

AMENDED IN SENATE SEPTEMBER 2, 2011

AMENDED IN SENATE AUGUST 31, 2011

AMENDED IN SENATE AUGUST 15, 2011

AMENDED IN SENATE JULY 14, 2011

AMENDED IN SENATE JUNE 27, 2011

AMENDED IN ASSEMBLY MAY 24, 2011

AMENDED IN ASSEMBLY MAY 10, 2011

AMENDED IN ASSEMBLY MARCH 29, 2011

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, and 1357.14 of, to amend, repeal, and add Sections 1357.12 and 1357.15 of, and to add Section 1348.95 to, the Health and Safety Code, and to amend Sections 10700, 10705, 10706, 10707, 10708, 10709, and 10716 of, to amend, repeal, and add Sections 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 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 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,  
15 point-of-service, PPO, Medicare excluding Medicare supplement,  
16 Medi-Cal managed care, and traditional indemnity non-PPO health  
17 insurance. The department shall publicly report the data provided  
18 by each health care service plan pursuant to this section, including,  
19 but not limited to, posting the data on the department's Internet  
20 Web site. The department shall consult with the Department of

1 Insurance to ensure that the data reported is comparable and  
2 consistent.

3 SEC. 2. Section 1357 of the Health and Safety Code is amended  
4 to read:

5 1357. As used in this article:

6 (a) “Dependent” means the spouse or child of an eligible  
7 employee, subject to applicable terms of the health care plan  
8 contract covering the employee, and includes dependents of  
9 guaranteed association members if the association elects to include  
10 dependents under its health coverage at the same time it determines  
11 its membership composition pursuant to subdivision (o).

12 (b) “Eligible employee” means either of the following:

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

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

33 (B) The employer offers the employees health coverage under  
34 a health benefit plan.

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

37 (D) The employee must have worked at least 20 hours per  
38 normal workweek for at least 50 percent of the weeks in the  
39 previous calendar quarter. The health care service plan may request  
40 any necessary information to document the hours and time period

1 in question, including, but not limited to, payroll records and  
2 employee wage and tax filings.

3 (2) Any member of a guaranteed association as defined in  
4 subdivision (o).

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

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

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

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

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

39 (C) He or she has lost or will lose coverage under another  
40 employer health benefit plan as a result of termination of

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

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

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

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

22 (4) (A) Until December 31, 2013, in the case of an eligible  
23 employee, as defined in paragraph (1) of subdivision (b), the plan  
24 cannot produce a written statement from the employer stating that  
25 the individual or the person through whom the individual was  
26 eligible to be covered as a dependent, prior to declining coverage,  
27 was provided with, and signed, acknowledgment of an explicit  
28 written notice in boldface type specifying that failure to elect  
29 coverage during the initial enrollment period permits the plan to  
30 impose, at the time of the individual's later decision to elect  
31 coverage, an exclusion from coverage for a period of 12 months  
32 as well as a six-month preexisting condition exclusion, unless the  
33 individual meets the criteria specified in paragraph (1), (2), or (3).  
34 For plan years commencing on or after January 1, 2014, a waiting  
35 period of no longer than 90 days is permitted, unless the individual  
36 meets the criteria specified in paragraph (1), (2), or (3).

37 (B) Until December 31, 2013, in the case of an association  
38 member who did not purchase coverage through a guaranteed  
39 association, the plan cannot produce a written statement from the  
40 association stating that the association sent a written notice in

1 boldface type to all potentially eligible association members at  
2 their last known address prior to the initial enrollment period  
3 informing members that failure to elect coverage during the initial  
4 enrollment period permits the plan to impose, at the time of the  
5 member's later decision to elect coverage, an exclusion from  
6 coverage for a period of 12 months as well as a six-month  
7 preexisting condition exclusion unless the member can demonstrate  
8 that he or she meets the requirements of subparagraphs (A), (C),  
9 and (D) of paragraph (1) or meets the requirements of paragraph  
10 (2) or (3). For plan years commencing on or after January 1, 2014,  
11 a waiting period of no longer than 90 days is permitted, unless the  
12 individual meets the criteria specified in paragraph (1), (2), or (3).

13 (C) In the case of an employer or person who is not a member  
14 of an association, was eligible to purchase coverage through a  
15 guaranteed association, and did not do so, and would not be eligible  
16 to purchase guaranteed coverage unless purchased through a  
17 guaranteed association, the employer or person can demonstrate  
18 that he or she meets the requirements of subparagraphs (A), (C),  
19 and (D) of paragraph (1), or meets the requirements of paragraph  
20 (2) or (3), or that he or she recently had a change in status that  
21 would make him or her eligible and that application for enrollment  
22 was made within 30 days of the change.

23 (5) The individual is an employee or dependent who meets the  
24 criteria described in paragraph (1) and was under a COBRA  
25 continuation provision and the coverage under that provision has  
26 been exhausted. For purposes of this section, the definition of  
27 "COBRA" set forth in subdivision (e) of Section 1373.621 shall  
28 apply.

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

34 (7) The individual is an eligible employee who previously  
35 declined coverage under an employer health benefit plan and who  
36 has subsequently acquired a dependent who would be eligible for  
37 coverage as a dependent of the employee through marriage, birth,  
38 adoption, or placement for adoption, and who enrolls for coverage  
39 under that employer health benefit plan on his or her behalf and  
40 on behalf of his or her dependent within 30 days following the

1 date of marriage, birth, adoption, or placement for adoption, in  
2 which case the effective date of coverage shall be the first day of  
3 the month following the date the completed request for enrollment  
4 is received in the case of marriage, or the date of birth, or the date  
5 of adoption or placement for adoption, whichever applies. Notice  
6 of the special enrollment rights contained in this paragraph shall  
7 be provided by the employer to an employee at or before the time  
8 the employee is offered an opportunity to enroll in plan coverage.

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

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

28 (f) (1) For plan years commencing on or before December 31,  
29 2013, “preexisting condition provision” means a contract provision  
30 that excludes coverage for charges or expenses incurred during a  
31 specified period following the employee’s effective date of  
32 coverage, as to a condition for which medical advice, diagnosis,  
33 care, or treatment was recommended or received during a specified  
34 period immediately preceding the effective date of coverage.

35 (2) For plan years commencing on or after January 1, 2014, no  
36 health care service plan shall limit or exclude coverage for any  
37 individual based on a preexisting condition whether or not any  
38 medical advice, diagnosis, care, or treatment was recommended  
39 or received before that date. A preexisting condition provision  
40 includes any limitation or exclusion of benefits, including a denial

1 of coverage, applicable to an individual as a result of information  
2 relating to an individual’s health status before the individual’s  
3 effective date of coverage under a group health plan, such as a  
4 condition identified as a result of a preenrollment questionnaire  
5 or physical examination given to the individual, or review of  
6 medical records relating to the preenrollment period.

7 (g) “Creditable coverage” means:

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

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

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

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

29 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
30 (Civilian Health and Medical Program of the Uniformed Services  
31 (CHAMPUS)).

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

34 (7) A state health benefits risk pool.

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

38 (9) A public health plan as defined in federal regulations  
39 authorized by Section 2701(c)(1)(I) of the Public Health Service

1 Act, as amended by Public Law 104-191, the Health Insurance  
2 Portability and Accountability Act of 1996.

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

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

8 (h) “Rating period” means the period for which premium rates  
9 established by a plan are in effect and shall be no less than 12  
10 months. This subdivision shall be implemented to the extent  
11 permitted under the federal Patient Protection and Affordable Care  
12 Act (Public Law 111-148) and any rules, regulations, or guidance  
13 issued consistent with that law.

14 (i) “Risk adjusted employee risk rate” means the rate determined  
15 for an eligible employee of a small employer in a particular risk  
16 category after applying the risk adjustment factor. For plan years  
17 commencing on or after January 1, 2014, no risk adjustment factor  
18 shall be used in the determination of rates.

19 (j) “Risk adjustment factor” means the percentage adjustment  
20 to be applied equally to each standard employee risk rate for a  
21 particular small employer, based upon any expected deviations  
22 from standard cost of services. This factor may not be more than  
23 120 percent or less than 80 percent until July 1, 1996. Effective  
24 July 1, 1996, this factor may not be more than 110 percent or less  
25 than 90 percent. For plan years commencing on or after January  
26 1, 2014, no risk adjustment factor shall be used in the determination  
27 of rates.

28 (k) “Risk category” means the following characteristics of an  
29 eligible employee: age, geographic region, and family composition  
30 of the employee, plus the health benefit plan selected by the small  
31 employer to the extent permitted under the federal Patient  
32 Protection and Affordable Care Act (Public Law 111-148) and  
33 any rules, regulations, or guidance issued consistent with that law.

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

- 36 Under 30
- 37 30–39
- 38 40–49
- 39 50–54
- 40 55–59

1 60–64

2 65 and over

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

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

13 (A) Single.

14 (B) Married couple or registered domestic partners. “Domestic  
15 partner” shall have the same meaning as that term is used in Section  
16 297 of the Family Code.

17 (C) One adult and child or children.

18 (D) Married couple and child or children or registered domestic  
19 partners and child or children.

20 (3) The director may issue regulations developed ~~in collaboration~~  
21 *after consultation* with the Insurance Commissioner that are  
22 necessary to carry out the purpose of this subdivision to make the  
23 categories of age, family size, and geographic region consistent  
24 with the federal Patient Protection and Affordable Care Act (Public  
25 Law 111-148), and any rules, regulations, or guidance issued  
26 consistent with that law. Any rules and regulations adopted  
27 pursuant to this subdivision may be adopted as emergency  
28 regulations in accordance with the Administrative Procedure Act  
29 (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
30 Division 3 of Title 2 of the Government Code). Until December  
31 31, 2015, the adoption of these regulations shall be deemed an  
32 emergency and necessary for the immediate preservation of the  
33 public peace, health and safety, or general welfare.

34 (4) (A) In determining rates for small employers, a plan that  
35 operates statewide shall use no more than nine geographic regions  
36 in the state, have no region smaller than an area in which the first  
37 three digits of all its ZIP Codes are in common within a county,  
38 and divide no county into more than two regions. Plans shall be  
39 deemed to be operating statewide if their coverage area includes  
40 90 percent or more of the state’s population. Geographic regions

1 established pursuant to this section shall, as a group, cover the  
2 entire state, and the area encompassed in a geographic region shall  
3 be separate and distinct from areas encompassed in other  
4 geographic regions. Geographic regions may be noncontiguous.

5 (B) (i) In determining rates for small employers, a plan that  
6 does not operate statewide shall use no more than the number of  
7 geographic regions in the state that is determined by the following  
8 formula: the population, as determined in the last federal census,  
9 of all counties that are included in their entirety in a plan's service  
10 area divided by the total population of the state, as determined in  
11 the last federal census, multiplied by nine. The resulting number  
12 shall be rounded to the nearest whole integer. No region may be  
13 smaller than an area in which the first three digits of all its ZIP  
14 Codes are in common within a county and no county may be  
15 divided into more than two regions. The area encompassed in a  
16 geographic region shall be separate and distinct from areas  
17 encompassed in other geographic regions. Geographic regions  
18 may be noncontiguous. No plan shall have less than one geographic  
19 area.

20 (ii) If the formula in clause (i) results in a plan that operates in  
21 more than one county having only one geographic region, then the  
22 formula in clause (i) shall not apply and the plan may have two  
23 geographic regions, provided that no county is divided into more  
24 than one region.

25 Nothing in this section shall be construed to require a plan to  
26 establish a new service area or to offer health coverage on a  
27 statewide basis, outside of the plan's existing service area.

28 (l) "Small employer" means any of the following:

29 (1) For plan years commencing on or before December 31,  
30 2013, any person, firm, proprietary or nonprofit corporation,  
31 partnership, public agency, or association that is actively engaged  
32 in business or service, that, on at least 50 percent of its working  
33 days during the preceding calendar quarter or preceding calendar  
34 year, employed at least two, but no more than 50, eligible  
35 employees, the majority of whom were employed within this state,  
36 that was not formed primarily for purposes of buying health care  
37 service plan contracts, and in which a bona fide employer-employee  
38 relationship exists. For plan years commencing on or after January  
39 1, 2014, and on or before December 31, 2015, any person, firm,  
40 proprietary or nonprofit corporation, partnership, public agency,

1 or association that is actively engaged in business or service, that,  
2 on at least 50 percent of its working days during the preceding  
3 calendar quarter or preceding calendar year, employed at least one,  
4 but no more than 50, eligible employees, the majority of whom  
5 were employed within this state, that was not formed primarily for  
6 purposes of buying health care service plan contracts, and in which  
7 a bona fide employer-employee relationship exists. For plan years  
8 commencing on or after January 1, 2016, any person, firm,  
9 proprietary or nonprofit corporation, partnership, public agency,  
10 or association that is actively engaged in business or service, that,  
11 on at least 50 percent of its working days during the preceding  
12 calendar quarter or preceding calendar year, employed at least one,  
13 but no more than 100, eligible employees, the majority of whom  
14 were employed within this state, that was not formed primarily for  
15 purposes of buying health care service plan contracts, and in which  
16 a bona fide employer-employee relationship exists. In determining  
17 whether to apply the calendar quarter or calendar year test, a health  
18 care service plan shall use the test that ensures eligibility if only  
19 one test would establish eligibility. In determining the number of  
20 eligible employees, companies that are affiliated companies and  
21 that are eligible to file a combined tax return for purposes of state  
22 taxation shall be considered one employer. Subsequent to the  
23 issuance of a health care service plan contract to a small employer  
24 pursuant to this article, and for the purpose of determining  
25 eligibility, the size of a small employer shall be determined  
26 annually. Except as otherwise specifically provided in this article,  
27 provisions of this article that apply to a small employer shall  
28 continue to apply until the plan contract anniversary following the  
29 date the employer no longer meets the requirements of this  
30 definition. It includes any small employer as defined in this  
31 paragraph who purchases coverage through a guaranteed  
32 association, and any employer purchasing coverage for employees  
33 through a guaranteed association. This paragraph shall be  
34 implemented to the extent consistent with the federal Patient  
35 Protection and Affordable Care Act (Public Law 111-148; PPACA)  
36 and any rules, regulations, or guidance issued consistent with that  
37 law, except that the minimum requirement of one employee shall  
38 be implemented only to the extent required by PPACA *and any*  
39 *rules, regulations, or guidance issued consistent with that law.*

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

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

10 (m) “Standard employee risk rate” means the rate applicable to  
11 an eligible employee in a particular risk category in a small  
12 employer group.

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

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

4 For purposes of this subdivision, an association formed by a  
5 merger of two or more associations after January 1, 1992, and  
6 otherwise meeting the criteria of this subdivision shall be deemed  
7 to have been in active existence on January 1, 1992, if its  
8 predecessor organizations had been in active existence on January  
9 1, 1992, and for at least five years prior to that date and otherwise  
10 met the criteria of this subdivision.

11 (o) “Members of a guaranteed association” means any individual  
12 or employer meeting the association’s membership criteria if that  
13 person is a member of the association and chooses to purchase  
14 health coverage through the association. At the association’s  
15 discretion, it also may include employees of association members,  
16 association staff, retired members, retired employees of members,  
17 and surviving spouses and dependents of deceased members.  
18 However, if an association chooses to include these persons as  
19 members of the guaranteed association, the association shall make  
20 that election in advance of purchasing a plan contract. Health care  
21 service plans may require an association to adhere to the  
22 membership composition it selects for up to 12 months.

23 (p) “Affiliation period” means a period that, under the terms of  
24 the health care service plan contract, must expire before health  
25 care services under the contract become effective. An affiliation  
26 period under a health care service plan contract shall run  
27 concurrently with any waiting period under that plan contract. An  
28 affiliation period may not exceed 60 days or, in the case of a late  
29 enrollee, 90 days.

30 (q) “Waiting period” means the period that is required to pass  
31 with respect to the employee before the employee is eligible to be  
32 covered for benefits under the terms of the policy. However, such  
33 periods shall not be based upon the health status of the employee  
34 or dependent. For plan years commencing on or after January 1,  
35 2014, a health plan may apply a waiting period of up to 90 days  
36 as a condition of employment if applied equally to all full-time  
37 employees, consistent with the federal Patient Protection and  
38 Affordable Care Act (Public Law 111-148) and any rules,  
39 regulations, or guidance issued consistent with that law.

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

3 (s) “PPACA” means the federal Patient Protection and  
4 Affordable Care Act (Public Law 111-148), as amended by the  
5 federal Health Care and Education Reconciliation Act of 2010  
6 (Public Law 111-152), and any rules, regulations, or guidance  
7 issued thereunder.

8 (t) “Grandfathered health plan” has the meaning set forth in  
9 Section 1251 of PPACA.

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

12 1357.03. (a) (1) Upon the effective date of this article, a plan  
13 shall fairly and affirmatively offer, market, and sell all of the plan’s  
14 health care service plan contracts that are sold to small employers  
15 or to associations that include small employers to all small  
16 employers in each service area in which the plan provides or  
17 arranges for the provision of health care services.

18 (2) Each plan shall make available to each small employer all  
19 small employer health care service plan contracts that the plan  
20 offers and sells to small employers or to associations that include  
21 small employers in this state.

22 (3) No plan or solicitor shall induce or otherwise encourage a  
23 small employer to separate or otherwise exclude an eligible  
24 employee from a health care service plan contract that is provided  
25 in connection with the employee’s employment or membership in  
26 a guaranteed association.

27 (4) A plan contracting to participate in the voluntary purchasing  
28 pool for small employers offered through the California Health  
29 Benefit Exchange shall be deemed in compliance with the  
30 requirements of paragraph (1) for a contract offered through the  
31 California Health Benefit Exchange in those geographic regions  
32 in which plans participate in the California Health Benefit  
33 Exchange.

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

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

1 (ii) The plan provides appropriate notice of the grandfathered  
2 status of the contract in any materials provided to an enrollee of  
3 the contract describing the benefits provided under the contract,  
4 as required under PPACA.

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

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

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

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

4 (1) The small employer, as defined by paragraph (1) of  
5 subdivision (l) of Section 1357, offers health benefits to 100  
6 percent of its eligible employees, as defined by paragraph (1) of  
7 subdivision (b) of Section 1357. Employees who waive coverage  
8 on the grounds that they have other group coverage shall not be  
9 counted as eligible employees.

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

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

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

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

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

28 (2) Encourage or direct small employers to seek coverage from  
29 another plan or the voluntary purchasing pool established under  
30 the California Health Benefit Exchange because of the health  
31 status, claims experience, industry, occupation of the small  
32 employer, or geographic location provided that it is within the  
33 plan's approved service area.

34 (e) A plan shall not, directly or indirectly, enter into any contract,  
35 agreement, or arrangement with a solicitor that provides for or  
36 results in the compensation paid to a solicitor for the sale of a  
37 health care service plan contract to be varied because of the health  
38 status, claims experience, industry, occupation, or geographic  
39 location of the small employer or small employer's employees.  
40 This subdivision does not apply to a compensation arrangement

1 that provides compensation to a solicitor on the basis of percentage  
2 of premium, provided that the percentage shall not vary because  
3 of the health status, claims experience, industry, occupation, or  
4 geographic area of the small employer.

5 (f) A policy or contract that covers a small employer, as defined  
6 in Section 1304(b) of PPACA and in subdivision (l) of Section  
7 1357, shall not establish rules for eligibility, including continued  
8 eligibility, of an individual, or dependent of an individual, to enroll  
9 under the terms of the plan based on any of the following health  
10 status-related factors:

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

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

23 SEC. 4. Section 1357.05 of the Health and Safety Code is  
24 amended to read:

25 1357.05. (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 an actual or expected health  
31 condition of that employee or dependent. No plan contract may  
32 limit or exclude coverage for a specific eligible employee or  
33 dependent by type of illness, treatment, medical condition, or  
34 accident, except for preexisting conditions as permitted by Section  
35 1357.06.

36 (b) For plan years commencing on or after January 1, 2014, a  
37 plan may not exclude any eligible employee or dependent who  
38 would otherwise be entitled to health care services on the basis of  
39 an actual or expected health condition of that employee or  
40 dependent. No plan contract may limit or exclude coverage for a

1 specific eligible employee or dependent by type of illness,  
2 treatment, medical condition, or accident, except for preexisting  
3 conditions as permitted by Section 1357.06.

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

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

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

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

20 (b) (1) For plan years commencing on or before December 31,  
21 2013, a plan that does not utilize a preexisting condition provision  
22 may impose a waiting or affiliation period, not to exceed 60 days,  
23 before the coverage issued subject to this article shall become  
24 effective. During the waiting or affiliation period no premiums  
25 shall be charged to the enrollee or the subscriber.

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

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

38 (4) A plan may impose an affiliation period, not to exceed 60  
39 days or, in the case of a late enrollee, 90 days before the coverage  
40 issued subject to this article shall become effective. During the

1 affiliation period, no premiums shall be charged to the enrollee or  
2 the subscriber. An affiliation period under a plan contract shall  
3 run concurrently with any waiting period under that contract.

4 (c) For plan years commencing on or before December 31, 2013,  
5 in determining whether a preexisting condition provision or a  
6 waiting or affiliation period applies to any person, a plan shall  
7 credit the time the person was covered under creditable coverage,  
8 provided the person becomes eligible for coverage under the  
9 succeeding plan contract within 62 days of termination of prior  
10 coverage, exclusive of any waiting or affiliation period, and applies  
11 for coverage with the succeeding plan contract within the applicable  
12 enrollment period. A plan shall also credit any time an eligible  
13 employee must wait before enrolling in the plan, including any  
14 affiliation or employer-imposed waiting or affiliation period.  
15 However, if a person's employment has ended, the availability of  
16 health coverage offered through employment or sponsored by an  
17 employer has terminated, or an employer's contribution toward  
18 health coverage has terminated, a plan shall credit the time the  
19 person was covered under creditable coverage if the person  
20 becomes eligible for health coverage offered through employment  
21 or sponsored by an employer within 180 days, exclusive of any  
22 waiting or affiliation period, and applies for coverage under the  
23 succeeding plan contract within the applicable enrollment period.

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

1 exclusive of any waiting or affiliation period, and applies for  
2 coverage under the succeeding plan contract within the applicable  
3 enrollment period.

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

15 (f) An individual's period of creditable coverage shall be  
16 certified pursuant to subdivision (e) of Section 2704 of Title XXVII  
17 of the federal Public Health Service Act (42 U.S.C. Sec.  
18 300gg-3(e)).

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

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 2702 of the federal Patient Protection and Affordable Care  
3 Act (Public Law 111-148) and any rules, regulations, or guidance  
4 issued consistent with that law.

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

7 1357.12. Premiums for contracts offered or delivered by plans  
8 on or after the effective date of this article shall be subject to the  
9 following requirements:

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

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

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

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

1 12 months. For plan years commencing on or after January 1, 2014,  
2 no risk adjustment factor shall be used in the determination of  
3 rates.

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

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

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

32 (2) The composite rates shall be used for all employees and  
33 dependents covered throughout a rating period of no less than six  
34 months nor more than 12 months, except that a plan may reserve  
35 the right to redetermine the composite rates if the enrollment under  
36 the contract changes by more than a specified percentage during  
37 the rating period. Any redetermination of the composite rates shall  
38 be based on the same risk adjusted employee risk rates used to  
39 determine the initial composite rates for the rating period. If a plan  
40 reserves the right to redetermine the rates and the enrollment

1 changes more than the specified percentage, the plan shall  
2 redetermine the composite rates if the redetermined rates would  
3 result in a lower premium for the small employer. A plan reserving  
4 the right to redetermine the composite rates based upon a change  
5 in enrollment shall use the same specified percentage to measure  
6 that change with respect to all small employers electing composite  
7 rates.

8 (d) 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. 8. Section 1357.12 is added to the Health and Safety  
12 Code, to read:

13 1357.12. (a) Premium rates for contracts offered or delivered  
14 by plans on or after January 1, 2014, shall be subject to the  
15 following requirements:

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

19 (A) Whether such plan or coverage covers an individual or  
20 family.

21 (B) Rating area.

22 (C) Age, except that such rate shall not vary by more than 3 to  
23 1 for adults.

24 (2) Such rate shall not vary with respect to the particular plan  
25 or coverage involved by any other factor not described in paragraph  
26 (1).

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

28 SEC. 9. Section 1357.14 of the Health and Safety Code is  
29 amended to read:

30 1357.14. In connection with the offering for sale of any plan  
31 contract to a small employer, each plan shall make a reasonable  
32 disclosure, as part of its solicitation and sales materials, of the  
33 following:

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

- 1 (b) The provisions concerning the plan’s right to change
- 2 premium rates and the factors other than provision of services
- 3 experience that affect changes in premium rates.
- 4 (c) Provisions relating to the guaranteed issue and renewal of
- 5 contracts.
- 6 (d) For plan years commencing on or before December 31,
- 7 2013, provisions relating to the effect of any preexisting condition
- 8 provision.
- 9 (e) Provisions relating to the small employer’s right to apply
- 10 for any contract written, issued, or administered by the plan at the
- 11 time of application for a new health care service plan contract, or
- 12 at the time of renewal of a health care service plan contract,
- 13 consistent with the requirements of PPACA.
- 14 (f) The availability, upon request, of a listing of all the plan’s
- 15 contracts and benefit plan designs offered, both inside and outside
- 16 the California Health Benefit Exchange, to small employers,
- 17 including the rates for each contract.
- 18 (g) At the time it offers a contract to a small employer, each
- 19 plan shall provide the small employer with a statement of all of
- 20 its plan contracts offered to small employers, including the rates
- 21 for each plan contract, in the service area in which the employer’s
- 22 employees and eligible dependents who are to be covered by the
- 23 plan contract work or reside. For purposes of this subdivision,
- 24 plans that are affiliated plans or that are eligible to file a
- 25 consolidated income tax return shall be treated as one health plan.
- 26 (h) Each plan shall do all of the following:
- 27 (1) Prepare a brochure that summarizes all of its plan contracts
- 28 offered to small employers and to make this summary available
- 29 to any small employer and to solicitors upon request. The summary
- 30 shall include for each contract information on benefits provided,
- 31 a generic description of the manner in which services are provided,
- 32 such as how access to providers is limited, benefit limitations,
- 33 required copayments and deductibles, for plan years commencing
- 34 on or before December 31, 2013, standard employee risk rates,
- 35 and, for plan years commencing on or before December 31, 2013,
- 36 an explanation of the manner in which creditable coverage is
- 37 calculated if a preexisting condition or affiliation period is imposed.
- 38 The summary shall also include a telephone number that can be
- 39 called for more detailed benefit information. Plans are required to
- 40 keep the information contained in the brochure accurate and up to

1 date and, upon updating the brochure, send copies to solicitors and  
2 solicitor firms with whom the plan contracts to solicit enrollments  
3 or subscriptions. For plan years commencing on or after January  
4 1, 2014, a health benefit plan offered to a small employer shall not  
5 impose any preexisting condition provision upon any individual.  
6 Nothing in this paragraph shall be construed as prohibiting a health  
7 benefit plan from restricting enrollment of enrollees to open  
8 enrollment periods as authorized under Section 2702 of the federal  
9 Patient Protection and Affordable Care Act (Public Law 111-148)  
10 and any rules, regulations, or guidance issued consistent with that  
11 law.

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

17 (3) For plan years commencing on or before December 31,  
18 2013, provide to small employers and solicitors, upon request, for  
19 any given small employer the sum of the standard employee risk  
20 rates and the sum of the risk adjusted employee risk rates. When  
21 requesting this information, small employers, solicitors, and  
22 solicitor firms shall provide the plan with the information the plan  
23 needs to determine the small employer's risk adjusted employee  
24 risk rate. For plan years commencing on or after January 1, 2014,  
25 no risk adjustment factor may be used in the determination of rates.

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

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

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

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

38 (A) Advise the small employer of the plan's obligation to sell  
39 to any small employer any plan contract it offers to small

1 employers and provide them, upon request, with the actual rates  
2 that would be charged to that employer for a given contract.

3 (B) Notify the small employer that the solicitor or solicitor firm  
4 will procure rate and benefit information for the small employer  
5 on any plan contract offered by a plan whose contract the solicitor  
6 sells.

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

12 (D) Notify the small employer of the availability of coverage  
13 ~~through the California Health Benefit Exchange~~ and the availability  
14 of tax credits for certain employers, ~~and through the Exchange.~~  
15 *consistent with the federal Patient Protection and Affordable Care*  
16 *Act (Public Law 111-148) and state law, including any rules,*  
17 *regulations, or guidance issued in connection therewith.*

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

23 (3) Prior to filing an application for a small employer for a  
24 particular contract:

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

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

34 (C) For plan years commencing on or before December 31,  
35 2013, notify the small employer that actual rates may be 10 percent  
36 higher or lower than the sum of the standard employee risk rates,  
37 depending on how the plan assesses the risk of the small  
38 employer's group. For plan years commencing on or after January  
39 1, 2014, no risk adjustment factor may be used in the determination  
40 of rates.

1 (D) For plan years commencing on or before December 31,  
2 2013, notify the small employer that, upon request, the solicitor  
3 or solicitor firm will submit information to the plan to ascertain  
4 the small employer's sum of the risk adjusted employee risk rate  
5 for any contract the plan offers. On or after November 1, 2013,  
6 notify the small employer of the employee rate effective January  
7 1, 2014. For plan years commencing on or after January 1, 2014,  
8 no risk adjustment factor may be used in the determination of rates.

9 (E) Obtain a signed statement from the small employer  
10 acknowledging that the small employer has received the disclosures  
11 required by this section.

12 SEC. 10. Section 1357.15 of the Health and Safety Code is  
13 amended to read:

14 1357.15. (a) At least 60 calendar days prior to renewing or  
15 amending a plan contract subject to this article which will be in  
16 force on the operative date of this article, a plan shall file a notice  
17 of material modification with the director in accordance with the  
18 provisions of Section 1352. The notice of material modification  
19 shall include a statement certifying that the plan is in compliance  
20 with subdivision (j) of Section 1357 and Section 1357.12. For rates  
21 in effect until January 1, 2014, the certified statement shall set  
22 forth the standard employee risk rate for each risk category and  
23 the highest and lowest risk adjustment factors that will be used in  
24 setting the rates at which the contract will be renewed or amended.  
25 Any action by the director, as permitted under Section 1352, to  
26 disapprove, suspend, or postpone the plan's use of a plan contract  
27 shall be in writing, specifying the reasons that the plan contract  
28 does not comply with the requirements of this chapter.

29 (b) At least 60 calendar days prior to offering a plan contract  
30 subject to this article, all plans shall file a notice of material  
31 modification with the director in accordance with the provisions  
32 of Section 1352. The notice of material modification shall include  
33 a statement certifying that the plan is in compliance with  
34 subdivision (j) of Section 1357 and Section 1357.12. For rates in  
35 effect until January 1, 2014, the certified statement shall set forth  
36 the standard employee risk rate for each risk category and the  
37 highest and lowest risk adjustment factors that will be used in  
38 setting the rates at which the contract will be offered. Plans that  
39 will be offering to a small employer plan contracts approved by  
40 the director prior to the effective date of this article shall file a

1 notice of material modification in accordance with this subdivision.  
 2 Any action by the director, as permitted under Section 1352, to  
 3 disapprove, suspend, or postpone the plan’s use of a plan contract  
 4 shall be in writing, specifying the reasons that the plan contract  
 5 does not comply with the requirements of this chapter.

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

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

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

28 (f) For plan years commencing on or before December 31, 2013,  
 29 each plan shall make available to the director, on request, the risk  
 30 adjustment factor used in determining the rate for any particular  
 31 small employer.

32 (g) Nothing in this section shall be construed to limit the  
 33 director’s authority to enforce the rating practices set forth in this  
 34 article.

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

38 SEC. 11. Section 1357.15 is added to the Health and Safety  
 39 Code, to read:

1 1357.15. (a) At least 60 calendar days prior to renewing or  
2 amending a plan contract subject to this article which will be in  
3 force on the operative date of this article, a plan shall file a notice  
4 of material modification with the director in accordance with the  
5 provisions of Section 1352. The notice of material modification  
6 shall include a statement certifying that the plan is in compliance  
7 with subdivision (j) of Section 1357 and Section 1357.12. Any  
8 action by the director, as permitted under Section 1352, to  
9 disapprove, suspend, or postpone the plan's use of a plan contract  
10 shall be in writing, specifying the reasons that the plan contract  
11 does not comply with the requirements of this chapter.

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

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

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

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

32 SEC. 12. Section 106.5 is added to the Insurance Code, to read:

33 106.5. (a) All nongrandfathered policies of individual health  
34 insurance, except Medicare supplement policies, as defined in  
35 Article 6 (commencing with Section 10192.05) of Chapter 1 of  
36 Part 2, or small employer health insurance, as defined in Chapter  
37 8 (commencing with Section 10700) of Part 2, that are offered,  
38 sold, renewed, or delivered on or after January 1, 2014, shall  
39 provide coverage for essential health benefits, as described in

1 Section 2707 of the federal Patient Protection and Affordable Care  
2 Act (Public Law 111-148).

3 (b) A nongrandfathered policy is a policy that is not  
4 grandfathered, as defined in Section 147.140 of Title 45 of the  
5 Code of Federal Regulations.

6 SEC. 13. Section 10127.19 is added to the Insurance Code, to  
7 read:

8 10127.19. Commencing March 1, 2012, and at least annually  
9 thereafter, every health insurer, not including a health insurer  
10 offering specialized health insurance policies, shall provide to the  
11 department, in a form and manner determined by the department  
12 in consultation with the Department of Managed Health Care, the  
13 number of covered lives, as of December 31 of the prior year, that  
14 receive health care coverage under a health insurance policy that  
15 covers individuals, small groups, groups of 51-100, groups of 101  
16 or more, or administrative services only business lines. Health  
17 insurers shall include the unduplicated enrollment data in specific  
18 product lines as determined by the department, including, but not  
19 limited to HMO, point-of-service, PPO, Medicare excluding  
20 Medicare supplement, Medi-Cal managed care, and traditional  
21 indemnity non-PPO health insurance. The department shall publicly  
22 report the data provided by each health insurer pursuant to this  
23 section, including, but not limited to, posting the data on the  
24 department’s Internet Web site. The department shall consult with  
25 the Department of Managed Health Care to ensure that the data  
26 reported is comparable and consistent.

27 SEC. 14. Section 10700 of the Insurance Code is amended to  
28 read:

29 10700. As used in this chapter:

30 (a) “Agent or broker” means a person or entity licensed under  
31 Chapter 5 (commencing with Section 1621) of Part 2 of Division  
32 1.

33 (b) “Benefit plan design” means a specific health coverage  
34 product issued by a carrier to small employers, to trustees of  
35 associations that include small employers, or to individuals if the  
36 coverage is offered through employment or sponsored by an  
37 employer. It includes services covered and the levels of copayment  
38 and deductibles, and it may include the professional providers who  
39 are to provide those services and the sites where those services are  
40 to be provided. A benefit plan design may also be an integrated

1 system for the financing and delivery of quality health care services  
2 which has significant incentives for the covered individuals to use  
3 the system.

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

5 (d) “Carrier” means any disability insurance company or any  
6 other entity that writes, issues, or administers health benefit plans  
7 that cover the employees of small employers, regardless of the  
8 situs of the contract or master policyholder. For the purposes of  
9 Articles 3 (commencing with Section 10719) and 4 (commencing  
10 with Section 10730), “carrier” also includes health care service  
11 plans.

12 (e) “Dependent” means the spouse or child of an eligible  
13 employee, subject to applicable terms of the health benefit plan  
14 covering the employee, and includes dependents of guaranteed  
15 association members if the association elects to include dependents  
16 under its health coverage at the same time it determines its  
17 membership composition pursuant to subdivision (z).

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

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

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

39 (B) The employer offers the employee health coverage under a  
40 health benefit plan.

- 1 (C) All similarly situated individuals are offered coverage under  
 2 the health benefit plan.
- 3 (D) The employee must have worked at least 20 hours per  
 4 normal workweek for at least 50 percent of the weeks in the  
 5 previous calendar quarter. The insurer may request any necessary  
 6 information to document the hours and time period in question,  
 7 including, but not limited to, payroll records and employee wage  
 8 and tax filings.
- 9 (2) Any member of a guaranteed association as defined in  
 10 subdivision (z).
- 11 (g) “Enrollee” means an eligible employee or dependent who  
 12 receives health coverage through the program from a participating  
 13 carrier.
- 14 (h) “Financially impaired” means, for the purposes of this  
 15 chapter, a carrier that, on or after the effective date of this chapter,  
 16 is not insolvent and is either:
- 17 (1) Deemed by the commissioner to be potentially unable to  
 18 fulfill its contractual obligations.
- 19 (2) Placed under an order of rehabilitation or conservation by  
 20 a court of competent jurisdiction.
- 21 (i) “Fund” means the California Small Group Reinsurance Fund.
- 22 (j) “Health benefit plan” means a policy or contract written or  
 23 administered by a carrier that arranges or provides health care  
 24 benefits for the covered eligible employees of a small employer  
 25 and their dependents. The term does not include accident only,  
 26 credit, disability income, coverage of Medicare services pursuant  
 27 to contracts with the United States government, Medicare  
 28 supplement, long-term care insurance, dental, vision, coverage  
 29 issued as a supplement to liability insurance, automobile medical  
 30 payment insurance, or insurance under which benefits are payable  
 31 with or without regard to fault and that is statutorily required to  
 32 be contained in any liability insurance policy or equivalent  
 33 self-insurance.
- 34 (k) “In force business” means an existing health benefit plan  
 35 issued by the carrier to a small employer.
- 36 (l) “Late enrollee” means an eligible employee or dependent  
 37 who has declined health coverage under a health benefit plan  
 38 offered by a small employer at the time of the initial enrollment  
 39 period provided under the terms of the health benefit plan and who  
 40 subsequently requests enrollment in a health benefit plan of that

1 small employer, provided that the initial enrollment period shall  
2 be a period of at least 30 days. It also means any member of an  
3 association that is a guaranteed association as well as any other  
4 person eligible to purchase through the guaranteed association  
5 when that person has failed to purchase coverage during the initial  
6 enrollment period provided under the terms of the guaranteed  
7 association's health benefit plan and who subsequently requests  
8 enrollment in the plan, provided that the initial enrollment period  
9 shall be a period of at least 30 days. However, an eligible  
10 employee, another person eligible for coverage through a  
11 guaranteed association pursuant to subdivision (z), or an eligible  
12 dependent shall not be considered a late enrollee if any of the  
13 following is applicable:

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

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

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

29 (C) He or she has lost or will lose coverage under another  
30 employer health benefit plan as a result of termination of  
31 employment of the individual or of a person through whom the  
32 individual was covered as a dependent, change in employment  
33 status of the individual, or of a person through whom the individual  
34 was covered as a dependent, the termination of the other plan's  
35 coverage, cessation of an employer's contribution toward an  
36 employee's or dependent's coverage, death of the person through  
37 whom the individual was covered as a dependent, legal separation,  
38 or divorce; or he or she has lost or will lose coverage under the  
39 Healthy Families Program, the AIM Program, the Medi-Cal  
40 program, or the California Health Benefit Exchange.

1 (D) He or she requests enrollment within 30 days after  
2 termination of coverage or employer contribution toward coverage  
3 provided under another employer health benefit plan, or requests  
4 enrollment within 60 days after termination of Medi-Cal program  
5 coverage, AIM Program coverage, Healthy Families Program  
6 coverage, or coverage through the California Health Benefit  
7 Exchange.

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

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

13 (4) (A) For plan years commencing on or before December 31,  
14 2013, in the case of an eligible employee as defined in paragraph  
15 (1) of subdivision (f), the carrier cannot produce a written statement  
16 from the employer stating that the individual or the person through  
17 whom an individual was eligible to be covered as a dependent,  
18 prior to declining coverage, was provided with, and signed  
19 acknowledgment of, an explicit written notice in boldface type  
20 specifying that failure to elect coverage during the initial  
21 enrollment period permits the carrier to impose, at the time of the  
22 individual’s later decision to elect coverage, an exclusion from  
23 coverage for a period of 12 months as well as a six-month  
24 preexisting condition exclusion unless the individual meets the  
25 criteria specified in paragraph (1), (2), or (3). For plan years  
26 commencing on or after January 1, 2014, a waiting period of no  
27 longer than 90 days is permitted unless the individual meets the  
28 criteria specified in paragraph (1), (2), or (3).

29 (B) For plan years commencing on or before December 31,  
30 2013, in the case of an eligible employee who is a guaranteed  
31 association member, the plan cannot produce a written statement  
32 from the guaranteed association stating that the association sent a  
33 written notice in boldface type to all potentially eligible association  
34 members at their last known address prior to the initial enrollment  
35 period informing members that failure to elect coverage during  
36 the initial enrollment period permits the plan to impose, at the time  
37 of the member’s later decision to elect coverage, an exclusion from  
38 coverage for a period of 12 months as well as a six-month  
39 preexisting condition exclusion unless the member can demonstrate  
40 that he or she meets the requirements of subparagraphs (A), (C),

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

5 (C) In the case of an employer or person who is not a member  
6 of an association, was eligible to purchase coverage through a  
7 guaranteed association, and did not do so, and would not be eligible  
8 to purchase guaranteed coverage unless purchased through a  
9 guaranteed association, the employer or person can demonstrate  
10 that he or she meets the requirements of subparagraphs (A), (C),  
11 and (D) of paragraph (1), or meets the requirements of paragraph  
12 (2) or (3), or that he or she recently had a change in status that  
13 would make him or her eligible and that application for coverage  
14 was made within 30 days of the change.

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 10116.5 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, the Medi-Cal  
24 program, or the California Health Benefit Exchange, and requests  
25 enrollment within 60 days after termination 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 (m) “New business” means a health benefit plan issued to a  
19 small employer that is not the carrier’s in force business.

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

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

26 (p) (1) For plan years commencing on or before December 31,  
27 2013, “preexisting condition provision” means a policy provision  
28 that excludes coverage for charges or expenses incurred during a  
29 specified period following the insured’s effective date of coverage,  
30 as to a condition for which medical advice, diagnosis, care, or  
31 treatment was recommended or received during a specified period  
32 immediately preceding the effective date of coverage.

33 (2) For plan years commencing on or after January 1, 2014, no  
34 insurer shall limit or exclude coverage for any individual based  
35 on a preexisting condition whether or not any medical advice,  
36 diagnosis, care, or treatment was recommended or received before  
37 that date. A preexisting condition exclusion includes any limitation  
38 or exclusion of benefits, including a denial of coverage, applicable  
39 to an individual as a result of information relating to an individual’s  
40 health status before the individual’s effective date of coverage

1 under a group health plan, or group or individual health insurance  
2 coverage, such as a condition identified as a result of a  
3 preenrollment questionnaire or physical examination given to the  
4 individual, or review of medical records relating to the  
5 preenrollment period.

6 (q) “Creditable coverage” means:

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

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

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

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

28 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
29 (Civilian Health and Medical Program of the Uniformed Services  
30 (CHAMPUS)).

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

33 (7) A state health benefits risk pool.

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

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

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

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

6 (r) “Rating period” means the period for which premium rates  
7 established by a carrier are in effect and shall be no less than 12  
8 months. This subdivision shall be implemented 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 (s) “Risk adjusted employee risk rate” means the rate determined  
13 for an eligible employee of a small employer in a particular risk  
14 category after applying the risk adjustment factor. For plan years  
15 commencing on or after January 1, 2014, no risk adjustment factor  
16 shall be used in the determination of rates.

17 (t) “Risk adjustment factor” means the percent adjustment to  
18 be applied equally to each standard employee risk rate for a  
19 particular small employer, based upon any expected deviations  
20 from standard claims. This factor may not be more than 120 percent  
21 or less than 80 percent until July 1, 1996. Effective July 1, 1996,  
22 this factor may not be more than 110 percent or less than 90  
23 percent. For plan years commencing on or after January 1, 2014,  
24 no risk adjustment factor shall be used in the determination of  
25 rates.

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

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

- 34 Under 30
- 35 30–39
- 36 40–49
- 37 50–54
- 38 55–59
- 39 60–64
- 40 65 and over

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

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

10 (A) Single.

11 (B) Married couple or registered domestic partners. “Domestic  
12 partner” shall have the same meaning as that term is used in Section  
13 297 of the Family Code.

14 (C) One adult and child or children.

15 (D) Married couple and child or children or registered domestic  
16 partners and child or children.

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

32 (4) (A) In determining rates for small employers, a carrier that  
33 operates statewide shall use no more than nine geographic regions  
34 in the state, have no region smaller than an area in which the first  
35 three digits of all its ZIP Codes are in common within a county,  
36 and shall divide no county into more than two regions. Carriers  
37 shall be deemed to be operating statewide if their coverage area  
38 includes 90 percent or more of the state’s population. Geographic  
39 regions established pursuant to this section shall, as a group, cover  
40 the entire state, and the area encompassed in a geographic region

1 shall be separate and distinct from areas encompassed in other  
2 geographic regions. Geographic regions may be noncontiguous.

3 (B) In determining rates for small employers, a carrier that does  
4 not operate statewide shall use no more than the number of  
5 geographic regions in the state than is determined by the following  
6 formula: the population, as determined in the last federal census,  
7 of all counties which are included in their entirety in a carrier's  
8 service area divided by the total population of the state, as  
9 determined in the last federal census, multiplied by nine. The  
10 resulting number shall be rounded to the nearest whole integer.  
11 No region may be smaller than an area in which the first three  
12 digits of all its ZIP Codes are in common within a county and no  
13 county may be divided into more than two regions. The area  
14 encompassed in a geographic region shall be separate and distinct  
15 from areas encompassed in other geographic regions. Geographic  
16 regions may be noncontiguous. No carrier shall have less than one  
17 geographic area.

18 (v) "Small employer" means either of the following:

19 (1) For plan years commencing on or after December 31, 2013,  
20 any person, proprietary or nonprofit firm, corporation, partnership,  
21 public agency, or association that is actively engaged in business  
22 or service that, on at least 50 percent of its working days during  
23 the preceding calendar quarter, or preceding calendar year,  
24 employed at least two, but not more than 50, eligible employees,  
25 the majority of whom were employed within this state, that was  
26 not formed primarily for purposes of buying health insurance and  
27 in which a bona fide employer-employee relationship exists. For  
28 plan years commencing on or after January 1, 2014, and on or  
29 before December 31, 2015, 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 50, eligible employees, the majority of whom were employed  
35 within this state, that was not formed primarily for purposes of  
36 buying health insurance, and in which a bona fide  
37 employer-employee relationship exists. For plan years commencing  
38 on or after January 1, 2016, any person, firm, proprietary or  
39 nonprofit corporation, partnership, public agency, or association  
40 that is actively engaged in business or service, that, on at least 50

1 percent of its working days during the preceding calendar quarter  
2 or preceding calendar year, employed at least one, but no more  
3 than 100, eligible employees, the majority of whom were employed  
4 within this state, that was not formed primarily for purposes of  
5 buying health benefit plans, and in which a bona fide  
6 employer-employee relationship exists. In determining whether  
7 to apply the calendar quarter or calendar year test, the insurer shall  
8 use the test that ensures eligibility if only one test would establish  
9 eligibility. In determining the number of eligible employees,  
10 companies that are affiliated companies and that are eligible to file  
11 a combined income tax return for purposes of state taxation shall  
12 be considered one employer. Subsequent to the issuance of a health  
13 benefit plan to a small employer pursuant to this chapter, and for  
14 the purpose of determining eligibility, the size of a small employer  
15 shall be determined annually. Except as otherwise specifically  
16 provided, provisions of this chapter that apply to a small employer  
17 shall continue to apply until the health benefit plan anniversary  
18 following the date the employer no longer meets the requirements  
19 of this definition. It includes any small employer as defined in this  
20 paragraph who purchases coverage through a guaranteed  
21 association, and any employer purchasing coverage for employees  
22 through a guaranteed association. This paragraph shall be  
23 implemented to the extent consistent with the federal Patient  
24 Protection and Affordable Care Act (Public Law 111-148) and  
25 any rules, regulations, or guidance issued consistent with that law,  
26 except that the minimum requirement of one employee shall be  
27 implemented only to the extent required by PPACA *and any rules,*  
28 *regulations, or guidance issued consistent with that law.*

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

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

38 (w) “Standard employee risk rate” means the rate applicable to  
39 an eligible employee in a particular risk category in a small

1 employer group. For plan years commencing on or after January  
2 1, 2014, no risk adjustment factor shall be used to determine rates.

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

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

34 For purposes of this subdivision, an association formed by a  
35 merger of two or more associations after January 1, 1992, and  
36 otherwise meeting the criteria of this subdivision shall be deemed  
37 to have been in active existence on January 1, 1992, if its  
38 predecessor organizations had been in active existence on January  
39 1, 1992, and for at least five years prior to that date and otherwise  
40 met the criteria of this subdivision.

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

13 (z) “Affiliation period” means a period that, under the terms of  
14 the health benefit plan, must expire before health care services  
15 under the plan become *effective until December 31, 2013*. An  
16 affiliation period under a plan contract shall run concurrently with  
17 any waiting period under the plan contract. An affiliation period  
18 may not exceed 60 days or, in the case of a late enrollee, 90 days.

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

21 (ab) “PPACA” means the federal Patient Protection and  
22 Affordable Care Act (Public Law 111-148), as amended by the  
23 federal Health Care and Education Reconciliation Act of 2010  
24 (Public Law 111-152), and any rules, regulations, or guidance  
25 issued thereunder.

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

28 (ad) “Waiting period” means the period that is required to pass  
29 with respect to the employee before the employee is eligible to be  
30 covered for benefits under the terms of the policy. However, such  
31 periods shall not be based upon the health status of the employee  
32 or dependent. For plan years commencing on or after January 1,  
33 2014, a health benefit plan may apply a waiting period of up to 90  
34 days as a condition of employment if applied equally to all full-time  
35 employees, consistent with the federal Patient Protection and  
36 Affordable Care Act (Public Law 111-148) and any rules,  
37 regulations, or guidance issued consistent with that law.

38 SEC. 15. Section 10705 of the Insurance Code is amended to  
39 read:

40 10705. Upon the effective date of this act:

1 (a) No group or individual policy or contract or certificate of  
2 group insurance or statement of group coverage providing benefits  
3 to employees of small employers as defined in this chapter shall  
4 be issued or delivered by a carrier subject to the jurisdiction of the  
5 commissioner regardless of the situs of the contract or master  
6 policyholder or of the domicile of the carrier nor, except as  
7 otherwise provided in Sections 10270.91 and 10270.92, shall a  
8 carrier provide coverage subject to this chapter until a copy of the  
9 form of the policy, contract, certificate, or statement of coverage  
10 is filed with and approved by the commissioner in accordance with  
11 Sections 10290 and 10291, and the carrier has complied with the  
12 requirements of Section 10717.

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

19 (2) A carrier contracting to participate in the California Health  
20 Benefit Exchange shall be deemed to be in compliance with  
21 paragraph (1) for a benefit plan design offered in those geographic  
22 regions in which the carrier participates in the California Health  
23 Benefit Exchange.

24 (3) (A) A carrier shall be deemed to meet the requirements of  
25 paragraph (1) and subdivision (c) with respect to a benefit plan  
26 design that qualifies as a grandfathered health plan under Section  
27 1251 of PPACA if all of the following requirements are met:

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

31 (ii) The carrier provides appropriate notice of the grandfathered  
32 status of the benefit plan design in any materials provided to an  
33 insured of the design describing the benefits provided under the  
34 design, as required under PPACA.

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

39 (B) For purposes of this paragraph, “PPACA” means the federal  
40 Patient Protection and Affordable Care Act (Public Law 111-148),

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

6 (4) Nothing in this section shall be construed to require an  
7 association, or a trust established and maintained by an association  
8 to receive a master insurance policy issued by an admitted insurer  
9 and to administer the benefits thereof solely for association  
10 members, to offer, market, or sell a benefit plan design to those  
11 who are not members of the association. However, if the  
12 association markets, offers, or sells a benefit plan design to those  
13 who are not members of the association it is subject to the  
14 requirements of this section. This shall apply to an association that  
15 otherwise meets the requirements of paragraph (8) formed by  
16 merger of two or more associations after January 1, 1992, if the  
17 predecessor organizations had been in active existence on January  
18 1, 1992, and for at least five years prior to that date and met the  
19 requirements of paragraph (5).

20 (5) A carrier which (A) effective January 1, 1992, and at least  
21 20 years prior to that date, markets, offers, or sells benefit plan  
22 designs only to all members of one association and (B) does not  
23 market, offer, or sell any other individual, selected group, or group  
24 policy or contract providing medical, hospital, and surgical benefits  
25 shall not be required to market, offer, or sell to those who are not  
26 members of the association. However, if the carrier markets, offers,  
27 or sells any benefit plan design or any other individual, selected  
28 group, or group policy or contract providing medical, hospital, and  
29 surgical benefits to those who are not members of the association  
30 it is subject to the requirements of this section.

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

36 (7) Each carrier that sells health benefit plans to members of  
37 any association shall submit an annual statement to the  
38 commissioner which lists each association to which the carrier  
39 sells health benefit plans, the industry or profession which is served  
40 by the association, the association’s membership criteria, a list of

1 officers, the state in which the association is organized, and the  
2 site of its principal office.

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

22 (c) Each carrier shall make available to each small employer  
23 all benefit plan designs that the carrier offers or sells to small  
24 employers or to associations that include small employers.  
25 Notwithstanding subdivision (d) of Section 10700, for purposes  
26 of this subdivision, companies that are affiliated companies or that  
27 are eligible to file a consolidated income tax return shall be treated  
28 as one carrier.

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

30 (1) Prepare a brochure that summarizes all of its benefit plan  
31 designs and make this summary available to small employers,  
32 agents, and brokers upon request. The summary shall include for  
33 each benefit plan design information on benefits provided, a generic  
34 description of the manner in which services are provided, such as  
35 how access to providers is limited, benefit limitations, required  
36 copayments and deductibles, standard employee risk rates, and,  
37 until January 1, 2014, an explanation of how creditable coverage  
38 is calculated if a preexisting condition or affiliation period is  
39 imposed. The summary shall also include a telephone number that  
40 can be called for more detailed benefit information. Carriers are

1 required to keep the information contained in the brochure accurate  
2 and up to date, and, upon updating the brochure, send copies to  
3 agents and brokers representing the carrier. Any entity that provides  
4 administrative services only with regard to a benefit plan design  
5 written or issued by another carrier shall not be required to prepare  
6 a summary brochure which includes that benefit plan design. For  
7 plan years commencing on or after January 1, 2014, a health benefit  
8 plan offered to a small employer shall not impose any preexisting  
9 condition provision upon any individual. Nothing in this paragraph  
10 shall be construed as prohibiting a health benefit plan from  
11 restricting enrollment of enrollees to open enrollment periods as  
12 authorized under Section 2702 of the federal Patient Protection  
13 and Affordable Care Act (Public Law 111-148) and any rules,  
14 regulations, or guidance issued consistent with that law.

15 (2) For each benefit plan design, prepare a more detailed  
16 evidence of coverage and make it available to small employers,  
17 agents and brokers upon request. The evidence of coverage shall  
18 contain all information that a prudent buyer would need to be aware  
19 of in making selections of benefit plan designs. An entity that  
20 provides administrative services only with regard to a benefit plan  
21 design written or issued by another carrier shall not be required to  
22 prepare an evidence of coverage for that benefit plan design.

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

32 (4) Provide copies of the current summary brochure to all agents  
33 or brokers who represent the carrier and, upon updating the  
34 brochure, send copies of the updated brochure to agents and brokers  
35 representing the carrier for the purpose of selling health benefit  
36 plans.

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

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

4 (1) When providing information on a health benefit plan to a  
5 small employer but making no specific recommendations on  
6 particular benefit plan designs:

7 (A) Advise the small employer of the carrier's obligation to sell  
8 to any small employer any of the benefit plan designs it offers to  
9 small employers and provide them, upon request, with the actual  
10 rates that would be charged to that employer for a given benefit  
11 plan design.

12 (B) Notify the small employer that the agent or broker will  
13 procure rate and benefit information for the small employer on  
14 any benefit plan design offered by a carrier for whom the agent or  
15 broker sells health benefit plans.

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

20 (D) Notify the small employer of the availability of coverage  
21 ~~through the California Health Benefit Exchange~~ and the availability  
22 of tax credits for certain employers, ~~and effective January 1, 2014,~~  
23 ~~the availability of tax credits through the Exchange.~~ *consistent*  
24 *with the federal Patient Protection and Affordable Care Act (Public*  
25 *Law 111-148) and state law, including any rules, regulations, or*  
26 *guidance issued in connection therewith.*

27 (2) When recommending a particular benefit plan design or  
28 designs, advise the small employer that, upon request, the agent  
29 will provide the small employer with the brochure required by  
30 paragraph (1) of subdivision (d) containing the benefit plan design  
31 or designs being recommended by the agent or broker.

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

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

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

4 (C) For plan years commencing on or before December 31,  
5 2013, notify the small employer that actual rates may be 10 percent  
6 higher or lower than the sum of the standard employee risk rates  
7 depending on how the carrier assesses the risk of the small  
8 employer's group. For plan years commencing on or after January  
9 1, 2014, no risk adjustment factor may be used in the determination  
10 of rates.

11 (D) For plan years commencing on or before December 31,  
12 2013, notify the small employer that, upon request, the agent or  
13 broker will submit information to the carrier to ascertain the small  
14 employer's sum of the risk adjusted standard employee risk rate  
15 for any benefit plan design the carrier offers. On or after November  
16 1, 2013, notify the small employer of the employee rate effective  
17 January 1, 2014. For plan years commencing on or after January  
18 1, 2014, no risk adjustment factor may be used in the determination  
19 of rates.

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

23 (f) No carrier, agent, or broker shall induce or otherwise  
24 encourage a small employer to separate or otherwise exclude an  
25 eligible employee from a health benefit plan which, in the case of  
26 an eligible employee meeting the definition in paragraph (1) of  
27 subdivision (f) of Section 10700, is provided in connection with  
28 the employee's employment or which, in the case of an eligible  
29 employee as defined in paragraph (2) of subdivision (f) of Section  
30 10700, is provided in connection with a guaranteed association.

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

33 (1) The small employer as defined by paragraph (1) of  
34 subdivision (w) of Section 10700 offers health benefits to 100  
35 percent of its eligible employees as defined in paragraph (1) of  
36 subdivision (f) of Section 10700. Employees who waive coverage  
37 on the grounds that they have other group coverage shall not be  
38 counted as eligible employees.

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

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

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

8 (2) Encourage or direct small employers to seek coverage from  
9 another carrier or the California Health Benefit Exchange because  
10 of the health status, claims experience, industry, occupation, or  
11 geographic location within the carrier's approved service area of  
12 the small employer or the small employer's employees.

13 (i) No carrier shall, directly or indirectly, enter into any contract,  
14 agreement, or arrangement with an agent or broker that provides  
15 for or results in the compensation paid to an agent or broker for a  
16 health benefit plan to be varied because of the health status, claims  
17 experience, industry, occupation, or geographic location of the  
18 small employer or the small employer's employees. This  
19 subdivision shall not apply with respect to a compensation  
20 arrangement that provides compensation to an agent or broker on  
21 the basis of percentage of premium, provided that the percentage  
22 shall not vary because of the health status, claims experience,  
23 industry, occupation, or geographic area of the small employer.

24 (j) For plan years commencing on or before December 31, 2013,  
25 in the case of a late insured, or for satisfaction of a preexisting  
26 condition clause in the case of initial coverage of an eligible  
27 employee, a health insurer may not exclude any eligible employee  
28 or dependent who would otherwise be entitled to health care  
29 services on the basis of any of the following: the health status, the  
30 medical condition, including both physical and mental illnesses,  
31 the claims experience, the medical history, receipt of health care,  
32 the genetic information, the disability or evidence of insurability,  
33 including conditions arising out of acts of domestic violence of  
34 that employee or dependent, or any other health status-related  
35 factor as determined by the department. No health benefit plan  
36 may limit or exclude coverage for a specific eligible employee or  
37 dependent by type of illness, treatment, medical condition, or  
38 accident, except for preexisting conditions as permitted by Section  
39 10198.7 or 10708. However, this exception for preexisting  
40 conditions shall not apply after December 31, 2013. For plan years

1 commencing on or after January 1, 2014, a health benefit plan  
2 offered to a small employer shall not impose any preexisting  
3 condition provision upon any individual. Nothing in this  
4 subdivision shall be construed as prohibiting a health benefit plan  
5 from restricting enrollment of enrollees, including late enrollees,  
6 to open enrollment periods as authorized under Section 2702 of  
7 the federal Patient Protection and Affordable Care Act (Public  
8 Law 111-148) and any rules, regulations, or guidance issued  
9 consistent with that law.

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

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

32 (2) Certification shall be deemed approved if not disapproved  
33 within 45 days after submission to the commissioner. If that  
34 certification is approved, the small employer carrier shall not offer  
35 coverage to any small employers under any health benefit plans  
36 during the remainder of the current year. If the certification is not  
37 approved, the carrier shall continue to issue coverage as required  
38 by subdivision (d) and be subject to administrative penalties as  
39 established in Section 10718.

1 SEC. 16. Section 10706 of the Insurance Code is amended to  
2 read:

3 10706. Every carrier shall file with the commissioner the  
4 reasonable participation requirements and employer contribution  
5 requirements that are to be included in its health benefit plans.  
6 Participation requirements shall be applied uniformly among all  
7 small employer groups, except that a carrier may vary application  
8 of minimum employer participation requirements by the size of  
9 the small employer group and whether the employer contributes  
10 100 percent of the eligible employee's premium. Employer  
11 contribution requirements shall not vary by employer size.  
12 Employer contribution requirements shall be consistent with the  
13 federal Patient Protection and Affordable Care Act (Public Law  
14 111-148). A carrier shall not establish a participation requirement  
15 that (1) requires a person who meets the definition of a dependent  
16 in subdivision (e) of Section 10700 to enroll as a dependent if he  
17 or she is otherwise eligible for coverage and wishes to enroll as  
18 an eligible employee and (2) allows a carrier to reject an otherwise  
19 eligible small employer because of the number of persons that  
20 waive coverage due to coverage through another employer.  
21 Members of an association eligible for health coverage eligible  
22 under subdivision (z) of Section 10700 but not electing any health  
23 coverage through the association shall not be counted as eligible  
24 employees for purposes of determining whether the guaranteed  
25 association meets a carrier's reasonable participation standards.

26 SEC. 17. Section 10707 of the Insurance Code is amended to  
27 read:

28 10707. (a) For plan years commencing on or before December  
29 31, 2013, except in the case of a late enrollee, or for satisfaction  
30 of a preexisting condition clause in the case of initial coverage of  
31 an eligible employee, a carrier may not exclude any eligible  
32 employee or dependent who would otherwise be covered, on the  
33 basis of an actual or expected health condition of that employee  
34 or dependent. No health benefit plan may limit or exclude coverage  
35 for a specific eligible employee or dependent by type of illness,  
36 treatment, medical condition, or accident, except for preexisting  
37 conditions as permitted by Section 10708.

38 (b) For plan years commencing on or after January 1, 2014, a  
39 carrier may not exclude any eligible employee or dependent who  
40 would otherwise be entitled to health care services on the basis of

1 an actual or expected health condition of that employee or  
2 dependent. No health benefit plan may limit or exclude coverage  
3 for a specific eligible employee or dependent by type of illness,  
4 treatment, medical condition, or accident.

5 SEC. 18. Section 10708 of the Insurance Code is amended to  
6 read:

7 10708. (a) (1) For plan years commencing on or before  
8 December 31, 2013, health benefit plans shall not exclude coverage  
9 for a period beyond six months following the individual's effective  
10 date of coverage and may only relate to conditions for which  
11 medical advice, diagnosis, care, or treatment, including the use of  
12 prescription medications, was recommended by or received from  
13 a licensed health practitioner during the six months immediately  
14 preceding the effective date of coverage.

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

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

21 (b) (1) For plan years commencing on or before December 31,  
22 2013, a carrier that does not utilize a preexisting condition  
23 provision may impose a waiting or affiliation period, not to exceed  
24 60 days, before the coverage issued subject to this chapter shall  
25 become effective. During the waiting or affiliation period, the  
26 carrier is not required to provide health care benefits and no  
27 premiums shall be charged to the subscriber or enrollee.

28 (2) For plan years commencing on or after January 1, 2014, no  
29 waiting or affiliation period based on a preexisting condition, health  
30 status, or any other factor prohibited under subdivision (e) of  
31 Section 10198.7 shall be imposed. A carrier may apply a waiting  
32 period of up to 90 days as a condition of employment if applied  
33 equally to all full-time employees and if consistent with the federal  
34 Patient Protection and Affordable Care Act (Public Law 111-148)  
35 and any rules, regulations, or guidance issued consistent with that  
36 law.

37 (c) For plan years commencing on or before December 31, 2013,  
38 in determining whether a preexisting condition provision or a  
39 waiting period applies to any person, a plan shall credit the time  
40 the person was covered under creditable coverage, provided the

1 person becomes eligible for coverage under the succeeding plan  
2 contract within 62 days of termination of prior coverage, exclusive  
3 of any waiting or affiliation period, and applies for coverage with  
4 the succeeding health benefit plan contract within the applicable  
5 enrollment period. A plan shall also credit any time an eligible  
6 employee must wait before enrolling in the health benefit plan,  
7 including any postenrollment or employer-imposed waiting or  
8 affiliation period. However, if a person's employment has ended,  
9 the availability of health coverage offered through employment  
10 or sponsored by an employer has terminated, or an employer's  
11 contribution toward health coverage has terminated, a plan shall  
12 credit the time the person was covered under creditable coverage  
13 if the person becomes eligible for health coverage offered through  
14 employment or sponsored by an employer within 180 days,  
15 exclusive of any waiting or affiliation period, and applies for  
16 coverage under the succeeding health benefit plan within the  
17 applicable enrollment period. Nothing in this subdivision shall be  
18 construed as prohibiting a health benefit plan from restricting  
19 enrollment of enrollees to open enrollment periods as authorized  
20 under Section 2702 of the federal Patient Protection and Affordable  
21 Care Act (Public Law 111-148) and any rules, regulations, or  
22 guidance issued under that law.

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

1     ~~(d)~~  
2     (e) Group health benefit plans may not impose a preexisting  
3 conditions exclusion to a condition relating to benefits for  
4 pregnancy or maternity care.

5     ~~(e)~~  
6     (f) (1) For plan years commencing on or before December 31,  
7 2013, a carrier providing aggregate or specific stop loss coverage  
8 or any other assumption of risk with reference to a health benefit  
9 plan shall provide that the plan meets all requirements of this  
10 section concerning preexisting condition provisions and waiting  
11 or affiliation periods.

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

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

19     ~~(f)~~  
20     (g) For plan years commencing on or before December 31,  
21 2013, in addition to the preexisting condition exclusions authorized  
22 by subdivision (a) and the waiting or affiliation period authorized  
23 by subdivision (b), carriers providing coverage to a guaranteed  
24 association may impose on employers or individuals purchasing  
25 coverage who would not be eligible for guaranteed coverage if  
26 they were not purchasing through the association a waiting or  
27 affiliation period, not to exceed 60 days, before the coverage issued  
28 subject to this chapter shall become effective. During the waiting  
29 or affiliation period, the carrier is not required to provide health  
30 care benefits and no premiums shall be charged to the insured. For  
31 plan years commencing on or after January 1, 2014, no waiting or  
32 affiliation period based on a preexisting condition, health status,  
33 or any other factor prohibited under subdivision (u) of Section  
34 10700 shall be imposed.

35     SEC. 19. Section 10709 of the Insurance Code is amended to  
36 read:

37     10709. (a) (1) Until December 31, 2013, no health benefit  
38 plan may exclude late enrollees from coverage for more than 12  
39 months from the date of the late enrollee's application for coverage.

1 No premiums shall be charged to the late enrollee until the  
 2 exclusion period has ended.

3 (2) For plan years commencing on or after January 1, 2014, no  
 4 health benefit plan may exclude late enrollees from coverage for  
 5 more than 90 days from the date of the late enrollee’s application  
 6 for coverage. No premium shall be charged to the late enrollee  
 7 until the ~~exclusion~~ *waiting* period has ended. Nothing in this  
 8 paragraph shall be construed as prohibiting a health benefit plan  
 9 from restricting enrollment of late enrollees to open enrollment  
 10 periods as authorized under Section 2702 of the federal Patient  
 11 Protection and Affordable Care Act (Public Law 111-148) and  
 12 any rules, regulations, or guidance issued consistent with that law.

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

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

25 SEC. 20. Section 10714 of the Insurance Code is amended to  
 26 read:

27 10714. Premiums for benefit plan designs written, issued, or  
 28 administered by carriers on or after the effective date of this act,  
 29 shall be subject to the following requirements:

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

1 January 1, 2014, no risk adjustment shall be used in the  
2 determination of rates.

3 (2) The premium charged a small employer for new business  
4 shall be equal to the sum of the risk adjusted employee risk rates.  
5 For plan years commencing on or after January 1, 2014, no risk  
6 adjustment shall be used in the determination of rates.

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

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

30 (2) The premium charged a small employer for in force business  
31 shall be equal to the sum of the risk adjusted employee risk rates.  
32 The standard employee risk rates shall be in effect for no less than  
33 12 months.

34 (3) For a benefit plan design that a carrier has discontinued  
35 offering, the risk adjustment factor applied to the standard  
36 employee risk rates for the first rating period of the new benefit  
37 plan design that the small employer elects to purchase shall be no  
38 greater than the risk adjustment factor applied in the prior rating  
39 period to the discontinued benefit plan design. However, the risk  
40 adjusted employee rate may not be more than 120 percent or less

1 than 80 percent of the carrier’s applicable standard employee risk  
 2 rate until July 1, 1996. Effective July 1, 1996, the risk adjusted  
 3 employee risk rate may not be more than 110 percent or less than  
 4 90 percent. The factor effective July 1, 1996, shall apply to in force  
 5 business at the earlier of either the time of renewal or July 1, 1997.  
 6 For plan years commencing on or after January 1, 2014, no risk  
 7 adjustment factor shall be used in the determination of rates. The  
 8 risk adjustment factor for a small employer may not be modified  
 9 more frequently than every 12 months.

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

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

34 (d) 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. 21. Section 10714 is added to the Insurance Code, to  
 38 read:

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

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

7 (A) Whether such plan or coverage covers an individual or  
8 family.

9 (B) Rating area.

10 (C) Age, except that such rate shall not vary by more than 3 to  
11 1 for adults.

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

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

16 SEC. 22. Section 10716 of the Insurance Code is amended to  
17 read:

18 10716. In connection with the offering for sale of any benefit  
19 plan design to small employers:

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

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

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

34 (c) Provisions relating to the guaranteed issue of policies and  
35 contracts.

36 (d) For plan years commencing on or before December 31,  
37 2013, provisions relating to the effect of any preexisting condition  
38 provision. For plan years commencing on or after January 1, 2014,  
39 a health benefit plan offered to a small employer shall not impose  
40 any preexisting condition provision upon any individual. Nothing

1 in this subdivision shall be construed as prohibiting a health benefit  
2 plan from restricting enrollment of late enrollees to open enrollment  
3 periods as authorized under Section 2702 of the federal Patient  
4 Protection and Affordable Care Act (Public Law 111-148) and  
5 any rules, regulations, or guidance issued consistent with that law.

6 (e) Provisions relating to the small employer's right to apply  
7 for any benefit plan design written, issued, or administered by the  
8 carrier at the time of application for a new health benefit plan, or  
9 at the time of renewal of a health benefit plan.

10 (f) The availability, upon request, of a listing of all the carrier's  
11 benefit plan designs, including the rates for each benefit plan  
12 design.

13 SEC. 23. Section 10717 of the Insurance Code is amended to  
14 read:

15 10717. (a) No carrier shall provide or renew coverage subject  
16 to this chapter until it has done all of the following:

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

31 (2) Until December 31, 2013:

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

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

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

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

11 (2) Until December 31, 2013:

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

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

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

31 (d) When submitting filings under subdivision (a), (b), or (c),  
32 a carrier may also file with the commissioner at the time of the  
33 filings, until December 31, 2013, a statement of the standard  
34 employee risk rate for each risk category the carrier intends to use  
35 for each month in the 12 months subsequent to the date of the  
36 filing. Once the requirements of the applicable subdivision (a),  
37 (b), or (c), have been met, these rates, until December 31, 2013,  
38 shall be used by the carrier for the 12-month period unless the  
39 carrier is otherwise informed by the commissioner in his or her  
40 response to the filings submitted under subdivision (a), (b), or (c),

1 provided that any subsequent change in the standard employee  
2 risk rates charged by the carrier which differ from those previously  
3 filed with the commissioner must be newly filed in accordance  
4 with this subdivision and provided that the carrier does not change  
5 the risk categories or risk adjustment factors for the benefit plan  
6 design. For plan years commencing on or after January 1, 2014,  
7 no risk adjustment factor may be used in the determination of rates.

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

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

21 (g) Each carrier shall make the information and documentation  
22 described in this section available to the commissioner upon  
23 request.

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

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

30 SEC. 24. Section 10717 is added to the Insurance Code, to  
31 read:

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

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

4 (c) Each carrier shall make the information and documentation  
5 described in this section available to the commissioner upon  
6 request.

7 (d) Nothing in this section shall be construed to limit the  
8 commissioner's authority to enforce the rating practices set forth  
9 in this chapter.

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

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

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