the standard
40 employee risk rates and the sum of the risk adjusted standard

1 employee risk rates. When requesting this information, small
2 employers, agents, and brokers shall provide the carrier with the
3 information the carrier needs to determine the small employer's
4 risk adjusted employee risk rate. For plan years commencing on
5 or after January 1, 2014, no risk adjustment factor may be used in
6 the determination of rates.

7 (4) Provide copies of the current summary brochure to all agents
8 or brokers who represent the carrier and, upon updating the
9 brochure, send copies of the updated brochure to agents and brokers
10 representing the carrier for the purpose of selling health benefit
11 plans.

12 (5) Notwithstanding subdivision (d) of Section 10700, for
13 purposes of this subdivision, companies that are affiliated
14 companies or that are eligible to file a consolidated income tax
15 return shall be treated as one carrier.

16 (e) Every agent or broker representing one or more carriers for
17 the purpose of selling health benefit plans to small employers shall
18 do all of the following:

19 (1) When providing information on a health benefit plan to a
20 small employer but making no specific recommendations on
21 particular benefit plan designs:

22 (A) Advise the small employer of the carrier's obligation to sell
23 to any small employer any of the benefit plan designs it offers to
24 small employers and provide them, upon request, with the actual
25 rates that would be charged to that employer for a given benefit
26 plan design.

27 (B) Notify the small employer that the agent or broker will
28 procure rate and benefit information for the small employer on
29 any benefit plan design offered by a carrier for whom the agent or
30 broker sells health benefit plans.

31 (C) Notify the small employer that, upon request, the agent or
32 broker will provide the small employer with the summary brochure
33 required in paragraph (1) of subdivision (d) for any benefit plan
34 design offered by a carrier whom the agent or broker represents.

35 (D) Notify the small employer of the availability of coverage
36 through the California Health Benefit Exchange and the availability
37 of tax credits for certain employers, and effective January 1, 2014,
38 the availability of tax credits through the Exchange.

39 (2) When recommending a particular benefit plan design or
40 designs, advise the small employer that, upon request, the agent

1 will provide the small employer with the brochure required by
2 paragraph (1) of subdivision (d) containing the benefit plan design
3 or designs being recommended by the agent or broker.

4 (3) Prior to filing an application for a small employer for a
5 particular health benefit plan:

6 (A) For each of the benefit plan designs offered by the carrier
7 whose benefit plan design the agent or broker is presenting, provide
8 the small employer with the benefit summary required in paragraph
9 (1) of subdivision (d) and the sum of the standard employee risk
10 rates for that particular employer.

11 (B) Notify the small employer that, upon request, the agent or
12 broker will provide the small employer with an evidence of
13 coverage brochure for each benefit plan design the carrier offers.

14 (C) For plan years commencing on or before December 31,
15 2013, notify the small employer that actual rates may be 10 percent
16 higher or lower than the sum of the standard employee risk rates
17 depending on how the carrier assesses the risk of the small
18 employer's group. For plan years commencing on or after January
19 1, 2014, no risk adjustment factor may be used in the determination
20 of rates.

21 (D) For plan years commencing on or before December 31,
22 2013, notify the small employer that, upon request, the agent or
23 broker will submit information to the carrier to ascertain the small
24 employer's sum of the risk adjusted standard employee risk rate
25 for any benefit plan design the carrier offers. On or after November
26 1, 2013, notify the small employer of the employee rate effective
27 January 1, 2014. For plan years commencing on or after January
28 1, 2014, no risk adjustment factor may be used in the determination
29 of rates.

30 (E) Obtain a signed statement from the small employer
31 acknowledging that the small employer has received the disclosures
32 required by this paragraph and Section 10716.

33 (f) No carrier, agent, or broker shall induce or otherwise
34 encourage a small employer to separate or otherwise exclude an
35 eligible employee from a health benefit plan which, in the case of
36 an eligible employee meeting the definition in paragraph (1) of
37 subdivision (f) of Section 10700, is provided in connection with
38 the employee's employment or which, in the case of an eligible
39 employee as defined in paragraph (2) of subdivision (f) of Section
40 10700, is provided in connection with a guaranteed association.

1 (g) No carrier shall reject an application from a small employer
2 for a benefit plan design provided:

3 (1) The small employer as defined by paragraph (1) of
4 subdivision (w) of Section 10700 offers health benefits to 100
5 percent of its eligible employees as defined in paragraph (1) of
6 subdivision (f) of Section 10700. Employees who waive coverage
7 on the grounds that they have other group coverage shall not be
8 counted as eligible employees.

9 (2) The small employer agrees to make the required premium
10 payments.

11 (h) No carrier or agent or broker shall, directly or indirectly,
12 engage in the following activities:

13 (1) Encourage or direct small employers to refrain from filing
14 an application for coverage with a carrier because of the health
15 status, claims experience, industry, occupation, or geographic
16 location within the carrier's approved service area of the small
17 employer or the small employer's employees.

18 (2) Encourage or direct small employers to seek coverage from
19 another carrier or the California Health Benefit Exchange because
20 of the health status, claims experience, industry, occupation, or
21 geographic location within the carrier's approved service area of
22 the small employer or the small employer's employees.

23 (i) No carrier shall, directly or indirectly, enter into any contract,
24 agreement, or arrangement with an agent or broker that provides
25 for or results in the compensation paid to an agent or broker for a
26 health benefit plan to be varied because of the health status, claims
27 experience, industry, occupation, or geographic location of the
28 small employer or the small employer's employees. This
29 subdivision shall not apply with respect to a compensation
30 arrangement that provides compensation to an agent or broker on
31 the basis of percentage of premium, provided that the percentage
32 shall not vary because of the health status, claims experience,
33 industry, occupation, or geographic area of the small employer.

34 (j) ~~Except~~ *For plan years commencing on or before December*
35 *31, 2013*, in the case of a late insured, or for ~~plan years~~
36 ~~commencing on or before December 31, 2013~~, for satisfaction of
37 a preexisting condition clause in the case of initial coverage of an
38 eligible employee, a health insurer may not exclude any eligible
39 employee or dependent who would otherwise be entitled to health
40 care services on the basis of any of the following: the health status,

1 the medical condition, including both physical and mental illnesses,
2 the claims experience, the medical history, receipt of health care,
3 the genetic information, the disability or evidence of insurability,
4 including conditions arising out of acts of domestic violence of
5 that employee or dependent, or any other health status-related
6 factor as determined by the department. No health benefit plan
7 may limit or exclude coverage for a specific eligible employee or
8 dependent by type of illness, treatment, medical condition, or
9 accident, except for preexisting conditions as permitted by Section
10 10198.7 or 10708. However, this exception for preexisting
11 conditions shall not apply after December 31, 2013. For plan years
12 commencing on or after January 1, 2014, a health benefit plan
13 offered to a small employer shall not impose any preexisting
14 condition provision upon any individual. Nothing in this
15 subdivision shall be construed as prohibiting a health benefit plan
16 from restricting enrollment of enrollees, including late enrollees,
17 to open enrollment periods as authorized under Section 2702 of
18 the federal Patient Protection and Affordable Care Act (Public
19 Law 111-148) and any rules, regulations, or guidance issued
20 consistent with that law.

21 (k) If a carrier enters into a contract, agreement, or other
22 arrangement with a third-party administrator or other entity to
23 provide administrative, marketing, or other services related to the
24 offering of health benefit plans to small employers in this state,
25 the third-party administrator shall be subject to this chapter.

26 (l) (1) With respect to the obligation to provide coverage newly
27 issued under subdivision (d), the carrier may cease enrolling new
28 small employer groups and new eligible employees as defined by
29 paragraph (2) of subdivision (f) of Section 10700 if it certifies to
30 the commissioner that the number of eligible employees and
31 dependents, of the employers newly enrolled or insured during the
32 current calendar year by the carrier equals or exceeds: (A) in the
33 case of a carrier that administers any self-funded health benefits
34 arrangement in California, 10 percent of the total number of eligible
35 employees, or eligible employees and dependents, respectively,
36 enrolled or insured in California by that carrier as of December
37 31 of the preceding year, or (B) in the case of a carrier that does
38 not administer any self-funded health benefit arrangements in
39 California, 8 percent of the total number of eligible employees, or
40 eligible employees and dependents, respectively, enrolled or

1 insured by the carrier in California as of December 31 of the
2 preceding year.

3 (2) Certification shall be deemed approved if not disapproved
4 within 45 days after submission to the commissioner. If that
5 certification is approved, the small employer carrier shall not offer
6 coverage to any small employers under any health benefit plans
7 during the remainder of the current year. If the certification is not
8 approved, the carrier shall continue to issue coverage as required
9 by subdivision (d) and be subject to administrative penalties as
10 established in Section 10718.

11 ~~SEC. 24.~~

12 *SEC. 16.* Section 10706 of the Insurance Code is amended to
13 read:

14 10706. Every carrier shall file with the commissioner the
15 reasonable participation requirements and employer contribution
16 requirements that are to be included in its health benefit plans.
17 Participation requirements shall be applied uniformly among all
18 small employer groups, except that a carrier may vary application
19 of minimum employer participation requirements by the size of
20 the small employer group and whether the employer contributes
21 100 percent of the eligible employee's premium. Employer
22 contribution requirements shall not vary by employer size.
23 Employer contribution requirements shall be consistent with the
24 federal Patient Protection and Affordable Care Act (Public Law
25 111-148). A carrier shall not establish a participation requirement
26 that (1) requires a person who meets the definition of a dependent
27 in subdivision (e) of Section 10700 to enroll as a dependent if he
28 or she is otherwise eligible for coverage and wishes to enroll as
29 an eligible employee and (2) allows a carrier to reject an otherwise
30 eligible small employer because of the number of persons that
31 waive coverage due to coverage through another employer.
32 Members of an association eligible for health coverage eligible
33 under subdivision (z) of Section 10700 but not electing any health
34 coverage through the association shall not be counted as eligible
35 employees for purposes of determining whether the guaranteed
36 association meets a carrier's reasonable participation standards.

37 ~~SEC. 25.~~

38 *SEC. 17.* Section 10707 of the Insurance Code is amended to
39 read:

1 10707. (a) For plan years commencing on or before December
 2 31, 2013, except in the case of a late enrollee, or for satisfaction
 3 of a preexisting condition clause in the case of initial coverage of
 4 an eligible employee, a carrier may not exclude any eligible
 5 employee or dependent who would otherwise be covered, on the
 6 basis of an actual or expected health condition of that employee
 7 or dependent. No health benefit plan may limit or exclude coverage
 8 for a specific eligible employee or dependent by type of illness,
 9 treatment, medical condition, or accident, except for preexisting
 10 conditions as permitted by Section 10708.

11 (b) For plan years commencing on or after January 1, 2014, a
 12 carrier may not exclude any eligible employee or dependent who
 13 would otherwise be entitled to health care services on the basis of
 14 an actual or expected health condition of that employee or
 15 dependent. No health benefit plan may limit or exclude coverage
 16 for a specific eligible employee or dependent by type of illness,
 17 treatment, medical condition, or accident.

18 ~~SEC. 26.~~

19 *SEC. 18.* Section 10708 of the Insurance Code is amended to
 20 read:

21 10708. (a) (1) For plan years commencing on or before
 22 December 31, 2013, health benefit plans shall not exclude coverage
 23 for a period beyond six months following the individual's effective
 24 date of coverage and may only relate to conditions for which
 25 medical advice, diagnosis, care, or treatment, including the use of
 26 prescription medications, was recommended by or received from
 27 a licensed health practitioner during the six months immediately
 28 preceding the effective date of coverage.

29 (2) Notwithstanding paragraph (1), a health benefit plan offered
 30 to a small employer shall not impose any preexisting condition
 31 provision upon any child under 19 years of age.

32 (3) For plan years commencing on or after January 1, 2014, a
 33 health benefit plan offered to a small employer shall not impose
 34 any preexisting condition provision upon any individual.

35 (b) (1) For plan years commencing on or before December 31,
 36 2013, a carrier that does not utilize a preexisting condition
 37 provision may impose a waiting or affiliation period, not to exceed
 38 60 days, before the coverage issued subject to this chapter shall
 39 become effective. During the waiting or affiliation period, the

1 carrier is not required to provide health care benefits and no
2 premiums shall be charged to the subscriber or enrollee.

3 (2) For plan years commencing on or after January 1, 2014, no
4 waiting or affiliation period based on a preexisting condition, health
5 status, or any other factor prohibited under subdivision ~~(f)~~ of
6 ~~Section 1357.03~~ (e) of Section 10198.7 shall be imposed. A carrier
7 may ~~permit~~ apply a waiting period of up to 90 days as a condition
8 of ~~enrollment~~ employment if applied equally to all full-time
9 employees and if consistent with the federal Patient Protection and
10 Affordable Care Act (Public Law 111-148) and any rules,
11 regulations, or guidance issued consistent with that law.

12 (c) For plan years commencing on or before December 31, 2013,
13 in determining whether a preexisting condition provision or a
14 waiting period applies to any person, a plan shall credit the time
15 the person was covered under creditable coverage, provided the
16 person becomes eligible for coverage under the succeeding plan
17 contract within 62 days of termination of prior coverage, exclusive
18 of any waiting or affiliation period, and applies for coverage with
19 the succeeding health benefit plan contract within the applicable
20 enrollment period. A plan shall also credit any time an eligible
21 employee must wait before enrolling in the health benefit plan,
22 including any postenrollment or employer-imposed waiting or
23 affiliation period. However, if a person's employment has ended,
24 the availability of health coverage offered through employment
25 or sponsored by an employer has terminated, or an employer's
26 contribution toward health coverage has terminated, a plan shall
27 credit the time the person was covered under creditable coverage
28 if the person becomes eligible for health coverage offered through
29 employment or sponsored by an employer within 180 days,
30 exclusive of any waiting or affiliation period, and applies for
31 coverage under the succeeding health benefit plan within the
32 applicable enrollment period. Nothing in this subdivision shall be
33 construed as prohibiting a health benefit plan from restricting
34 enrollment of enrollees to open enrollment periods as authorized
35 under Section 2702 of the federal Patient Protection and Affordable
36 Care Act (Public Law 111-148) and any rules, regulations, or
37 guidance issued under that law.

38 (d) Group health benefit plans may not impose a preexisting
39 conditions exclusion to a condition relating to benefits for
40 pregnancy or maternity care.

1 (e) (1) For plan years commencing on or before December 31,
 2 2013, a carrier providing aggregate or specific stop loss coverage
 3 or any other assumption of risk with reference to a health benefit
 4 plan shall provide that the plan meets all requirements of this
 5 section concerning preexisting condition provisions and waiting
 6 or affiliation periods.

7 (2) For plan years commencing on or after January 1, 2014, a
 8 carrier providing aggregate or specific stoploss coverage or any
 9 other assumption of risk with reference to a health benefit plan
 10 shall provide that the plan meets all requirements of this section
 11 concerning waiting periods.

12 (3) *The requirements set forth under this subdivision shall only*
 13 *be exercised to the extent they are not preempted by ERISA.*

14 (f) For plan years commencing on or before December 31, 2013,
 15 in addition to the preexisting condition exclusions authorized by
 16 subdivision (a) and the waiting or affiliation period authorized by
 17 subdivision (b), carriers providing coverage to a guaranteed
 18 association may impose on employers or individuals purchasing
 19 coverage who would not be eligible for guaranteed coverage if
 20 they were not purchasing through the association a waiting or
 21 affiliation period, not to exceed 60 days, before the coverage issued
 22 subject to this chapter shall become effective. During the waiting
 23 or affiliation period, the carrier is not required to provide health
 24 care benefits and no premiums shall be charged to the insured. For
 25 plan years commencing on or after January 1, 2014, ~~waiting periods~~
 26 ~~may only be used consistent with subdivision (c) of Section~~
 27 ~~10198.6.~~ *2014, no waiting or affiliation period based on a*
 28 *preexisting condition, health status, or any other factor prohibited*
 29 *under subdivision (u) of Section 10700 shall be imposed.*

30 ~~SEC. 27.~~

31 *SEC. 19.* Section 10709 of the Insurance Code is amended to
 32 read:

33 10709. (a) (1) Until December 31, 2013, no health benefit
 34 plan may exclude late enrollees from coverage for more than 12
 35 months from the date of the late enrollee’s application for coverage.
 36 No premiums shall be charged to the late enrollee until the
 37 exclusion period has ended.

38 (2) For plan years commencing on or after January 1, 2014, no
 39 health benefit plan may exclude late enrollees from coverage for
 40 more than 90 days from the date of the late enrollee’s application

1 for coverage. No premium shall be charged to the late enrollee
2 until the exclusion period has ended. Nothing in this paragraph
3 shall be construed as prohibiting a health benefit plan from
4 restricting enrollment of late enrollees to open enrollment periods
5 as authorized under Section 2702 of the federal Patient Protection
6 and Affordable Care Act (Public Law 111-148) and any rules,
7 regulations, or guidance issued consistent with that law.

8 (3) For plan years commencing on or after January 1, 2014, a
9 health benefit plan may ~~permit~~ *apply* a waiting period of up to 90
10 days as a condition of ~~enrollment~~ *employment* if applied equally
11 to all full-time employees and if consistent with the federal Patient
12 Protection and Affordable Care Act (Public Law 111-148) and
13 any rules, regulations, or guidance issued consistent with that law.

14 (b) A carrier providing aggregate or specific stop loss coverage
15 or any other assumption of risk with reference to a health benefit
16 plan shall provide that the plan meets all requirements of this
17 section concerning late enrollees. *The requirements set forth under*
18 *this subdivision shall only be exercised to the extent they are not*
19 *preempted by ERISA.*

20 ~~SEC. 28:~~

21 *SEC. 20.* Section 10714 of the Insurance Code is amended to
22 read:

23 10714. Premiums for benefit plan designs written, issued, or
24 administered by carriers on or after the effective date of this act,
25 shall be subject to the following requirements:

26 (a) (1) The premium for new business shall be determined for
27 an eligible employee in a particular risk category after applying a
28 risk adjustment factor to the carrier's standard employee risk rates.
29 The risk adjusted employee risk rate may not be more than 120
30 percent or less than 80 percent of the carrier's applicable standard
31 employee risk rate until July 1, 1996. Effective July 1, 1996, the
32 risk adjusted employee risk rate may not be more than 110 percent
33 or less than 90 percent. For plan years commencing on or after
34 January 1, 2014, no risk adjustment factor shall be used in the
35 determination of rates. For plan years commencing on or after
36 January 1, 2014, no risk adjustment shall be used in the
37 determination of rates.

38 (2) The premium charged a small employer for new business
39 shall be equal to the sum of the risk adjusted employee risk rates.

1 For plan years commencing on or after January 1, 2014, no risk
2 adjustment shall be used in the determination of rates.

3 (3) The standard employee risk rates applied to a small employer
4 for new business shall be in effect for no less than 12 months. This
5 subdivision shall be implemented to the extent permitted under
6 the federal Patient Protection and Affordable Care Act (Public
7 Law 111-148) and any rules, regulations, or guidance issued
8 consistent with that law.

9 (b) (1) The premium for in force business shall be determined
10 for an eligible employee in a particular risk category after applying
11 a risk adjustment factor to the carrier's standard employee risk
12 rates. The risk adjusted employee risk rates may not be more than
13 120 percent or less than 80 percent of the carrier's applicable
14 standard employee risk rate until July 1, 1996. Effective July 1,
15 1996, the risk adjusted employee risk rate may not be more than
16 110 percent or less than 90 percent. The factor effective July 1,
17 1996, shall apply to in force business at the earlier of either the
18 time of renewal or July 1, 1997. For plan years commencing on
19 or before December 31, 2013, the risk adjustment factor applied
20 to a small employer may not increase by more than 10 percentage
21 points from the risk adjustment factor applied in the prior rating
22 period. For plan years commencing on or after January 1, 2014,
23 no risk adjustment factor shall be used in the determination of
24 rates. The risk adjustment factor for a small employer may not be
25 modified more frequently than every 12 months.

26 (2) The premium charged a small employer for in force business
27 shall be equal to the sum of the risk adjusted employee risk rates.
28 The standard employee risk rates shall be in effect for no less than
29 12 months.

30 (3) For a benefit plan design that a carrier has discontinued
31 offering, the risk adjustment factor applied to the standard
32 employee risk rates for the first rating period of the new benefit
33 plan design that the small employer elects to purchase shall be no
34 greater than the risk adjustment factor applied in the prior rating
35 period to the discontinued benefit plan design. However, the risk
36 adjusted employee rate may not be more than 120 percent or less
37 than 80 percent of the carrier's applicable standard employee risk
38 rate until July 1, 1996. Effective July 1, 1996, the risk adjusted
39 employee risk rate may not be more than 110 percent or less than
40 90 percent. The factor effective July 1, 1996, shall apply to in force

1 business at the earlier of either the time of renewal or July 1, 1997.
2 For plan years commencing on or after January 1, 2014, no risk
3 adjustment factor shall be used in the determination of rates. The
4 risk adjustment factor for a small employer may not be modified
5 more frequently than every 12 months.

6 (c) (1) For any small employer, a carrier may, with the consent
7 of the small employer, establish composite employee and
8 dependent rates for either new business or renewal of in force
9 business. The composite rates shall be determined as the average
10 of the risk adjusted employee risk rates for the small employer, as
11 determined in accordance with the requirements of subdivisions
12 (a) and (b). The sum of the composite rates so determined shall be
13 equal to the sum of the risk adjusted employee risk rates for the
14 small employer.

15 (2) The composite rates shall be used for all employees and
16 dependents covered throughout a rating period of 12 months, except
17 that a carrier may reserve the right to redetermine the composite
18 rates if the enrollment under the health benefit plan changes by
19 more than a specified percentage during the rating period. Any
20 redetermination of the composite rates shall be based on the same
21 risk adjusted employee risk rates used to determine the initial
22 composite rates for the rating period. If a carrier reserves the right
23 to redetermine the rates and the enrollment changes more than the
24 specified percentage, the carrier shall redetermine the composite
25 rates if the redetermined rates would result in a lower premium
26 for the small employer. A carrier reserving the right to redetermine
27 the composite rates based upon a change in enrollment shall use
28 the same specified percentage to measure that change with respect
29 to all small employers electing composite rates.

30 (d) *This section shall remain in effect only until January 1, 2014,*
31 *and as of that date is repealed, unless a later enacted statute, that*
32 *is enacted before January 1, 2014, deletes or extends that date.*

33 *SEC. 21. Section 10714 is added to the Insurance Code, to*
34 *read:*

35 *10714. (a) Premium rates for contracts offered or delivered*
36 *by plans on or after January 1, 2014, shall be subject to the*
37 *following requirements:*

38 *(1) With respect to the premium rate charged by a health benefit*
39 *plan, such rate shall vary with respect to the particular plan or*
40 *coverage involved only by any of the following:*

1 (A) Whether such plan or coverage covers an individual or
2 family.

3 (B) Rating area.

4 (C) Age, except that such rate shall not vary by more than 3 to
5 1 for adults.

6 (2) Such rate shall not vary with respect to the particular plan
7 or coverage involved by any other factor not described in
8 subparagraph (1).

9 (b) This section shall become operative on January 1, 2014.

10 ~~SEC. 29.~~

11 SEC. 22. Section 10716 of the Insurance Code is amended to
12 read:

13 10716. In connection with the offering for sale of any benefit
14 plan design to small employers:

15 Each carrier shall make a reasonable disclosure, as part of its
16 solicitation and sales materials, of the following:

17 (a) For plan years commencing on or before December 31, 2013,
18 the extent to which the premium rates for a specified small
19 employer are established or adjusted in part based upon the actual
20 or expected variation in claims costs or actual or expected variation
21 in health conditions of the employees and dependents of the small
22 employer.

23 (b) The provisions concerning the carrier’s ability to change
24 premium rates and the factors other than claim experience which
25 affect changes in premium rates. For plan years commencing on
26 or after January 1, 2014, no premium rate adjustments based on
27 actual or expected claims costs or health conditions of employees
28 or dependents shall be used.

29 (c) Provisions relating to the guaranteed issue of policies and
30 contracts.

31 (d) For plan years commencing on or before December 31,
32 2013, provisions relating to the effect of any preexisting condition
33 provision. For plan years commencing on or after January 1, 2014,
34 a health benefit plan offered to a small employer shall not impose
35 any preexisting condition provision upon any individual. Nothing
36 in this subdivision shall be construed as prohibiting a health benefit
37 plan from restricting enrollment of late enrollees to open enrollment
38 periods as authorized under Section 2702 of the federal Patient
39 Protection and Affordable Care Act (Public Law 111-148) and
40 any rules, regulations, or guidance issued consistent with that law.

1 (e) Provisions relating to the small employer’s right to apply
2 for any benefit plan design written, issued, or administered by the
3 carrier at the time of application for a new health benefit plan, or
4 at the time of renewal of a health benefit plan.

5 (f) The availability, upon request, of a listing of all the carrier’s
6 benefit plan designs, including the rates for each benefit plan
7 design.

8 ~~SEC. 30.~~

9 *SEC. 23.* Section 10717 of the Insurance Code is amended to
10 read:

11 10717. (a) No carrier shall provide or renew coverage subject
12 to this chapter until it has done all of the following:

13 (1) A statement has been filed with the commissioner listing all
14 of the carrier’s benefit plan designs currently in force that are
15 offered or proposed to be offered for sale in this state, identified
16 by form number, and, if previously approved by the commissioner,
17 the date approved by the commissioner as well as, until December
18 31, 2013, the standard employee risk rate for each risk category
19 for each benefit plan design and the highest and lowest risk
20 adjustment factors that the carrier intends to use in determining
21 rates for each benefit plan design. When filing a new benefit plan
22 design pursuant to Section 10705, carriers may submit both the
23 policy form and, until December 31, 2013, the standard employee
24 risk rates for each risk category at the same time. For plan years
25 commencing on or after January 1, 2014, no risk adjustment factor
26 may be used in the determination of rates.

27 (2) Until December 31, 2013:

28 (A) Thirty days expires after that statement is filed without
29 written notice from the commissioner specifying the reasons for
30 his or her opinion that the carrier’s risk categories or risk
31 adjustment factors do not comply with the requirements of this
32 chapter.

33 (B) Prior to that time the commissioner gives the carrier written
34 notice that the carrier’s risk categories and risk adjustment factors
35 as filed comply with the requirements of this chapter.

36 (b) No carrier shall issue, deliver, renew, or revise a benefit plan
37 design lawfully provided pursuant to subdivision (a), and no carrier
38 shall change the risk categories, risk adjustment factors, or standard
39 employee risk rates for any benefit plan design until all of the
40 following requirements are met:

1 (1) The carrier files with the commissioner a statement of the
2 specific changes which the carrier proposes in the risk categories,
3 risk adjustment factors, or standard employee risk rates. For plan
4 years commencing on or after January 1, 2014, no risk adjustment
5 factor may be used in the determination of rates.

6 (2) Until December 31, 2013:

7 (A) Thirty days expires after such statement is filed without
8 written notice from the commissioner specifying the reasons for
9 his or her opinion that the carrier's risk categories or risk
10 adjustment factors do not comply with the requirements of this
11 chapter.

12 (B) Prior to that time the commissioner gives the carrier written
13 notice that the carrier's risk categories and risk adjustment factors
14 as filed comply with the requirements of this chapter.

15 (c) Notwithstanding any provision to the contrary, until
16 December 31, 2013, when a carrier is changing the standard
17 employee risk rates of a benefit plan design lawfully provided
18 under subdivision (a) or (b) but is not changing the risk categories
19 or risk adjustment factors which have been previously authorized,
20 the carrier need not comply with the requirements of paragraph
21 (2) of subdivision (b), but instead shall submit the revised standard
22 employee risk rates for the benefit plan design prior to offering or
23 renewing the benefit plan design. For plan years commencing on
24 or after January 1, 2014, no risk adjustment factor may be used in
25 the determination of rates.

26 (d) When submitting filings under subdivision (a), (b), or (c),
27 a carrier may also file with the commissioner at the time of the
28 filings, until December 31, 2013, a statement of the standard
29 employee risk rate for each risk category the carrier intends to use
30 for each month in the 12 months subsequent to the date of the
31 filing. Once the requirements of the applicable subdivision (a),
32 (b), or (c), have been met, these rates, until December 31, 2013,
33 shall be used by the carrier for the 12-month period unless the
34 carrier is otherwise informed by the commissioner in his or her
35 response to the filings submitted under subdivision (a), (b), or (c),
36 provided that any subsequent change in the standard employee
37 risk rates charged by the carrier which differ from those previously
38 filed with the commissioner must be newly filed in accordance
39 with this subdivision and provided that the carrier does not change
40 the risk categories or risk adjustment factors for the benefit plan

1 design. For plan years commencing on or after January 1, 2014,
2 no risk adjustment factor may be used in the determination of rates.

3 (e) Until December 31, 2013, if the commissioner notifies the
4 carrier, in writing, that the carrier's risk categories or risk
5 adjustment factors do not comply with the requirements of this
6 chapter, specifying the reasons for his or her opinion, it is unlawful
7 for the carrier, at any time after the receipt of such notice, to utilize
8 the noncomplying health benefit plan, benefit plan design, risk
9 categories, or risk adjustment factors in conjunction with the health
10 benefit plans or benefit plan designs for which the filing was made.
11 For plan years commencing on or after January 1, 2014, no risk
12 adjustment factor may be used in the determination of rates.

13 (f) Each carrier shall maintain at its principal place of business
14 copies of all information required to be filed with the commissioner
15 pursuant to this section.

16 (g) Each carrier shall make the information and documentation
17 described in this section available to the commissioner upon
18 request.

19 (h) Nothing in this section shall be construed to permit the
20 commissioner to establish or approve the rates charged to
21 policyholders for health benefit plans.

22 (i) This section shall remain in effect only until January 1, 2014,
23 and as of that date is repealed, unless a later enacted statute, that
24 is enacted before January 1, 2014, deletes or extends that date.

25 ~~SEC. 31.~~

26 *SEC. 24.* Section 10717 is added to the Insurance Code, to
27 read:

28 10717. (a) For plan years commencing on or after January 1,
29 2014, no carrier shall provide or renew coverage subject to this
30 chapter until it has filed a statement with the commissioner listing
31 all of the carrier's benefit plan designs currently in force that are
32 offered or proposed to be offered for sale in this state, identified
33 by form number, and, if previously approved by the commissioner,
34 and the date approved by the commissioner.

35 (b) Each carrier shall maintain at its principal place of business
36 copies of all information required to be filed with the commissioner
37 pursuant to this section.

38 (c) Each carrier shall make the information and documentation
39 described in this section available to the commissioner upon
40 request.

1 (d) Nothing in this section shall be construed to limit the
2 commissioner’s authority to enforce the rating practices set forth
3 in this chapter.

4 (e) This section shall become operative on January 1, 2014.

5 ~~SEC. 32.~~

6 *SEC. 25.* Nothing in this act shall preclude the Legislature from
7 considering and adopting future legislation to allow premium
8 ratings based on tobacco use and wellness incentives, to the extent
9 permitted under the federal Patient Protection and Affordable Care
10 Act (Public Law 111-148) and any rules, regulations, or guidance
11 issued consistent with that law.

12 ~~SEC. 33.~~

13 *SEC. 26.* No reimbursement is required by this act pursuant to
14 Section 6 of Article XIII B of the California Constitution because
15 the only costs that may be incurred by a local agency or school
16 district will be incurred because this act creates a new crime or
17 infraction, eliminates a crime or infraction, or changes the penalty
18 for a crime or infraction, within the meaning of Section 17556 of
19 the Government Code, or changes the definition of a crime within
20 the meaning of Section 6 of Article XIII B of the California
21 Constitution.