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CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1083**

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

February 18, 2011

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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 ~~1357.01, 1385.01, 1389, and 1393.6~~ of, to add Section ~~1348.95 to~~, Section 1348.95, 1357.19, and 1357.55 to, to add Article 3.17 (commencing with Section 1357.600) to Chapter 2.2 of Division 2 of, and to repeal and add Article 3.1 (commencing with Section 1357) and Article 3.15 (commencing with Section 1357.50) of Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections ~~10700, 10705, 10706, 10707, 10708, 10709, and 10716~~ ~~10181, 10291.5, and 10702~~ of, to amend, repeal, and add Sections ~~10714 and 10717~~ of, and to add Sections ~~106.5 and 10127.19, 10198.10, and 10750~~ to, to add

*Chapter 8.01 (commencing with Section 10755) to Part 2 of Division 2 of, to repeal and add Article 7 (commencing with Section 10198.6) of Chapter 1 of Part 2 of Division 2 of, and to repeal and add Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of, 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 federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect with respect to plan years on or after January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate charged by a health insurance issuer offering small group or individual coverage to vary only by family composition, rating area, age, and tobacco use and prohibits discrimination against individuals based on health status, as specified. PPACA specifies that certain of these provisions do not apply to grandfathered health plans, as defined.*

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~~ *insurers* by the Department of Insurance. Existing law provides for the regulation of health care service plans and health ~~carriers~~ *insurers* 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. Existing law requires a plan or insurer to offer, market, and sell all of its small employer health benefit plans to all small employers in each service area in which the plan provides or arranges for the provisions of health care services and provides certain limits on the rates for these plans. Existing law prohibits a group health benefit plan from excluding coverage for an individual on the basis of a preexisting condition provision for a period greater than 6 months, except as specified.~~

~~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.~~

*This bill would prohibit a health care service plan contract or health insurance policy, with respect to plan years on or after January 1, 2014, from imposing any preexisting condition provision upon any individual, except as specified. The bill would repeal the provisions applicable to small employer health benefit plans as of January 1, 2014, and would revise and recast those provisions to apply to grandfathered small employer plans with respect to plan years on or after January 1, 2014, consistent with PPACA. The bill would require a health care service plan or health insurer to issue a specified notice at least 60 days prior to the renewal date of a grandfathered small employer plan to all individual subscribers and insureds. The bill would also enact provisions that apply to nongrandfathered plans with respect to plan years on or after January 1, 2014. Among other things, the bill would require a plan or insurer, on and after October 1, 2013, to offer, market, and sell all of the plan's or insurer's nongrandfathered plans that are sold in the small group market to all small employers in each service area in which the plan provides or arranges for the provision of health care services. The bill would require nongrandfathered plans to provide open enrollment periods consistent with federal law and special enrollment periods and coverage effective dates consistent with the individual nongrandfathered market and would authorize plans and insurers to use only age, geographic region, and whether the plan covers an individual or family for purposes of establishing rates for nongrandfathered small employer plans, as specified. The bill would enact other related provisions and make related conforming changes. The bill would authorize the Department of Managed Health Care and the Department of Insurance to implement certain of these provisions through plan or insurer letters until regulations are adopted and would require the departments to adopt emergency regulations implementing those provisions by August 31, 2012. The bill would require plans and insurers to report to the departments the number of enrollees and covered lives that receive coverage under specified contracts or policies, and would require the departments to post that information on their Internet Web sites.*

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, 2013, 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  
17 health insurance. The department shall publicly report the data  
18 provided by each health care service plan pursuant to this section,  
19 including, but not limited to, posting the data on the department’s  
20 Internet Web site. The department shall consult with the  
21 Department of Insurance to ensure that the data reported is  
22 comparable and consistent.

23     SEC. 2. Article 3.1 (commencing with Section 1357) is added  
24 to Chapter 2.2 of Division 2 of the Health and Safety Code, to  
25 read:

26  
27             Article 3.1. Nongrandfathered Small Employer Plans  
28

29     1357. As used in this article, the following definitions shall  
30 apply:

31     (a) “Child” means a child described in Section 22775 of the  
32 Government Code and subdivisions (n) to (p), inclusive, of Section  
33 599.500 of Title 2 of the California Code of Regulations.

1 (b) “Dependent” means the spouse, domestic partner, or child  
2 of an eligible employee, subject to applicable terms of the health  
3 care service plan contract covering the employee, and includes  
4 dependents of guaranteed association members if the association  
5 elects to include dependents under its health coverage at the same  
6 time it determines its membership composition pursuant to  
7 subdivision (m).

8 (c) “Eligible employee” means either of the following:

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

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

29 (B) The employer offers the employees health coverage under  
30 a health benefit plan.

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

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

39 (2) Any member of a guaranteed association as defined in  
40 subdivision (m).

1 (d) “Exchange” means the California Health Benefit Exchange  
2 created by Section 100500 of the Government Code.

3 (e) “In force business” means an existing health benefit plan  
4 contract issued by the plan to a small employer.

5 (f) “Late enrollee” means an eligible employee or dependent  
6 who has declined enrollment in a health benefit plan offered by a  
7 small employer at the time of the initial enrollment period provided  
8 under the terms of the health benefit plan consistent with the  
9 periods provided pursuant to Section 1357.03 and who  
10 subsequently requests enrollment in a health benefit plan of that  
11 small employer, except where the employee or dependent qualifies  
12 for a special enrollment period provided pursuant to Section  
13 1357.03. It also means any member of an association that is a  
14 guaranteed association as well as any other person eligible to  
15 purchase through the guaranteed association when that person  
16 has failed to purchase coverage during the initial enrollment period  
17 provided under the terms of the guaranteed association’s plan  
18 contract consistent with the periods provided pursuant to Section  
19 1357.03 and who subsequently requests enrollment in the plan,  
20 except where that member or person qualifies for a special  
21 enrollment period provided pursuant to Section 1357.03.

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

24 (h) “Preexisting condition provision” means a contract  
25 provision that excludes coverage for charges or expenses incurred  
26 during a specified period following the enrollee’s effective date  
27 of coverage, as to a condition for which medical advice, diagnosis,  
28 care, or treatment was recommended or received during a specified  
29 period immediately preceding the effective date of coverage. No  
30 health care service plan shall limit or exclude coverage for any  
31 individual based on a preexisting condition whether or not any  
32 medical advice, diagnosis, care, or treatment was recommended  
33 or received before that date.

34 (i) “Creditable coverage” means:

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

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

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

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

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

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

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

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

24 (8) *A public health plan as defined in federal regulations*  
25 *authorized by Section 2701(c)(1)(I) of the Public Health Service*  
26 *Act, as amended by Public Law 104-191, the Health Insurance*  
27 *Portability and Accountability Act of 1996.*

28 (9) *A health benefit plan under Section 5(e) of the Peace Corps*  
29 *Act (22 U.S.C. Sec. 2504(e)).*

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

33 (j) *"Rating period" means the period for which premium rates*  
34 *established by a plan are in effect and shall be from January 1 to*  
35 *December 31, inclusive.*

36 (k) (1) *"Small employer" means any of the following:*

37 (A) *For plan years commencing on or after January 1, 2014,*  
38 *and on or before December 31, 2015, any person, firm, proprietary*  
39 *or nonprofit corporation, partnership, public agency, or*  
40 *association that is actively engaged in business or service, that,*

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

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

38 (2) For plan years commencing on or after January 1, 2014,  
39 the definition of an employer, for purposes of determining whether  
40 an employer with one employee shall include sole proprietors,

1 certain owners of “S” corporations, or other individuals, shall be  
2 consistent with Section 1304 of PPACA.

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

31 This subdivision applies regardless of whether a contract issued  
32 by a plan is with an association, or a trust formed for or sponsored  
33 by an association, to administer 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 (m) “Members of a guaranteed association” means any  
2 individual or employer meeting the association’s membership  
3 criteria if that person is a member of the association and chooses  
4 to purchase health coverage through the association. At the  
5 association’s discretion, it also may include employees of  
6 association members, association staff, retired members, retired  
7 employees of members, and surviving spouses and dependents of  
8 deceased members. However, if an association chooses to include  
9 these persons as members of the guaranteed association, the  
10 association shall make that election in advance of purchasing a  
11 plan contract. Health care service plans may require an association  
12 to adhere to the membership composition it selects for up to 12  
13 months.

14 (n) “Affiliation period” means a period that, under the terms  
15 of the health care service plan contract, must expire before health  
16 care services under the contract become effective.

17 (o) “Grandfathered health plan” has the meaning set forth in  
18 Section 1251 of PPACA.

19 (p) “Nongrandfathered small employer health care service plan  
20 contract” means a small employer health care service plan  
21 contract that is not a grandfathered health plan.

22 (q) “Plan year” has the meaning set forth in Section 144.103  
23 of Title 45 of the Code of Federal Regulations.

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

29 (s) “Small employer health care service plan contract” means  
30 a health care service plan contract issued to a small employer.

31 (t) “Waiting period” means a period that is required to pass  
32 with respect to an employee before the employee is eligible to be  
33 covered for benefits under the terms of the contract.

34 1357.01. This article shall apply only to nongrandfathered  
35 small employer health care service plan contracts and only with  
36 respect to plan years beginning on or after January 1, 2014.

37 1357.02. (a) A health care service plan providing or arranging  
38 for the provision of essential health benefits, as defined by the state  
39 pursuant to Section 1302 of PPACA, to small employers shall be  
40 subject to this article if either of the following conditions is met:

1 (1) Any portion of the premium is paid by a small employer, or  
 2 any covered individual is reimbursed, whether through wage  
 3 adjustments or otherwise, by a small employer for any portion of  
 4 the premium.

5 (2) The plan contract is treated by the small employer or any  
 6 of the covered individuals as part of a plan or program for the  
 7 purposes of Section 106 or 162 of the Internal Revenue Code.

8 (b) This article shall not apply to health care service plan  
 9 contracts for coverage of Medicare services pursuant to contracts  
 10 with the United States government, Medicare supplement, Medi-Cal  
 11 contracts with the State Department of Health Care Services,  
 12 long-term care coverage, or specialized health care service plan  
 13 contracts.

14 1357.025. Nothing in this article shall be construed to preclude  
 15 the application of this chapter to either of the following:

16 (a) An association, trust, or other organization acting as a  
 17 “health care service plan” as defined under Section 1345.

18 (b) An association, trust, or other organization or person  
 19 presenting information regarding a health care service plan to  
 20 persons who may be interested in subscribing or enrolling in the  
 21 plan.

22 1357.03. (a) (1) On and after October 1, 2013, a plan shall  
 23 fairly and affirmatively offer, market, and sell all of the plan’s  
 24 small employer health care service plan contracts to all small  
 25 employers in each service area in which the plan provides or  
 26 arranges for the provision of health care services.

27 (2) On and after October 1, 2013, a plan shall make available  
 28 to each small employer all small employer health care service plan  
 29 contracts that the plan offers and sells to small employers or to  
 30 associations that include small employers in this state.

31 (3) A plan that offers qualified health plans through the  
 32 Exchange shall be deemed to be in compliance with paragraphs  
 33 (1) and (2) with respect to small employer health care service plan  
 34 contracts offered through the Exchange in those geographic  
 35 regions in which the plan offers plan contracts through the  
 36 Exchange.

37 (b) A plan shall provide enrollment periods consistent with  
 38 PPACA and set forth in Section 155.725 of Title 45 of the Code  
 39 of Federal Regulations. A plan shall provide special enrollment  
 40 periods consistent with the special enrollment periods required in

1 *the individual nongrandfathered market in the state, except for the*  
2 *triggering events identified in paragraphs (d)(3) and (d)(6) of*  
3 *Section 155.420 of Title 45 of the Code of Federal Regulations*  
4 *with respect to plan contracts offered through the Exchange.*

5 *(c) No plan or solicitor shall induce or otherwise encourage a*  
6 *small employer to separate or otherwise exclude an eligible*  
7 *employee from a health care service plan contract that is provided*  
8 *in connection with employee's employment or membership in a*  
9 *guaranteed association.*

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

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

34 *(1) The small employer offers health benefits to 100 percent of*  
35 *its eligible employees. Employees who waive coverage on the*  
36 *grounds that they have other group coverage shall not be counted*  
37 *as eligible employees.*

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

1     (3) *The small employer agrees to inform the small employer's*  
2 *employees of the availability of coverage and the provision that*  
3 *those not electing coverage must wait until the next open*  
4 *enrollment or a special enrollment period to obtain coverage*  
5 *through the group if they later decide they would like to have*  
6 *coverage.*

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

11     (f) *No plan or solicitor shall, directly or indirectly, engage in*  
12 *the following activities:*

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

18         (2) *Encourage or direct small employers to seek coverage from*  
19 *another plan because of the health status, claims experience,*  
20 *industry, occupation of the small employer, or geographic location*  
21 *provided that it is within the plan's approved service area.*

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

33     (h) (1) *A policy or contract that covers a small employer, as*  
34 *defined in Section 1304(b) of PPACA and in Section 1357, shall*  
35 *not establish rules for eligibility, including continued eligibility,*  
36 *of an individual, or dependent of an individual, to enroll under*  
37 *the terms of the plan based on any of the following health*  
38 *status-related factors:*

39         (A) *Health status.*

40         (B) *Medical condition, including physical and mental illnesses.*

- 1 (C) *Claims experience.*
- 2 (D) *Receipt of health care.*
- 3 (E) *Medical history.*
- 4 (F) *Genetic information.*
- 5 (G) *Evidence of insurability, including conditions arising out*
- 6 *of acts of domestic violence.*
- 7 (H) *Disability.*
- 8 (I) *Any other health status-related factor as determined by any*
- 9 *federal regulations, rules, or guidance issued pursuant to Section*
- 10 *2705 of the federal Public Health Service Act.*
- 11 (2) *A health care service plan shall not require an eligible*
- 12 *employee or dependent to fill out a health assessment or medical*
- 13 *questionnaire prior to enrollment under a small employer health*
- 14 *care service plan contract.*
- 15 (i) *A plan shall comply with the requirements of Section 1374.3.*
- 16 *1357.035. (a) For plan contracts subject to this article, an*
- 17 *association that meets the definition of a guaranteed association,*
- 18 *as set forth in Section 1357, except for the requirement that 1,000*
- 19 *persons be covered, shall be entitled to purchase small employer*
- 20 *health coverage as if the association were a guaranteed*
- 21 *association, except that the coverage shall be guaranteed only for*
- 22 *those members of an association, as defined in subdivision (m) of*
- 23 *Section 1357, (1) who were receiving coverage or had successfully*
- 24 *applied for coverage through the association as of June 30, 1993,*
- 25 *(2) who were receiving coverage through the association as of*
- 26 *December 31, 1992, and whose coverage lapsed at any time*
- 27 *thereafter because the employment through which coverage was*
- 28 *received ended or an employer's contribution to health coverage*
- 29 *ended, or (3) who were covered at any time between June 30, 1993,*
- 30 *and July 1, 1994, under a contract that was in force on June 30,*
- 31 *1993.*
- 32 (b) *An association obtaining health coverage for its members*
- 33 *pursuant to this section shall otherwise be afforded all the rights*
- 34 *of a guaranteed association under this chapter, including, but not*
- 35 *limited to, guaranteed renewability of coverage.*
- 36 *1357.04. (a) With respect to small employer health care service*
- 37 *plan contracts offered outside the Exchange, after a small employer*
- 38 *submits a completed application form for a plan contract, the*
- 39 *health care service plan shall, within 30 days, notify the employer*
- 40 *of the employer's actual premium charges for that plan contract*

1 established in accordance with Section 1357.12. The employer  
2 shall have 30 days in which to exercise the right to buy coverage  
3 at the quoted premium charges.

4 (b) (1) Except as provided in paragraph (2), when a small  
5 employer submits a premium payment, based on the quoted  
6 premium charges, and that payment is delivered or postmarked,  
7 whichever occurs earlier, within the first 15 days of the month,  
8 coverage under the plan contract shall become effective no later  
9 than the first day of the following month. When that payment is  
10 neither delivered nor postmarked until after the 15th day of a  
11 month, coverage shall become effective no later than the first day  
12 of the second month following delivery or postmark of the payment.

13 (2) A health care service plan shall apply coverage effective  
14 dates for plan contracts subject to this article consistent with the  
15 coverage effective dates applicable to nongrandfathered individual  
16 health care service plan contracts.

17 (c) During the first 30 days after the effective date of the plan  
18 contract, the small employer shall have the option of changing  
19 coverage to a different plan contract offered by the same health  
20 care service plan. If a small employer notifies the plan of the  
21 change within the first 15 days of a month, coverage under the  
22 new plan contract shall become effective no later than the first  
23 day of the following month. If a small employer notifies the plan  
24 of the change after the 15th day of a month, coverage under the  
25 new plan contract shall become effective no later than the first  
26 day of the second month following notification.

27 1357.06. (a) A small employer health care service plan  
28 contract shall not impose a preexisting condition provision upon  
29 any individual.

30 (b) A plan contract may apply a waiting period of up to 60 days  
31 as a condition of employment if applied equally to all eligible  
32 employees and dependents and if consistent with PPACA. A plan  
33 contract through a health maintenance organization, as defined  
34 in Section 2791 of the federal Public Health Service Act, may  
35 impose an affiliation period not to exceed 60 days. A waiting or  
36 affiliation period shall not be based on a preexisting condition of  
37 an employee or dependent, the health status of an employee or  
38 dependent, or any other factor listed in subdivision (h) of Section  
39 1357.03. An affiliation period shall run concurrently with a waiting  
40 period. During the waiting or affiliation period, the plan is not

1 *required to provide health care services and no premium shall be*  
2 *charged to the subscriber or enrollees.*

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

22 *(d) An individual's period of creditable coverage shall be*  
23 *certified pursuant to subsection (e) of Section 2704 of Title XXVII*  
24 *of the federal Public Health Service Act (42 U.S.C. Sec.*  
25 *300gg-3(e)).*

26 *1357.07. Nothing in this article shall be construed as*  
27 *prohibiting a health care service plan from restricting enrollment*  
28 *of late enrollees to open enrollment periods provided under Section*  
29 *1357.03 as authorized under Section 2702 of the federal Public*  
30 *Health Service Act. No premium shall be charged to the late*  
31 *enrollee until the exclusion period has ended.*

32 *1357.08. A small employer health care service plan contract*  
33 *shall provide to subscribers and enrollees at least all of the*  
34 *essential health benefits as defined by the state pursuant to Section*  
35 *1302 of PPACA.*

36 *1357.09. To the extent permitted by PPACA, no plan shall be*  
37 *required to offer a health care service plan contract or accept*  
38 *applications for the contract pursuant to this article in the case of*  
39 *any of the following:*

1 (a) To a small employer, if the small employer is not physically  
2 located in a plan's approved service areas, or if an eligible  
3 employee and dependents who are to be covered by the plan  
4 contract do not work or reside within a plan's approved service  
5 areas.

6 (b) (1) Within a specific service area or portion of a service  
7 area, if a plan reasonably anticipates and demonstrates to the  
8 satisfaction of the director that it will not have sufficient health  
9 care delivery resources to ensure that health care services will be  
10 available and accessible to the eligible employee and dependents  
11 of the employee because of its obligations to existing enrollees.

12 (2) A plan that cannot offer a health care service plan contract  
13 to small employers because it is lacking in sufficient health care  
14 delivery resources within a service area or a portion of a service  
15 area may not offer a contract in the area in which the plan is not  
16 offering coverage to small employers to new employer groups with  
17 more than 50 eligible employees until the plan notifies the director  
18 that it has the ability to deliver services to small employer groups,  
19 and certifies to the director that from the date of the notice it will  
20 enroll all small employer groups requesting coverage in that area  
21 from the plan unless the plan has met the requirements of  
22 subdivision (d).

23 (3) Nothing in this article shall be construed to limit the  
24 director's authority to develop and implement a plan of  
25 rehabilitation for a health care service plan whose financial  
26 viability or organizational and administrative capacity has become  
27 impaired.

28 (c) Offer coverage to a small employer or an eligible employee  
29 as defined in paragraph (2) of subdivision (c) of Section 1357 that,  
30 within 12 months of application for coverage, disenrolled from a  
31 plan contract offered by the plan.

32 (d) (1) The director approves the plan's certification that the  
33 number of eligible employees and dependents enrolled under  
34 contracts issued during the current calendar year equals or exceeds  
35 either of the following:

36 (A) In the case of a plan that administers any self-funded health  
37 coverage arrangements in California, 10 percent of the total  
38 enrollment of the plan in California as of December 31 of the  
39 preceding year.

1 (B) In the case of a plan that does not administer any self-funded  
2 health coverage arrangements in California, 8 percent of the total  
3 enrollment of the plan in California as of December 31 of the  
4 preceding year. If that certification is approved, the plan shall not  
5 offer any health care service plan contract to any small employers  
6 during the remainder of the current year.

7 (2) If a health care service plan treats an affiliate or subsidiary  
8 as a separate carrier for the purpose of this article because one  
9 health care service plan is qualified under the federal Health  
10 Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and  
11 does not offer coverage to small employers, while the affiliate or  
12 subsidiary offers a plan contract that is not qualified under the  
13 federal Health Maintenance Organization Act (42 U.S.C. Sec.  
14 300e et seq.) and offers plan contracts to small employers, the  
15 health care service plan offering coverage to small employers shall  
16 enroll new eligible employees and dependents, equal to the  
17 applicable percentage of the total enrollment of both the health  
18 care service plan qualified under the federal Health Maintenance  
19 Organization Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or  
20 subsidiary.

21 (3) (A) The certified statement filed pursuant to this subdivision  
22 shall state the following:

23 (i) Whether the plan administers any self-funded health coverage  
24 arrangements in California.

25 (ii) The plan's total enrollment as of December 31 of the  
26 preceding year.

27 (iii) The number of eligible employees and dependents enrolled  
28 under contracts issued to small employer groups during the current  
29 calendar year.

30 (B) The director shall, within 45 days, approve or disapprove  
31 the certified statement. If the certified statement is disapproved,  
32 the plan shall continue to issue coverage as required by Section  
33 1357.03 and be subject to disciplinary action as set forth in Article  
34 7 (commencing with Section 1386).

35 (e) A health care service plan that, as of December 31 of the  
36 prior year, had a total enrollment of fewer than 100,000 and 50  
37 percent or more of the plan's total enrollment have premiums paid  
38 by the Medi-Cal program.

39 (f) A social health maintenance organization, as described in  
40 subsection (a) of Section 2355 of the federal Deficit Reduction Act

1 of 1984 (Public Law 98-369), that, as of December 31 of the prior  
2 year, had a total enrollment of fewer than 100,000 and has 50  
3 percent or more of the organization's total enrollment premiums  
4 paid by the Medi-Cal program or Medicare Program, or by a  
5 combination of Medi-Cal and Medicare. In no event shall this  
6 exemption be based upon enrollment in Medicare supplement  
7 contracts, as described in Article 3.5 (commencing with Section  
8 1358).

9 1357.10. The director may require a plan to discontinue the  
10 offering of contracts or acceptance of applications from any small  
11 employer or group upon a determination by the director that the  
12 plan does not have sufficient financial viability, or organizational  
13 and administrative capacity to ensure the delivery of health care  
14 services to its enrollees. In determining whether the conditions of  
15 this section have been met, the director shall consider, but not be  
16 limited to, the plan's compliance with the requirements of Section  
17 1367, Article 6 (commencing with Section 1375), and the rules  
18 adopted thereunder.

19 1357.12. (a) The premium rate for a small employer health  
20 care service plan contract shall vary with respect to the particular  
21 coverage involved only by the following:

22 (1) Age, as described in regulations adopted by the department  
23 in conjunction with the Department of Insurance that do not  
24 prevent the application of PPACA. Rates based on age shall be  
25 determined based on the individual's birthday. A plan shall not  
26 use any age bands for rating purposes that are inconsistent with  
27 the age bands established by the United States Secretary of Health  
28 and Human Services pursuant to Section 2701(a)(3) of the federal  
29 Public Health Service Act (42 U.S.C. Sec. 300gg (a)(3)).

30 (2) Geographic region. The geographic regions for purposes  
31 of rating shall be the following:

32 (A) Region 1 shall consist of the Counties of Alpine, Del Norte,  
33 Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama,  
34 Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter,  
35 Yuba, Colusa, Amador, Calaveras, and Tuolumne.

36 (B) Region 2 shall consist of the Counties of Napa, Sonoma,  
37 Solano, and Marin.

38 (C) Region 3 shall consist of the Counties of Sacramento, Placer,  
39 El Dorado, and Yolo.

1 (D) Region 4 shall consist of the Counties of San Francisco,  
2 Contra Costa, Alameda, Santa Clara, and San Mateo.

3 (E) Region 5 shall consist of the Counties of Santa Cruz,  
4 Monterey, and San Benito.

5 (F) Region 6 shall consist of the Counties of San Joaquin,  
6 Stanislaus, Merced, Mariposa, Madera, Fresno, Kings, and Tulare.

7 (G) Region 7 shall consist of the Counties of San Luis Obispo,  
8 Santa Barbara, and Ventura.

9 (H) Region 8 shall consist of the Counties of Mono, Inyo, Kern,  
10 and Imperial.

11 (I) Region 9 shall consist of the ZIP Codes in Los Angeles  
12 County starting with 906 to 912, inclusive, 915, 917, 918, and 935.

13 (J) Region 10 shall consist of the ZIP Codes in Los Angeles  
14 County other than those identified in subparagraph (I).

15 (K) Region 11 shall consist of the Counties of San Bernardino  
16 and Riverside.

17 (L) Region 12 shall consist of the County of Orange.

18 (M) Region 13 shall consist of the County of San Diego.

19 (3) Whether the contract covers an individual or family.

20 (b) The rate for a health care service plan contract subject to  
21 this section shall not vary by any factor not described in this  
22 section.

23 (c) The rating period for rates subject to this section shall be  
24 from January 1 to December 31, inclusive.

25 (d) (1) Notwithstanding the Administrative Procedure Act  
26 (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
27 Division 3 of Title 2 of the Government Code), the department may  
28 implement and administer this section through plan letters or  
29 similar instruction from the department until regulations are  
30 adopted.

31 (2) The department shall adopt emergency regulations  
32 implementing this section no later than August 31, 2013. The  
33 department may readopt any emergency regulation authorized by  
34 this section that is the same as or substantially equivalent to an  
35 emergency regulation previously adopted under this section.

36 (3) The initial adoption of emergency regulations implementing  
37 this section and the one readoption of emergency regulations  
38 authorized by this section shall be deemed an emergency and  
39 necessary for the immediate preservation of the public peace,  
40 health, safety, or general welfare. Initial emergency regulations

1 *and the one readoption of emergency regulations authorized by*  
2 *this section shall be exempt from review by the Office of*  
3 *Administrative Law. The initial emergency regulations and the*  
4 *one readoption of emergency regulations authorized by this section*  
5 *shall be submitted to the Office of Administrative Law for filing*  
6 *with the Secretary of State and each shall remain in effect for no*  
7 *more than 180 days, by which time final regulations may be*  
8 *adopted.*

9 *1357.14. In connection with the offering for sale of a small*  
10 *employer health care service plan contract subject to this article,*  
11 *each plan shall make a reasonable disclosure, as part of its*  
12 *solicitation and sales materials, of the following:*

13 *(a) The provisions concerning the plan's right to change*  
14 *premium rates and the factors other than provision of services*  
15 *experience that affect changes in premium rates.*

16 *(b) Provisions relating to the guaranteed issue and renewal of*  
17 *contracts.*

18 *(c) A statement that no preexisting condition provisions shall*  
19 *be allowed.*

20 *(d) Provisions relating to the small employer's right to apply*  
21 *for any small employer health care service plan contract written,*  
22 *issued, or administered by the plan at the time of application for*  
23 *a new health care service plan contract, or at the time of renewal*  
24 *of a health care service plan contract, consistent with the*  
25 *requirements of PPACA.*

26 *(e) The availability, upon request, of a listing of all the plan's*  
27 *contracts and benefit plan designs offered, both inside and outside*  
28 *the Exchange, to small employers, including the rates for each*  
29 *contract.*

30 *(f) At the time it offers a contract to a small employer, each plan*  
31 *shall provide the small employer with a statement of all of its small*  
32 *employer health care service plan contracts, including the rates*  
33 *for each plan contract, in the service area in which the employer's*  
34 *employees and eligible dependents who are to be covered by the*  
35 *plan contract work or reside. For purposes of this subdivision,*  
36 *plans that are affiliated plans or that are eligible to file a*  
37 *consolidated income tax return shall be treated as one health plan.*

38 *(g) Each plan shall do all of the following:*

39 *(1) Prepare a brochure that summarizes all of its plan contracts*  
40 *offered to small employers and to make this summary available to*

1 any small employer and to solicitors upon request. The summary  
2 shall include for each contract information on benefits provided,  
3 a generic description of the manner in which services are provided,  
4 such as how access to providers is limited, benefit limitations,  
5 required copayments and deductibles, an explanation of the manner  
6 in which creditable coverage is calculated if a waiting or affiliation  
7 period is imposed, and a phone number that can be called for more  
8 detailed benefit information. Plans are required to keep the  
9 information contained in the brochure accurate and up to date  
10 and, upon updating the brochure, send copies to solicitors and  
11 solicitor firms with whom the plan contracts to solicit enrollments  
12 or subscriptions.

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

18 (3) Provide copies of the current summary brochure to all  
19 solicitors and solicitor firms contracting with the plan to solicit  
20 enrollments or subscriptions from small employers.

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

24 (h) Every solicitor or solicitor firm contracting with one or more  
25 plans to solicit enrollments or subscriptions from small employers  
26 shall do all of the following:

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

30 (A) Advise the small employer of the plan's obligation to sell  
31 to any small employer any small employer health care service plan  
32 contract, consistent with PPACA, and provide the small employer,  
33 upon request, with the actual rates that would be charged to that  
34 employer for a given contract.

35 (B) Notify the small employer that the solicitor or solicitor firm  
36 will procure rate and benefit information for the small employer  
37 on any plan contract offered by a plan whose contract the solicitor  
38 sells.

39 (C) Notify the small employer that upon request the solicitor or  
40 solicitor firm will provide the small employer with the summary

1 brochure required under paragraph (1) of subdivision (g) for any  
2 plan contract offered by a plan with which the solicitor or solicitor  
3 firm has contracted to solicit enrollments or subscriptions.

4 (D) Notify the small employer of the availability of coverage  
5 and the availability of tax credits for certain employers consistent  
6 with PPACA and state law, including any rules, regulations, or  
7 guidance issued in connection therewith.

8 (2) When recommending a particular benefit plan design or  
9 designs, advise the small employer that, upon request, the agent  
10 will provide the small employer with the brochure required by  
11 paragraph (1) of subdivision (g) containing the benefit plan design  
12 or designs being recommended by the agent or broker.

13 (3) Prior to filing an application for a small employer for a  
14 particular contract:

15 (A) For each of the plan contracts offered by the plan whose  
16 contract the solicitor or solicitor firm is offering, provide the small  
17 employer with the benefit summary required in paragraph (1) of  
18 subdivision (g) and the premium for that particular employer.

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

22 (C) Obtain a signed statement from the small employer  
23 acknowledging that the small employer has received the disclosures  
24 required by this section.

25 1357.15. (a) At least 20 business days prior to renewing or  
26 amending a plan contract subject to this article which will be in  
27 force on the operative date of this article, a plan shall file a notice  
28 of material modification with the director in accordance with the  
29 provisions of Section 1352. The notice of material modification  
30 shall include a statement certifying that the plan is in compliance  
31 Section 1357.12. Any action by the director, as permitted under  
32 Section 1352, to disapprove, suspend, or postpone the plan's use  
33 of a plan contract shall be in writing, specifying the reasons that  
34 the plan contract does not comply with the requirements of this  
35 chapter.

36 (b) At least 20 business days prior to offering a plan contract  
37 subject to this article, all plans shall file a notice of material  
38 modification with the director in accordance with the provisions  
39 of Section 1352. The notice of material modification shall include  
40 a statement certifying that the plan is in compliance with Section

1 1357.12. Plans that will be offering to a small employer plan  
2 contracts approved by the director prior to the effective date of  
3 this article shall file a notice of material modification in  
4 accordance with this subdivision. Any action by the director, as  
5 permitted under Section 1352, to disapprove, suspend, or postpone  
6 the plan's use of a plan contract shall be in writing, specifying the  
7 reasons that the plan contract does not comply with the  
8 requirements of this chapter.

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

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

15 1357.16. (a) Health care service plans may enter into  
16 contractual agreements with qualified associations, as defined in  
17 subdivision (b), under which these qualified associations may  
18 assume responsibility for performing specific administrative  
19 services, as defined in this section, for qualified association  
20 members. Health care service plans that enter into agreements  
21 with qualified associations for assumption of administrative  
22 services shall establish uniform definitions for the administrative  
23 services that may be provided by a qualified association or its  
24 third-party administrator. The health care service plan shall permit  
25 all qualified associations to assume one or more of these functions  
26 when the health care service plan determines the qualified  
27 association demonstrates the administrative capacity to assume  
28 these functions.

29 For the purposes of this section, administrative services provided  
30 by qualified associations or their third-party administrators shall  
31 be services pertaining to eligibility determination, enrollment,  
32 premium collection, sales, or claims administration on a per-claim  
33 basis that would otherwise be provided directly by the health care  
34 service plan or through a third-party administrator on a  
35 commission basis or an agent or solicitor workforce on a  
36 commission basis. Each health care service plan that enters into  
37 an agreement with any qualified association for the provision of  
38 administrative services shall offer all qualified associations with  
39 which it contracts the same premium discounts for performing  
40 those services the health care service plan has permitted the

1 *qualified association or its third-party administrator to assume.*  
2 *The health care service plan shall report to the department its*  
3 *schedule of discounts for each administrative service.*

4 *In no instance may a health care service plan provide discounts*  
5 *to qualified associations that are in any way intended to, or*  
6 *materially result in, a reduction in premium charges to the*  
7 *qualified association due to the health status of the membership*  
8 *of the qualified association. In addition to any other remedies*  
9 *available to the director to enforce this chapter, the director may*  
10 *declare a contract between a health care service plan and a*  
11 *qualified association for administrative services pursuant to this*  
12 *section null and void if the director determines any discounts*  
13 *provided to the qualified association are intended to, or materially*  
14 *result in, a reduction in premium charges to the qualified*  
15 *association due to the health status of the membership of the*  
16 *qualified association.*

17 *(b) For the purposes of this section, a qualified association is*  
18 *a nonprofit corporation comprised of a group of individuals or*  
19 *employers who associate based solely on participation in a*  
20 *specified profession or industry that conforms to all of the following*  
21 *requirements:*

22 *(1) It accepts for membership any individual or small employer*  
23 *meeting its membership criteria.*

24 *(2) It does not condition membership directly or indirectly on*  
25 *the health or claims history of any person.*

26 *(3) It uses membership dues solely for and in consideration of*  
27 *the membership and membership benefits, except that the amount*  
28 *of the dues shall not depend on whether the member applies for*  
29 *or purchases insurance offered by the association.*

30 *(4) It is organized and maintained in good faith for purposes*  
31 *unrelated to insurance.*

32 *(5) It existed on January 1, 1972, and has been in continuous*  
33 *existence since that date.*

34 *(6) It has a constitution and bylaws or other analogous*  
35 *governing documents that provide for election of the governing*  
36 *board of the association by its members.*

37 *(7) It offered, marketed, or sold health coverage to its members*  
38 *for 20 continuous years prior to January 1, 1993.*

39 *(8) It agrees to offer only to association members any plan*  
40 *contract.*

1 (9) *It agrees to include any member choosing to enroll in the*  
2 *plan contract offered by the association, provided that the member*  
3 *agrees to make required premium payments.*

4 (10) *It complies with all provisions of this article.*

5 (11) *It had at least 10,000 enrollees covered by association*  
6 *sponsored plans immediately prior to enactment of Chapter 1128*  
7 *of the Statutes of 1992.*

8 (12) *It applies any administrative cost at an equal rate to all*  
9 *members purchasing coverage through the qualified association.*

10 (c) *A qualified association shall comply with Section 1357.52.*

11 SEC. 3. *Section 1357.01 of the Health and Safety Code is*  
12 *amended to read:*

13 1357.01. *Every health care service plan offering plan contracts*  
14 *to small employer groups shall in addition to complying with the*  
15 *provisions of this chapter and the rules adopted thereunder comply*  
16 *with the provisions of this article. This article shall only apply*  
17 *with respect to plan years commencing prior to January 1, 2014.*  
18 *For purposes of this section, “plan year” has the meaning provided*  
19 *in Section 144.03 of Title 45 of the Code of Federal Regulations.*

20 SEC. 4. *Section 1357.19 is added to the Health and Safety*  
21 *Code, to read:*

22 1357.19. *This article shall remain in effect only until January*  
23 *1, 2014, and as of that date is repealed, unless a later enacted*  
24 *statute, that is enacted before January 1, 2014, deletes or extends*  
25 *that date.*

26 SEC. 5. *Article 3.15 (commencing with Section 1357.50) is*  
27 *added to Chapter 2.2 of Division 2 of the Health and Safety Code,*  
28 *to read:*

29  
30 *Article 3.15. Preexisting Condition Provisions*

31  
32 1357.50. (a) *For purposes of this article, the following*  
33 *definitions shall apply:*

34 (1) *“Health benefit plan” means any individual or group*  
35 *insurance policy or health care service plan contract that provides*  
36 *medical, hospital, and surgical benefits. The term does not include*  
37 *accident only, credit, disability income, coverage of Medicare*  
38 *services pursuant to contracts with the United States government,*  
39 *Medicare supplement, long-term care insurance, dental, vision,*  
40 *coverage issued as a supplement to liability insurance, insurance*

1 arising out of a workers' compensation or similar law, automobile  
2 medical payment insurance, or insurance under which benefits  
3 are payable with or without regard to fault and that is statutorily  
4 required to be contained in any liability insurance policy or  
5 equivalent self-insurance.

6 (2) "Preexisting condition provision" means a contract  
7 provision that excludes coverage for charges or expenses incurred  
8 during a specified period following the enrollee's effective date  
9 of coverage, as to a condition for which medical advice, diagnosis,  
10 care, or treatment was recommended or received during a specified  
11 period immediately preceding the effective date of coverage.

12 (3) "Creditable coverage" means:

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

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

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

33 (D) Any other publicly sponsored program, provided in this  
34 state or elsewhere, of medical, hospital, and surgical care.

35 (E) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
36 (Civilian Health and Medical Program of the Uniformed Services  
37 (CHAMPUS)).

38 (F) A medical care program of the Indian Health Service or of  
39 a tribal organization.

1 (G) A health plan offered under 5 U.S.C. Chapter 89  
2 (commencing with Section 8901) (Federal Employees Health  
3 Benefits Program (FEHBP)).

4 (H) A public health plan as defined in federal regulations  
5 authorized by Section 2701(c)(1)(I) of the Public Health Service  
6 Act, as amended by Public Law 104-191, the Health Insurance  
7 Portability and Accountability Act of 1996.

8 (I) A health benefit plan under Section 5(e) of the Peace Corps  
9 Act (22 U.S.C. Sec. 2504(e)).

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

13 (4) “Waivered condition” means a contract provision that  
14 excludes coverage for charges or expenses incurred during a  
15 specified period of time for one or more specific, identified, medical  
16 conditions.

17 (5) “Affiliation period” means a period that, under the terms  
18 of the health benefit plan, must expire before health care services  
19 under the plan become effective.

20 (6) “Waiting period” means a period that is required to pass  
21 with respect to an employee before the employee is eligible to be  
22 covered for benefits under the terms of the plan.

23 (7) “Grandfathered health benefit plan” means a health benefit  
24 plan that is a grandfathered health plan, as defined in Section  
25 1251 of PPACA.

26 (8) “Nongrandfathered health benefit plan” means a health  
27 benefit plan that is not a grandfathered health plan as defined in  
28 Section 1251 of PPACA.

29 (9) “PPACA” means the federal Patient Protection and  
30 Affordable Care Act (Public Law 111-148), as amended by the  
31 federal Health Care and Education Reconciliation Act of 2010  
32 (Public Law 111-152), and any rules, regulations, or guidance  
33 issued pursuant to that law.

34 1357.51. (a) A nongrandfathered health benefit plan for group  
35 or individual coverage or a grandfathered health benefit plan for  
36 group coverage shall not impose any preexisting condition or  
37 waived condition upon any enrollee.

38 (b) A grandfathered health benefit plan for individual coverage  
39 shall not exclude coverage on the basis of a waived condition  
40 or preexisting condition provision for a period greater than 12

1 months following the enrollee's effective date of coverage, nor  
2 limit or exclude coverage for a specific enrollee by type of illness,  
3 treatment, medical condition, or accident, except for satisfaction  
4 of a preexisting condition clause pursuant to this article. Waivered  
5 conditions or preexisting condition provisions contained in  
6 individual grandfathered health benefit plans may relate only to  
7 conditions for which medical advice, diagnosis, care, or treatment,  
8 including use of prescription drugs, was recommended or received  
9 from a licensed health practitioner during the 12 months  
10 immediately preceding the effective date of coverage.

11 (c) (1) A health benefit plan for group coverage may apply a  
12 waiting period of up to 60 days as a condition of employment if  
13 applied equally to all eligible employees and dependents and if  
14 consistent with PPACA. A health benefit plan for group coverage  
15 through a health maintenance organization, as defined in Section  
16 2791 of the federal Public Health Service Act, shall not impose  
17 any affiliation period that exceeds 60 days. A waiting or affiliation  
18 period shall not be based on a preexisting condition of an employee  
19 or dependent, the health status of an employee or dependent, or  
20 any other factor listed in Section 1357.52. An affiliation period  
21 shall run concurrently with a waiting period. During the waiting  
22 or affiliation period, the plan is not required to provide health  
23 care services and no premium shall be charged to the subscriber  
24 or enrollees.

25 (2) A health benefit plan for individual coverage shall not  
26 impose any waiting or affiliation period.

27 (d) In determining whether a preexisting condition provision,  
28 a waived condition, or a waiting or affiliation period applies to  
29 an enrollee, a plan shall credit the time the enrollee was covered  
30 under creditable coverage, provided that the enrollee becomes  
31 eligible for coverage under the succeeding plan contract within  
32 62 days of termination of prior coverage, exclusive of any waiting  
33 or affiliation period, and applies for coverage under the succeeding  
34 plan within the applicable enrollment period. A plan shall also  
35 credit any time that an eligible employee must wait before enrolling  
36 in the plan, including any postenrollment or employer-imposed  
37 waiting or affiliation period.

38 However, if a person's employment has ended, the availability  
39 of health coverage offered through employment or sponsored by  
40 an employer has terminated, or an employer's contribution toward

1 health coverage has terminated, a plan shall credit the time the  
2 person was covered under creditable coverage if the person  
3 becomes eligible for health coverage offered through employment  
4 or sponsored by an employer within 180 days, exclusive of any  
5 waiting or affiliation period, and applies for coverage under the  
6 succeeding plan contract within the applicable enrollment period.

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

10 1357.52. A health benefit plan for group coverage shall not  
11 establish rules for eligibility, including continued eligibility, of an  
12 individual, or dependent of an individual, to enroll under the terms  
13 of the plan based on any of the following health status-related  
14 factors:

15 (a) Health status.

16 (b) Medical condition, including physical and mental illnesses.

17 (c) Claims experience.

18 (d) Receipt of health care.

19 (e) Medical history.

20 (f) Genetic information.

21 (g) Evidence of insurability, including conditions arising out  
22 of acts of domestic violence.

23 (h) Disability.

24 (i) Any other health status-related factor as determined by any  
25 federal regulations, rules, or guidance issued pursuant to Section  
26 2705 of the Public Health Service Act.

27 1357.55. This article shall become operative on January 1,  
28 2014.

29 SEC. 6. Section 1357.55 is added to the Health and Safety  
30 Code, to read:

31 1357.55. This article shall remain in effect only until January  
32 1, 2014, and as of that date is repealed, unless a later enacted  
33 statute, that is enacted before January 1, 2014, deletes or extends  
34 that date.

35 SEC. 7. Article 3.17 (commencing with Section 1357.600) is  
36 added to Chapter 2.2 of Division 2 of the Health and Safety Code,  
37 to read:

1           Article 3.17. *Grandfathered Small Employer Plans*

2  
3           1357.600. *As used in this article, the following definitions shall*  
4 *apply:*

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

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

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

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

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

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

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

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

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

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*  
16 *has 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*  
22 *to subdivision (n), 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 coverage*  
28 *through the California Health Benefit Exchange at the time the*  
29 *individual was 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 *coverage through the California Health Benefit Exchange was the*  
34 *reason for declining enrollment, provided that, if the individual*  
35 *was covered under another employer health benefit plan, including*  
36 *a plan offered through the California Health Benefit Exchange,*  
37 *the individual was given the opportunity to make the certification*  
38 *required by this subdivision and was notified that failure to do so*  
39 *could result in later treatment as a late enrollee.*

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

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

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

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

25 (4) (A) In the case of an eligible employee, as defined in  
26 paragraph (1) of subdivision (b), the plan cannot produce a written  
27 statement from the employer stating that the individual or the  
28 person through whom the individual was eligible to be covered as  
29 a dependent, prior to declining coverage, was provided with, and  
30 signed, acknowledgment of an explicit written notice in boldface  
31 type specifying that failure to elect coverage during the initial  
32 enrollment period permits the plan to impose, at the time of the  
33 individual's later decision to elect coverage, a waiting period of  
34 no longer than 60 days, unless the individual meets the criteria  
35 specified in paragraph (1), (2), or (3).

36 (B) In the case of an association member who did not purchase  
37 coverage through a guaranteed association, the plan cannot  
38 produce a written statement from the association stating that the  
39 association sent a written notice in boldface type to all potentially  
40 eligible association members at their last known address prior to

1 *the initial enrollment period informing members that failure to*  
2 *elect coverage during the initial enrollment period permits the*  
3 *plan to impose, at the time of the member’s later decision to elect*  
4 *coverage, a waiting period of no longer than 60 days, unless the*  
5 *individual meets the requirements of subparagraphs (A), (C), and*  
6 *(D) of paragraph (1) or meets the requirements of paragraph (2)*  
7 *or (3).*

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

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

24 *(6) The individual is a dependent of an enrolled eligible*  
25 *employee who has lost or will lose his or her coverage under the*  
26 *Healthy Families Program, the AIM Program, the Medi-Cal*  
27 *program, or a health benefit plan offered through the California*  
28 *Health Benefit Exchange and requests enrollment within 60 days*  
29 *after termination of that coverage.*

30 *(7) The individual is an eligible employee who previously*  
31 *declined coverage under an employer health benefit plan, including*  
32 *a plan offered through the California Health Benefit Exchange,*  
33 *and who has subsequently acquired a dependent who would be*  
34 *eligible for coverage as a dependent of the employee through*  
35 *marriage, birth, adoption, or placement for adoption, and who*  
36 *enrolls for coverage under that employer health benefit plan on*  
37 *his or her behalf and on behalf of his or her dependent within 30*  
38 *days following the date of marriage, birth, adoption, or placement*  
39 *for adoption, in which case the effective date of coverage shall be*  
40 *the first day of the month following the date the completed request*

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

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

25 (e) “Preexisting condition provision” means a contract  
26 provision that excludes coverage for charges or expenses incurred  
27 during a specified period following the enrollee’s effective date  
28 of coverage, as to a condition for which medical advice, diagnosis,  
29 care, or treatment was recommended or received during a specified  
30 period immediately preceding the effective date of coverage. No  
31 health care service plan shall limit or exclude coverage for any  
32 individual based on a preexisting condition whether or not any  
33 medical advice, diagnosis, care, or treatment was recommended  
34 or received before that date.

35 (f) “Creditable coverage” means:

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

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

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

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

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

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

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

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

25 (8) A public health plan as defined in federal regulations  
26 authorized by Section 2701(c)(1)(I) of the Public Health Service  
27 Act, as amended by Public Law 104-191, the Health Insurance  
28 Portability and Accountability Act of 1996.

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

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

34 (g) "Rating period" means the period for which premium rates  
35 established by a plan are in effect and shall be no less than 12  
36 months from the date of issuance or renewal of the health care  
37 service plan contract.

38 (h) "Risk adjusted employee risk rate" means the rate  
39 determined for an eligible employee of a small employer in a  
40 particular risk category after applying the risk adjustment factor.

1 (i) “Risk adjustment factor” means the percentage adjustment  
 2 to be applied equally to each standard employee risk rate for a  
 3 particular small employer, based upon any expected deviations  
 4 from standard cost of services. This factor may not be more than  
 5 110 percent or less than 90 percent.

6 (j) “Risk category” means the following characteristics of an  
 7 eligible employee: age, geographic region, and family composition  
 8 of the employee, plus the health benefit plan selected by the small  
 9 employer.

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

- 12 Under 30
- 13 30–39
- 14 40–49
- 15 50–54
- 16 55–59
- 17 60–64
- 18 65 and over

19 However, for the 65 and over age category, separate premium  
 20 rates may be specified depending upon whether coverage under  
 21 the plan contract will be primary or secondary to benefits provided  
 22 by the Medicare Program pursuant to Title XVIII of the federal  
 23 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

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

- 27 (A) Single.
- 28 (B) Married couple.
- 29 (C) One adult and child or children.
- 30 (D) Married couple and child or children.

31 (3) (A) In determining rates for small employers, a plan that  
 32 operates statewide shall use no more than nine geographic regions  
 33 in the state, have no region smaller than an area in which the first  
 34 three digits of all its ZIP Codes are in common within a county,  
 35 and divide no county into more than two regions. Plans shall be  
 36 deemed to be operating statewide if their coverage area includes  
 37 90 percent or more of the state’s population. Geographic regions  
 38 established pursuant to this section shall, as a group, cover the  
 39 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) (i) In determining rates for small employers, a plan that  
4 does not operate statewide shall use no more than the number of  
5 geographic regions in the state that is determined by the following  
6 formula: the population, as determined in the last federal census,  
7 of all counties that are included in their entirety in a plan's service  
8 area divided by the total population of the state, as determined in  
9 the last federal census, multiplied by nine. The resulting number  
10 shall be rounded to the nearest whole integer. No region may be  
11 smaller than an area in which the first three digits of all its ZIP  
12 Codes are in common within a county and no county may be  
13 divided into more than two regions. The area encompassed in a  
14 geographic region shall be separate and distinct from areas  
15 encompassed in other geographic regions. Geographic regions  
16 may be noncontiguous. No plan shall have less than one  
17 geographic area.

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

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

26 (k) (1) "Small employer" means any of the following:

27 (A) For plan years commencing on or after January 1, 2014,  
28 and on or before December 31, 2015, any person, firm, proprietary  
29 or nonprofit corporation, partnership, public agency, or  
30 association that is actively engaged in business or service, that,  
31 on at least 50 percent of its working days during the preceding  
32 calendar quarter or preceding calendar year, employed at least  
33 one, but no more than 50, eligible employees, the majority of whom  
34 were employed within this state, that was not formed primarily for  
35 purposes of buying health care service plan contracts, and in which  
36 a bona fide employer-employee relationship exists. For plan years  
37 commencing on or after January 1, 2016, any person, firm,  
38 proprietary or nonprofit corporation, partnership, public agency,  
39 or association that is actively engaged in business or service, that,  
40 on at least 50 percent of its working days during the preceding

1 calendar quarter or preceding calendar year, employed at least  
2 one, but no more than 100, eligible employees, the majority of  
3 whom were employed within this state, that was not formed  
4 primarily for purposes of buying health care service plan contracts,  
5 and in which a bona fide employer-employee relationship exists.  
6 In determining whether to apply the calendar quarter or calendar  
7 year test, a health care service plan shall use the test that ensures  
8 eligibility if only one test would establish eligibility. In determining  
9 the number of eligible employees, companies that are affiliated  
10 companies and that are eligible to file a combined tax return for  
11 purposes of state taxation shall be considered one employer.  
12 Subsequent to the issuance of a health care service plan contract  
13 to a small employer pursuant to this article, and for the purpose  
14 of determining eligibility, the size of a small employer shall be  
15 determined annually. Except as otherwise specifically provided in  
16 this article, provisions of this article that apply to a small employer  
17 shall continue to apply until the plan contract 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 subparagraph who purchases coverage through a guaranteed  
21 association, and any employer purchasing coverage for employees  
22 through a guaranteed association. This subparagraph shall be  
23 implemented to the extent consistent with PPACA, except that the  
24 minimum requirement of one employee shall be implemented only  
25 to the extent required by PPACA.

26 (B) Any guaranteed association, as defined in subdivision (m),  
27 that purchases health coverage for members of the association.

28 (2) For plan years commencing on or after January 1, 2014,  
29 the definition of an employer, for purposes of determining whether  
30 an employer with one employee shall include sole proprietors,  
31 certain owners of "S" corporations, or other individuals, shall be  
32 consistent with Section 1304 of PPACA.

33 (l) "Standard employee risk rate" means the rate applicable to  
34 an eligible employee in a particular risk category in a small  
35 employer group.

36 (m) "Guaranteed association" means a nonprofit organization  
37 comprised of a group of individuals or employers who associate  
38 based solely on participation in a specified profession or industry,  
39 accepting for membership any individual or employer meeting its  
40 membership criteria, and that (1) includes one or more small

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

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

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

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

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

7 (o) *“Affiliation period” means a period that, under the terms*  
 8 *of the health care service plan contract, must expire before health*  
 9 *care services under the contract become effective.*

10 (p) *“Grandfathered small employer health care service plan*  
 11 *contract” means a small employer health care service plan*  
 12 *contract that constitutes a grandfathered health plan.*

13 (q) *“Grandfathered health plan” has the meaning set forth in*  
 14 *Section 1251 of PPACA.*

15 (r) *“Nongrandfathered small employer health care service plan*  
 16 *contract” means a small employer health care service plan*  
 17 *contract that is not a grandfathered health plan.*

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

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

25 (u) *“Small employer health care service plan contract” means*  
 26 *a health care service plan contract issued to a small employer.*

27 (v) *“Waiting period” means a period that is required to pass*  
 28 *with respect to an employee before the employee is eligible to be*  
 29 *covered for benefits under the terms of the contract.*

30 *1357.601. This article shall apply only to grandfathered small*  
 31 *group health care service plan contracts and only with respect to*  
 32 *plan years commencing on or after January 1, 2014.*

33 *1357.602. (a) A health care service plan providing or*  
 34 *arranging for the provision of basic health care services to small*  
 35 *employers shall be subject to this article if either of the following*  
 36 *conditions are met:*

37 *(1) Any portion of the premium is paid by a small employer, or*  
 38 *any covered individual is reimbursed, whether through wage*  
 39 *adjustments or otherwise, by a small employer for any portion of*  
 40 *the premium.*

1 (2) *The plan contract is treated by the small employer or any*  
2 *of the covered individuals as part of a plan or program for the*  
3 *purposes of Section 106 or 162 of the Internal Revenue Code.*

4 (b) *This article shall not apply to health care service plan*  
5 *contracts for coverage of Medicare services pursuant to contracts*  
6 *with the United States government, Medicare supplement, Medi-Cal*  
7 *contracts with the State Department of Health Care Services,*  
8 *long-term care coverage, or specialized health care service plan*  
9 *contracts.*

10 1357.603. *Nothing in this article shall be construed to preclude*  
11 *the application of this chapter to either of the following:*

12 (a) *An association, trust, or other organization acting as a*  
13 *“health care service plan” as defined under Section 1345.*

14 (b) *An association, trust, or other organization or person*  
15 *presenting information regarding a health care service plan to*  
16 *persons who may be interested in subscribing or enrolling in the*  
17 *plan.*

18 1357.604. (a) (1) *A plan shall fairly and affirmatively renew*  
19 *a grandfathered health plan contract with a small employer.*

20 (2) *Each plan shall make available to each small employer all*  
21 *nongrandfathered small employer health care service plan*  
22 *contracts that the plan offers and sells to small employers or to*  
23 *associations that include small employers in this state consistent*  
24 *with Article 3.1 (commencing with Section 1357).*

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

30 (b) *Every plan shall file with the director the reasonable*  
31 *employee participation requirements and employer contribution*  
32 *requirements that will be applied in renewing its grandfathered*  
33 *health care service plan contracts. Participation requirements*  
34 *shall be applied uniformly among all small employer groups, except*  
35 *that a plan may vary application of minimum employee*  
36 *participation requirements by the size of the small employer group*  
37 *and whether the employer contributes 100 percent of the eligible*  
38 *employee’s premium. Employer contribution requirements shall*  
39 *not vary by employer size. A health care service plan shall not*  
40 *establish a participation requirement that (1) requires a person*

1 *who meets the definition of a dependent in subdivision (a) of*  
 2 *Section 1357.600 to enroll as a dependent if he or she is otherwise*  
 3 *eligible for coverage and wishes to enroll as an eligible employee*  
 4 *and (2) allows a plan to reject an otherwise eligible small employer*  
 5 *because of the number of persons that waive coverage due to*  
 6 *coverage through another employer. Members of an association*  
 7 *eligible for health coverage under subdivision (n) of Section*  
 8 *1357.600, but not electing any health coverage through the*  
 9 *association, shall not be counted as eligible employees for purposes*  
 10 *of determining whether the guaranteed association meets a plan's*  
 11 *reasonable participation standards.*

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

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

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

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

35 *(e) A policy or contract that covers a small employer, as defined*  
 36 *in Section 1304(b) of PPACA and in subdivision (k) of Section*  
 37 *1357.600 shall not establish rules for eligibility, including*  
 38 *continued eligibility, of an individual, or dependent of an*  
 39 *individual, to enroll under the terms of the plan based on any of*  
 40 *the following health status-related factors:*

- 1 (1) *Health status.*
- 2 (2) *Medical condition, including physical and mental illnesses.*
- 3 (3) *Claims experience.*
- 4 (4) *Receipt of health care.*
- 5 (5) *Medical history.*
- 6 (6) *Genetic information.*
- 7 (7) *Evidence of insurability, including conditions arising out*
- 8 *of acts of domestic violence.*
- 9 (8) *Disability.*
- 10 (9) *Any other health status-related factor as determined by any*
- 11 *federal regulations, rules, or guidance issued pursuant to Section*
- 12 *2705 of the federal Public Health Service Act.*

13 (f) *A plan shall comply with the requirements of Section 1374.3.*  
14 *1357.606. (a) For plan contracts expiring after July 1, 1994,*  
15 *60 days prior to July 1, 1994, an association that meets the*  
16 *definition of a guaranteed association, as set forth in Section*  
17 *1357.600, except for the requirement that 1,000 persons be*  
18 *covered, shall be entitled to renew grandfathered small employer*  
19 *health care service plan contracts as if the association were a*  
20 *guaranteed association, except that the coverage shall be*  
21 *guaranteed only for those members of an association, as defined*  
22 *in Section 1357.600, (1) who were receiving coverage or had*  
23 *successfully applied for coverage through the association as of*  
24 *June 30, 1993, (2) who were receiving coverage through the*  
25 *association as of December 31, 1992, and whose coverage lapsed*  
26 *at any time thereafter because the employment through which*  
27 *coverage was received ended or an employer's contribution to*  
28 *health coverage ended, or (3) who were covered at any time*  
29 *between June 30, 1993, and July 1, 1994, under a contract that*  
30 *was in force on June 30, 1993.*

31 (b) *An association obtaining health coverage for its members*  
32 *pursuant to this section shall otherwise be afforded all the rights*  
33 *of a guaranteed association under this chapter, including, but not*  
34 *limited to, guaranteed renewability of coverage.*

35 *1357.607. (a) A small employer health care service plan*  
36 *contract shall not impose a preexisting condition provision upon*  
37 *any individual.*

38 (b) *A plan contract may apply a waiting period of up to 60 days*  
39 *as a condition of employment if applied equally to all eligible*  
40 *employees and dependents and if consistent with PPACA. A plan*

1 contract through a health maintenance organization, as defined  
2 in Section 2791 of the federal Public Health Service Act, may  
3 impose an affiliation period not to exceed 60 days. A waiting or  
4 affiliation period shall not be based on a preexisting condition of  
5 an employee or dependent, the health status of an employee or  
6 dependent, or any other factor listed in subdivision (e) of Section  
7 1357.604. An affiliation period shall run concurrently with a  
8 waiting period. During the waiting or affiliation period, the plan  
9 is not required to provide health care services and no premium  
10 shall be charged to the subscriber or enrollees.

11 (c) In determining whether a waiting or affiliation period applies  
12 to any person, a plan shall credit the time the person was covered  
13 under creditable coverage, provided the person becomes eligible  
14 for coverage under the succeeding plan contract within 62 days  
15 of termination of prior coverage, exclusive of any waiting or  
16 affiliation period, and applies for coverage with the succeeding  
17 plan contract within the applicable enrollment period. A plan shall  
18 also credit any time an eligible employee must wait before enrolling  
19 in the plan, including any affiliation or employer-imposed waiting  
20 or affiliation period. However, if a person's employment has ended,  
21 the availability of health coverage offered through employment or  
22 sponsored by an employer has terminated, or an employer's  
23 contribution toward health coverage has terminated, a plan shall  
24 credit the time the person was covered under creditable coverage  
25 if the person becomes eligible for health coverage offered through  
26 employment or sponsored by an employer within 180 days,  
27 exclusive of any waiting or affiliation period, and applies for  
28 coverage under the succeeding plan contract within the applicable  
29 enrollment period.

30 (d) An individual's period of creditable coverage shall be  
31 certified pursuant to subsection (e) of Section 2704 of Title XXVII  
32 of the federal Public Health Service Act (42 U.S.C. Sec.  
33 300gg-3(e)).

34 1357.608. Nothing in this article shall be construed as  
35 prohibiting a health care service plan from restricting enrollment  
36 of late enrollees to open enrollment periods consistent with federal  
37 law. No premium shall be charged to the late enrollee until the  
38 exclusion period has ended.

39 1357.609. All grandfathered small employer health care service  
40 plan contracts shall provide to subscribers and enrollees at least

1 *all of the basic health care services included in subdivision (b) of*  
2 *Section 1345, and in Section 1300.67 of the California Code of*  
3 *Regulations.*

4 *1357.610. (a) No plan shall be required by the provisions of*  
5 *this article:*

6 *(1) To include in a small employer health care service plan*  
7 *contract an otherwise eligible employee or dependent, when the*  
8 *eligible employee or dependent does not work or reside within*  
9 *plan's approved service area, except as provided in Section*  
10 *Chapter 7 (commencing with Section 3750) of Part 1 of Division*  
11 *9 of the Family Code.*

12 *(2) To include in a small employer health care service plan*  
13 *contract an eligible employee, as defined in paragraph (2) of*  
14 *subdivision (b) of Section 1357.600, who within 12 months of*  
15 *application for coverage terminated from a small employer health*  
16 *care service plan contract offered by the plan*

17 *(b) Nothing in this article shall be construed to limit the*  
18 *director's authority to develop and implement a plan of*  
19 *rehabilitation for a health care service plan whose financial*  
20 *viability or organizational and administrative capacity has become*  
21 *impaired.*

22 *1357.611. (a) The director may require a plan to discontinue*  
23 *the renewal of grandfathered small employer health care service*  
24 *plan contracts or the offering or acceptance of applications from*  
25 *any group upon a determination by the director that the plan does*  
26 *not have sufficient financial viability, or organizational and*  
27 *administrative capacity to ensure the delivery of health care*  
28 *services to its enrollees. In determining whether the conditions of*  
29 *this section have been met, the director shall consider, but not be*  
30 *limited to, the plan's compliance with the requirements of Section*  
31 *1367, Article 6 (commencing with Section 1375), and the rules*  
32 *adopted thereunder.*

33 *(b) Nothing in this article shall be construed to limit the*  
34 *director's authority to develop and implement a plan of*  
35 *rehabilitation for a health care service plan whose financial*  
36 *viability or organizational and administrative capacity has become*  
37 *impaired.*

38 *1357.612. Premiums for grandfathered contracts renewed by*  
39 *plans on or after January 1, 2014, shall be subject to the following*  
40 *requirements:*

1 (a) (1) The premium for in force business shall be determined  
2 for an eligible employee in a particular risk category after applying  
3 a risk adjustment factor to the plan's standard employee risk rates.  
4 The risk adjusted employee risk rates may not be more than 110  
5 percent or less than 90 percent. The risk adjustment factor applied  
6 to a small employer may not increase by more than 10 percentage  
7 points from the risk adjustment factor applied in the prior rating  
8 period. The risk adjustment factor for a small employer may not  
9 be modified more frequently than every 12 months.

10 (2) The premium charged a small employer for in force business  
11 shall be equal to the sum of the risk adjusted employee risk rates.  
12 The standard employee risk rates shall be in effect for no less than  
13 12 months.

14 (b) (1) For any small employer, a plan may, with the consent  
15 of the small employer, establish composite employee and dependent  
16 rates for renewal of in force business. The composite rates shall  
17 be determined as the average of the risk adjusted employee risk  
18 rates for the small employer, as determined in accordance with  
19 the requirements of subdivision (a). The sum of the composite rates  
20 so determined shall be equal to the sum of the risk adjusted  
21 employee risk rates for the small employer.

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

37 1357.613. Plans shall apply standard employee risk rates  
38 consistently with respect to all small employers.

39 1357.614. In connection with the renewal of a grandfathered  
40 small employer health care service plan contract, each plan shall

1 *make a reasonable disclosure, as part of its solicitation and sales*  
2 *materials, of the following:*

3 *(a) The extent to which premium rates for a specified small*  
4 *employer are established or adjusted in part based upon the actual*  
5 *or expected variation in service costs or actual or expected*  
6 *variation in health condition of the employees and dependents of*  
7 *the small employer.*

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

11 *(c) Provisions relating to the guaranteed issue and renewal of*  
12 *contracts.*

13 *(d) Provisions relating to the effect of any waiting or affiliation*  
14 *provision.*

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

21 *(f) The availability, upon request, of a listing of all the plan's*  
22 *nongrandfathered small employer health care service plan*  
23 *contracts and benefit plan designs offered, both inside and outside*  
24 *the California Health Benefit Exchange, including the rates for*  
25 *each contract.*

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

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

36 *(1) Prepare a brochure that summarizes all of its small employer*  
37 *health care service plan contracts and to make this summary*  
38 *available to any small employer and to solicitors upon request.*  
39 *The summary shall include for each contract information on*  
40 *benefits provided, a generic description of the manner in which*

1 services are provided, such as how access to providers is limited,  
2 benefit limitations, required copayments and deductibles, standard  
3 employee risk rates, an explanation of the manner in which  
4 creditable coverage is calculated if a waiting or affiliation period  
5 is imposed, and a phone number that can be called for more  
6 detailed benefit information. Plans are required to keep the  
7 information contained in the brochure accurate and up to date  
8 and, upon updating the brochure, send copies to solicitors and  
9 solicitor firms with which the plan contracts to solicit enrollments  
10 or subscriptions.

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

16 (3) Provide to small employers and solicitors, upon request, for  
17 any given small employer the sum of the standard employee risk  
18 rates and the sum of the risk adjusted employee risk rates. When  
19 requesting this information, small employers, solicitors, and  
20 solicitor firms shall provide the plan with the information the plan  
21 needs to determine the small employer's risk adjusted employee  
22 risk rate.

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

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

29 1357.615. (a) At least 20 business days prior to renewing or  
30 amending a small employer health care service plan contract  
31 subject to this article, a plan shall file a notice of material  
32 modification with the director in accordance with the provisions  
33 of Section 1352. The notice of material modification shall include  
34 a statement certifying that the plan is in compliance with  
35 subdivision (i) of Section 1357.600 and Section 1357.612. The  
36 certified statement shall set forth the standard employee risk rate  
37 for each risk category and the highest and lowest risk adjustment  
38 factors that will be used in setting the rates at which the contract  
39 will be renewed or amended. Any action by the director, as  
40 permitted under Section 1352, to disapprove, suspend, or postpone

1 *the plan's use of a plan contract shall be in writing, specifying the*  
2 *reasons that the plan contract does not comply with the*  
3 *requirements of this chapter.*

4 *(b) Prior to making any changes in the risk categories, risk*  
5 *adjustment factors or standard employee risk rates filed with the*  
6 *director pursuant to subdivision (a), the plan shall file as an*  
7 *amendment a statement setting forth the changes and certifying*  
8 *that the plan is in compliance with subdivision (i) of Section*  
9 *1357.600 and Section 1357.612. A plan may commence utilizing*  
10 *the changed risk categories set forth in the certified statement on*  
11 *the 31st day from the date of the filing, or at an earlier time*  
12 *determined by the director, unless the director disapproves the*  
13 *amendment by written notice, stating the reasons therefor. If only*  
14 *the standard employee risk rate is being changed, and not the risk*  
15 *categories or risk adjustment factors, a plan may commence*  
16 *utilizing the changed standard employee risk rate upon filing the*  
17 *certified statement unless the director disapproves the amendment*  
18 *by written notice.*

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

23 *(d) Each plan shall maintain at its principal place of business*  
24 *all of the information required to be filed with the director pursuant*  
25 *to this section.*

26 *(e) Each plan shall make available to the director, on request,*  
27 *the risk adjustment factor used in determining the rate for any*  
28 *particular small employer.*

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

32 *1357.616. (a) Health care service plans may enter into*  
33 *contractual agreements with qualified associations, as defined in*  
34 *subdivision (b), under which these qualified associations may*  
35 *assume responsibility for performing specific administrative*  
36 *services, as defined in this section, for qualified association*  
37 *members. Health care service plans that enter into agreements*  
38 *with qualified associations for assumption of administrative*  
39 *services shall establish uniform definitions for the administrative*  
40 *services that may be provided by a qualified association or its*

1 *third-party administrator. The health care service plan shall permit*  
2 *all qualified associations to assume one or more of these functions*  
3 *when the health care service plan determines the qualified*  
4 *association demonstrates the administrative capacity to assume*  
5 *these functions.*

6 *For the purposes of this section, administrative services provided*  
7 *by qualified associations or their third-party administrators shall*  
8 *be services pertaining to eligibility determination, enrollment,*  
9 *premium collection, sales, or claims administration on a per-claim*  
10 *basis that would otherwise be provided directly by the health care*  
11 *service plan or through a third-party administrator on a*  
12 *commission basis or an agent or solicitor workforce on a*  
13 *commission basis.*

14 *Each health care service plan that enters into an agreement with*  
15 *any qualified association for the provision of administrative*  
16 *services shall offer all qualified associations with which it contracts*  
17 *the same premium discounts for performing those services the*  
18 *health care service plan has permitted the qualified association*  
19 *or its third-party administrator to assume. The health care service*  
20 *plan shall apply these uniform discounts to the health care service*  
21 *plan's risk adjusted employee risk rates after the health plan has*  
22 *determined the qualified association's risk adjusted employee risk*  
23 *rates pursuant to Section 1357.612. The health care service plan*  
24 *shall report to the department its schedule of discounts for each*  
25 *administrative service.*

26 *In no instance may a health care service plan provide discounts*  
27 *to qualified associations that are in any way intended to, or*  
28 *materially result in, a reduction in premium charges to the*  
29 *qualified association due to the health status of the membership*  
30 *of the qualified association. In addition to any other remedies*  
31 *available to the director to enforce this chapter, the director may*  
32 *declare a contract between a health care service plan and a*  
33 *qualified association for administrative services pursuant to this*  
34 *section null and void if the director determines any discounts*  
35 *provided to the qualified association are intended to, or materially*  
36 *result in, a reduction in premium charges to the qualified*  
37 *association due to the health status of the membership of the*  
38 *qualified association.*

39 *(b) For the purposes of this section, a qualified association is*  
40 *a nonprofit corporation comprised of a group of individuals or*

1 *employers who associate based solely on participation in a*  
2 *specified profession or industry, that conforms to all of the*  
3 *following requirements:*

4 *(1) It accepts for membership any individual or small employer*  
5 *meeting its membership criteria.*

6 *(2) It does not condition membership directly or indirectly on*  
7 *the health or claims history of any person.*

8 *(3) It uses membership dues solely for and in consideration of*  
9 *the membership and membership benefits, except that the amount*  
10 *of the dues shall not depend on whether the member applies for*  
11 *or purchases insurance offered by the association.*

12 *(4) It is organized and maintained in good faith for purposes*  
13 *unrelated to insurance.*

14 *(5) It existed on January 1, 1972, and has been in continuous*  
15 *existence since that date.*

16 *(6) It has a constitution and bylaws or other analogous*  
17 *governing documents that provide for election of the governing*  
18 *board of the association by its members.*

19 *(7) It offered, marketed, or sold health coverage to its members*  
20 *for 20 continuous years prior to January 1, 1993.*

21 *(8) It agrees to offer only to association members any plan*  
22 *contract.*

23 *(9) It agrees to include any member choosing to enroll in the*  
24 *plan contract offered by the association, provided that the member*  
25 *agrees to make required premium payments.*

26 *(10) It complies with all provisions of this article.*

27 *(11) It had at least 10,000 enrollees covered by association*  
28 *sponsored plans immediately prior to enactment of Chapter 1128*  
29 *of the Statutes of 1992.*

30 *(12) It applies any administrative cost at an equal rate to all*  
31 *members purchasing coverage through the qualified association.*

32 *(c) A qualified association shall comply with Section 1357.52.*  
33 *1357.617. (a) On or before October 1, 2013, and annually*  
34 *thereafter, a health care service plan shall issue the following*  
35 *notice to all individual subscribers enrolled in a grandfathered*  
36 *small employer health care service plan contract:*

37  
38 *“Beginning on and after January 1, 2014, new improved health*  
39 *insurance options are available in California. You currently have*  
40 *health insurance that is exempt from many of the new requirements.*

1 *You have the option to remain in your current plan or switch to a*  
 2 *new plan. Under the new rules, a health insurance company cannot*  
 3 *deny your application based on any health conditions you may*  
 4 *have. For more information about your options, please contact*  
 5 *the California Health Benefit Exchange, the Office of Patient*  
 6 *Advocate, your plan or policy representative, an insurance broker,*  
 7 *or a health care navigator.”*

8  
 9 *(b) A health care service plan shall include the notice described*  
 10 *in subdivision (a) in any marketing material of the grandfathered*  
 11 *small employer health care service plan contract.*

12 *1357.618. (a) Notwithstanding the Administrative Procedure*  
 13 *Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of*  
 14 *Division 3 of Title 2 of the Government Code), the department may*  
 15 *implement and administer this article through plan letters or*  
 16 *similar instruction from the department until regulations are*  
 17 *adopted.*

18 *(b) The department shall adopt emergency regulations*  
 19 *implementing this article no later than August 31, 2013. The*  
 20 *department may readopt any emergency regulation authorized by*  
 21 *this section that is the same as or substantially equivalent to an*  
 22 *emergency regulation previously adopted under this section.*

23 *(c) The initial adoption of emergency regulations implementing*  
 24 *this section and the one readoption of emergency regulations*  
 25 *authorized by this section shall be deemed an emergency and*  
 26 *necessary for the immediate preservation of the public peace,*  
 27 *health, safety, or general welfare. Initial emergency regulations*  
 28 *and the one readoption of emergency regulations authorized by*  
 29 *this section shall be exempt from review by the Office of*  
 30 *Administrative Law. The initial emergency regulations and the*  
 31 *one readoption of emergency regulations authorized by this section*  
 32 *shall be submitted to the Office of Administrative Law for filing*  
 33 *with the Secretary of State and each shall remain in effect for no*  
 34 *more than 180 days, by which time final regulations may be*  
 35 *adopted.*

36 *SEC. 8. Section 1385.01 of the Health and Safety Code is*  
 37 *amended to read:*

38 *1385.01. For purposes of this article, the following definitions*  
 39 *shall apply:*

1 (a) “Large group health care service plan contract” means a  
2 group health care service plan contract other than a contract issued  
3 to a small employer, as defined in Section 1357 or 1357.600.

4 (b) “Small group health care service plan contract” means a  
5 group health care service plan contract issued to a small employer,  
6 as defined in Section 1357 or 1357.600.

7 (c) “PPACA” means Section 2794 of the federal Public Health  
8 Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal  
9 Patient Protection and Affordable Care Act—~~(P.L. (Public Law~~  
10 111-48), and any subsequent rules, regulations, or guidance issued  
11 under that section.

12 (d) “Unreasonable rate increase” has the same meaning as that  
13 term is defined in PPACA.

14 *SEC. 9. Section 1389.1 of the Health and Safety Code is*  
15 *amended to read:*

16 1389.1. (a) The director shall not approve any plan contract  
17 unless the director finds that the application conforms to ~~both of~~  
18 the following requirements, *as applicable*:

19 (1) All applications for coverage, *except that which is*  
20 *guaranteed issue*, which include health-related questions shall  
21 contain clear and unambiguous questions designed to ascertain the  
22 health condition or history of the applicant.

23 (2) The application questions related to an applicant’s health *in*  
24 *applications described in paragraph (1)* shall be based on medical  
25 information that is reasonable and necessary for medical  
26 underwriting purposes. The application shall include a prominently  
27 displayed notice that shall read:

28  
29 “California law prohibits an HIV test from being required or  
30 used by health care service plans as a condition of obtaining  
31 coverage.”

32  
33 (3) *All applications for coverage subject to Article 3.1*  
34 *(commencing with Section 1357) shall comply with paragraph (2)*  
35 *of subdivision (h) of Section 1357.03.*

36 (b) Nothing in this section shall authorize the director to  
37 establish or require a single or standard application form for  
38 application questions.

39 *SEC. 10. Section 1393.6 of the Health and Safety Code is*  
40 *amended to read:*

1 1393.6. For violations of Article 3.1 (commencing with Section  
 2 1357) ~~and~~, Article 3.15 (commencing with Section 1357.50), *and*  
 3 *Article 3.17 (commencing with Section 1357.600)*, the director  
 4 may, after appropriate notice and opportunity for hearing, by order  
 5 levy administrative penalties as follows:

6 (a) Any person, solicitor, or solicitor firm, other than a health  
 7 care service plan, who willfully violates any provision of this  
 8 chapter, or who willfully violates any rule or order adopted or  
 9 issued pursuant to this chapter, is liable for administrative penalties  
 10 of not less than two hundred fifty dollars (\$250) for each first  
 11 violation, and of not less than one thousand dollars (\$1,000) and  
 12 not more than two thousand five hundred dollars (\$2,500) for each  
 13 subsequent violation.

14 (b) Any health care service plan that willfully violates any  
 15 provision of this chapter, or that willfully violates any rule or order  
 16 adopted or issued pursuant to this chapter, is liable for  
 17 administrative penalties of not less than two thousand five hundred  
 18 dollars (\$2,500) for each first violation, and of not less than five  
 19 thousand dollars (\$5,000) nor more than ten thousand dollars  
 20 (\$10,000) for each second violation, and of not less than fifteen  
 21 thousand dollars (\$15,000) and not more than one hundred  
 22 thousand dollars (\$100,000) for each subsequent violation.

23 (c) The administrative penalties shall be paid to the Managed  
 24 Care Administrative Fines and Penalties Fund and shall be used  
 25 for the purposes specified in Section 1341.45.

26 (d) The administrative penalties available to the director pursuant  
 27 to this section are not exclusive, and may be sought and employed  
 28 in any combination with civil, criminal, and other administrative  
 29 remedies deemed advisable by the director to enforce the provisions  
 30 of this chapter.

31 *SEC. 11. Section 10127.19 is added to the Insurance Code, to*  
 32 *read:*

33 *10127.19. Commencing March 1, 2013, and at least annually*  
 34 *thereafter, every health insurer, not including a health insurer*  
 35 *offering specialized health insurance policies, shall provide to the*  
 36 *department, in a form and manner determined by the department*  
 37 *in consultation with the Department of Managed Health Care, the*  
 38 *number of covered lives, as of December 31 of the prior year, that*  
 39 *receive health care coverage under a health insurance policy that*  
 40 *covers individuals, small groups, groups of 51-100, groups of 101*

1 or more, or administrative services only business lines. Health  
2 insurers shall include the unduplicated enrollment data in specific  
3 product lines as determined by the department, including, but not  
4 limited to HMO, point-of-service, PPO, Medicare excluding  
5 Medicare supplement, Medi-Cal managed care, and traditional  
6 indemnity non-PPO health insurance. The department shall  
7 publicly report the data provided by each health insurer pursuant  
8 to this section, including, but not limited to, posting the data on  
9 the department's Internet Web site. The department shall consult  
10 with the Department of Managed Health Care to ensure that the  
11 data reported is comparable and consistent.

12 SEC. 12. Section 10181 of the Insurance Code is amended to  
13 read:

14 10181. For purposes of this article, the following definitions  
15 shall apply:

16 (a) "Large group health insurance policy" means a group health  
17 insurance policy other than a policy issued to a small employer,  
18 as defined in Section 10700 or 10755.

19 (b) "Small group health insurance policy" means a group health  
20 insurance policy issued to a small employer, as defined in Section  
21 10700 or 10755.

22 (c) "PPACA" means Section 2794 of the federal Public Health  
23 Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal  
24 Patient Protection and Affordable Care Act (~~P.L.~~ (Public Law  
25 111-148), and any subsequent rules, regulations, or guidance issued  
26 pursuant to that law.

27 (d) "Unreasonable rate increase" has the same meaning as that  
28 term is defined in PPACA.

29 SEC. 13. Article 7 (commencing with Section 10198.6) is added  
30 to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to  
31 read:

32

33 *Article 7. Preexisting Condition Provisions*

34

35 10198.6. For purposes of this article, the following definitions  
36 shall apply:

37 (a) "Health benefit plan" means any group or individual policy  
38 of health insurance, as defined in Section 106. The term does not  
39 include coverage of Medicare services pursuant to contracts with  
40 the United States government, Medicare supplement coverage, or

1 coverage consisting solely of excepted benefits as described in  
 2 Sections 2722 and 2791 of the federal Public Health Service Act,  
 3 subject to Section 10198.61.

4 (b) “Preexisting condition provision” means a policy provision  
 5 that excludes coverage for charges or expenses incurred during  
 6 a specified period following the insured’s effective date of  
 7 coverage, as to a condition for which medical advice, diagnosis,  
 8 care, or treatment was recommended or received during a specified  
 9 period immediately preceding the effective date of coverage.

10 (c) “Creditable coverage” means:

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

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

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

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

33 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
 34 (Civilian Health and Medical Program of the Uniformed Services  
 35 (CHAMPUS)).

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

38 (7) A health plan offered under 5 U.S.C. Chapter 89  
 39 (commencing with Section 8901) (Federal Employees Health  
 40 Benefits Program (FEHBP)).

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

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

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

10 (d) “Affiliation period” means a period that, under the terms  
11 of the health benefit plan, must expire before health care services  
12 under the plan become effective.

13 (e) “Waivered condition” means a contract provision that  
14 excludes coverage for charges or expenses incurred during a  
15 specified period of time for one or more specific, identified, medical  
16 conditions.

17 (f) “Grandfathered health benefit plan” means a health benefit  
18 plan that is a grandfathered health plan, as defined in Section  
19 1251 of PPACA.

20 (g) “Nongrandfathered health benefit plan” means a health  
21 benefit plan that is not a grandfathered health plan as defined in  
22 Section 1251 of PPACA.

23 (h) “PPACA” means the federal Patient Protection and  
24 Affordable Care Act (Public Law 111-148), as amended by the  
25 federal Health Care and Education Reconciliation Act of 2010  
26 (Public Law 111-152), and any rules, regulations, or guidance  
27 issued pursuant to that law.

28 10198.61. (a) For purposes of this article, “health benefit  
29 plan” does not include policies or certificates of specified disease  
30 or hospital confinement indemnity provided that the carrier offering  
31 those policies or certificates complies with the following:

32 (1) The carrier files, on or before March 1 of each year, a  
33 certification with the commissioner that contains the statement  
34 and information described in paragraph (2).

35 (2) The certification required in paragraph (1) shall contain  
36 the following:

37 (A) A statement from the carrier certifying that policies or  
38 certificates described in this section (i) are being offered and  
39 marketed as supplemental health insurance and not as a substitute  
40 for coverage that provides essential health benefits as defined by

1 *the state pursuant to Section 1302 of PPACA, (ii) the disclosure*  
2 *forms as described in Section 10603 contains the following*  
3 *statement prominently on the first page: “This is a supplement to*  
4 *health insurance. It is not a substitute for essential health benefits*  
5 *or minimum essential coverage as defined in federal law.*  
6 *Commencing January 1, 2014, you may be subject to a federal tax*  
7 *if you do not obtain minimum essential coverage,” and (iii) are*  
8 *not being offered, marketed, or sold in a manner that would make*  
9 *the purchase of the policies contingent upon the sale of any product*  
10 *sold under Sections 10700 and 10718, or under Section 1357 of*  
11 *the Health and Safety Code or renewal of a product under Section*  
12 *10755 or Section 1357.600 of the Health and Safety Code.*

13 *(B) A summary description of each policy or certificate*  
14 *described in this section, including the average annual premium*  
15 *rates, or range of premium rates in cases where premiums vary*  
16 *by age, gender, or other factors, charged for the policies and*  
17 *certificates in this state.*

18 *(3) In the case of a policy or certificate described in this section*  
19 *and that is offered for the first time in this state for plan years on*  
20 *or after January 1, 2014, the carrier files with the commissioner*  
21 *the information and statement required in paragraph (2) at least*  
22 *30 days prior to the date such a policy or certificate is issued or*  
23 *delivered in this state.*

24 *(b) As used in this section, “policies or certificates of specified*  
25 *disease” and “policies or certificates of hospital confinement*  
26 *indemnity” mean policies or certificates of insurance sold to an*  
27 *insured to supplement other health insurance coverage as specified*  
28 *in this section. An insurer issuing a “policy or certificate of*  
29 *specified disease” or a “policy or certificate of hospital*  
30 *confinement indemnity” shall require that the person to be insured*  
31 *is covered by an individual or group policy or contract that*  
32 *arranges or provides medical, hospital, and surgical coverage not*  
33 *designed to supplement other private or governmental plans.*

34 *10198.7. (a) A nongrandfathered health benefit plan for group*  
35 *or individual coverage or a grandfathered health benefit plan for*  
36 *group coverage shall not impose any preexisting condition or*  
37 *waivered condition upon any individual.*

38 *(b) A grandfathered health benefit plan for individual coverage*  
39 *shall not exclude coverage on the basis of a waivered condition*  
40 *or preexisting condition provision for a period greater than 12*

1 months following the individual's effective date of coverage, nor  
2 limit or exclude coverage for a specific enrollee by type of illness,  
3 treatment, medical condition, or accident, except for satisfaction  
4 of a preexisting condition clause pursuant to this article. Waivered  
5 conditions or preexisting condition provisions contained in health  
6 benefit plans may relate only to conditions for which medical  
7 advice, diagnosis, care, or treatment, including use of prescription  
8 drugs, was recommended or received from a licensed health  
9 practitioner during the 12 months immediately preceding the  
10 effective date of coverage.

11 (c) (1) A health benefit plan for group coverage may apply a  
12 waiting period of up to 60 days as a condition of employment if  
13 applied equally to all eligible employees and dependents and if  
14 consistent with PPACA. A health benefit plan for group coverage  
15 through a health maintenance organization, as defined in Section  
16 2791 of the federal Public Health Service Act, shall not impose  
17 any affiliation period that exceeds 60 days. A waiting or affiliation  
18 period shall not be based on a preexisting condition of an employee  
19 or dependent, the health status of an employee or dependent, or  
20 any other factor listed in Section 10198.9. An affiliation period  
21 shall run concurrently with a waiting period. During the waiting  
22 or affiliation period, the health benefit plan is not required to  
23 provide health care services and no premium shall be charged to  
24 the policyholder or insureds.

25 (2) A health benefit plan for individual coverage shall not  
26 impose a waiting or affiliation period.

27 (d) In determining whether a preexisting condition provision,  
28 a waived condition, or a waiting or affiliation period applies to  
29 a person, a health benefit plan shall credit the time the person was  
30 covered under creditable coverage, provided that the person  
31 becomes eligible for coverage under the succeeding health benefit  
32 plan within 62 days of termination of prior coverage, exclusive of  
33 any waiting or affiliation period, and applies for coverage under  
34 the succeeding plan within the applicable enrollment period. A  
35 plan shall also credit any time that an eligible employee must wait  
36 before enrolling in the plan, including any postenrollment or  
37 employer-imposed waiting or affiliation period. However, if a  
38 person's employment has ended, the availability of health coverage  
39 offered through employment or sponsored by an employer has  
40 terminated, or an employer's contribution toward health coverage

1 *has terminated, a carrier shall credit the time the person was*  
2 *covered under creditable coverage if the person becomes eligible*  
3 *for health coverage offered through employment or sponsored by*  
4 *an employer within 180 days, exclusive of any waiting or affiliation*  
5 *period, and applies for coverage under the succeeding plan within*  
6 *the applicable enrollment period.*

7 *(e) An individual’s period of creditable coverage shall be*  
8 *certified pursuant to Section 2704(e) of Title XXVII of the federal*  
9 *Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).*

10 *10198.8. This article applies to all health benefit plans that*  
11 *provide hospital, medical, or surgical benefits to residents of this*  
12 *state regardless of the situs of the contract or group master*  
13 *policyholder.*

14 *10198.9. A health benefit plan for group coverage shall not*  
15 *establish rules for eligibility, including continued eligibility, of an*  
16 *individual, or dependent of an individual, to enroll under the terms*  
17 *of the plan based on any of the following health status-related*  
18 *factors:*

- 19 *(a) Health status.*
- 20 *(b) Medical condition, including physical and mental illnesses.*
- 21 *(c) Claims experience.*
- 22 *(d) Receipt of health care.*
- 23 *(e) Medical history.*
- 24 *(f) Genetic information.*
- 25 *(g) Evidence of insurability, including conditions arising out*  
26 *of acts of domestic violence.*
- 27 *(h) Disability.*
- 28 *(i) Any other health status-related factor as determined by any*  
29 *federal regulations, rules, or guidance issued pursuant to Section*  
30 *2705 of the federal Public Health Service Act.*

31 *10198.10. This article shall become operative on January 1,*  
32 *2014.*

33 *SEC. 14. Section 10198.10 is added to the Insurance Code, to*  
34 *read:*

35 *10198.10. This article shall remain in effect only until January*  
36 *1, 2014, and as of that date is repealed, unless a later enacted*  
37 *statute, that is enacted before January 1, 2014, deletes or extends*  
38 *that date.*

39 *SEC. 15. Section 10291.5 of the Insurance Code is amended*  
40 *to read:*

1 10291.5. (a) The purpose of this section is to achieve both of  
2 the following:

3 (1) Prevent, in respect to disability insurance, fraud, unfair trade  
4 practices, and insurance economically unsound to the insured.

5 (2) Assure that the language of all insurance policies can be  
6 readily understood and interpreted.

7 (b) The commissioner shall not approve any disability policy  
8 for insurance or delivery in this state in any of the following  
9 circumstances:

10 (1) If the commissioner finds that it contains any provision, or  
11 has any label, description of its contents, title, heading, backing,  
12 or other indication of its provisions which is unintelligible,  
13 uncertain, ambiguous, or abstruse, or likely to mislead a person to  
14 whom the policy is offered, delivered or issued.

15 (2) If it contains any provision for payment at a rate, or in an  
16 amount (other than the product of rate times the periods for which  
17 payments are promised) for loss caused by particular event or  
18 events (as distinguished from character of physical injury or illness  
19 of the insured) more than triple the lowest rate, or amount,  
20 promised in the policy for the same loss caused by any other event  
21 or events (loss caused by sickness, loss caused by accident, and  
22 different degrees of disability each being considered, for the  
23 purpose of this paragraph, a different loss); or if it contains any  
24 provision for payment for any confining loss of time at a rate more  
25 than six times the least rate payable for any partial loss of time or  
26 more than twice the least rate payable for any nonconfining total  
27 loss of time; or if it contains any provision for payment for any  
28 nonconfining total loss of time at a rate more than three times the  
29 least rate payable for any partial loss of time.

30 (3) If it contains any provision for payment for disability caused  
31 by particular event or events (as distinguished from character of  
32 physical injury or illness of the insured) payable for a term more  
33 than twice the least term of payment provided by the policy for  
34 the same degree of disability caused by any other event or events;  
35 or if it contains any benefit for total nonconfining disability payable  
36 for lifetime or for more than 12 months and any benefit for partial  
37 disability, unless the benefit for partial disability is payable for at  
38 least three months; or if it contains any benefit for total confining  
39 disability payable for lifetime or for more than 12 months, unless  
40 it also contains benefit for total nonconfining disability caused by

1 the same event or events payable for at least three months, and, if  
 2 it also contains any benefit for partial disability, unless the benefit  
 3 for partial disability is payable for at least three months. The  
 4 provisions of this paragraph shall apply separately to accident  
 5 benefits and to sickness benefits.

6 (4) If it contains provision or provisions which would have the  
 7 effect, upon any termination of the policy, of reducing or ending  
 8 the liability as the insurer would have, but for the termination, for  
 9 loss of time resulting from accident occurring while the policy is  
 10 in force or for loss of time commencing while the policy is in force  
 11 and resulting from sickness contracted while the policy is in force  
 12 or for other losses resulting from accident occurring or sickness  
 13 contracted while the policy is in force, and also contains provision  
 14 or provisions reserving to the insurer the right to cancel or refuse  
 15 to renew the policy, unless it also contains other provision or  
 16 provisions the effect of which is that termination of the policy as  
 17 the result of the exercise by the insurer of any such right shall not  
 18 reduce or end the liability in respect to the hereinafter specified  
 19 losses as the insurer would have had under the policy, including  
 20 its other limitations, conditions, reductions, and restrictions, had  
 21 the policy not been so terminated.

22 The specified losses referred to in the preceding paragraph are:

23 (i) Loss of time which commences while the policy is in force  
 24 and results from sickness contracted while the policy is in force.

25 (ii) Loss of time which commences within 20 days following  
 26 and results from accident occurring while the policy is in force.

27 (iii) Losses which result from accident occurring or sickness  
 28 contracted while the policy is in force and arise out of the care or  
 29 treatment of illness or injury and which occur within 90 days from  
 30 the termination of the policy or during a period of continuous  
 31 compensable loss or losses which period commences prior to the  
 32 end of such 90 days.

33 (iv) Losses other than those specified in clause (i), (ii), or (iii)  
 34 of this paragraph which result from accident occurring or sickness  
 35 contracted while the policy is in force and which losses occur  
 36 within 90 days following the accident or the contraction of the  
 37 sickness.

38 (5) If by any caption, label, title, or description of contents the  
 39 policy states, implies, or infers without reasonable qualification  
 40 that it provides loss of time indemnity for lifetime, or for any period

1 of more than two years, if the loss of time indemnity is made  
2 payable only when house confined or only under special  
3 contingencies not applicable to other total loss of time indemnity.

4 (6) If it contains any benefit for total confining disability payable  
5 only upon condition that the confinement be of an abnormally  
6 restricted nature unless the caption of the part containing any such  
7 benefit is accurately descriptive of the nature of the confinement  
8 required and unless, if the policy has a description of contents,  
9 label, or title, at least one of them contain reference to the nature  
10 of the confinement required.

11 (7) (A) If, irrespective of the premium charged therefor, any  
12 benefit of the policy is, or the benefits of the policy as a whole are,  
13 not sufficient to be of real economic value to the insured.

14 (B) In determining whether benefits are of real economic value  
15 to the insured, the commissioner shall not differentiate between  
16 insureds of the same or similar economic or occupational classes  
17 and shall give due consideration to all of the following:

18 (i) The right of insurers to exercise sound underwriting judgment  
19 in the selection and amounts of risks.

20 (ii) Amount of benefit, length of time of benefit, nature or extent  
21 of benefit, or any combination of those factors.

22 (iii) The relative value in purchasing power of the benefit or  
23 benefits.

24 (iv) Differences in insurance issued on an industrial or other  
25 special basis.

26 (C) To be of real economic value, it shall not be necessary that  
27 any benefit or benefits cover the full amount of any loss which  
28 might be suffered by reason of the occurrence of any hazard or  
29 event insured against.

30 (8) If it substitutes a specified indemnity upon the occurrence  
31 of accidental death for any benefit of the policy, other than a  
32 specified indemnity for dismemberment, which would accrue prior  
33 to the time of that death or if it contains any provision which has  
34 the effect, other than at the election of the insured exercisable  
35 within not less than 20 days in the case of benefits specifically  
36 limited to the loss by removal of one or more fingers or one or  
37 more toes or within not less than 90 days in all other cases, of  
38 doing any of the following:

39 (A) Of substituting, upon the occurrence of the loss of both  
40 hands, both feet, one hand and one foot, the sight of both eyes or

1 the sight of one eye and the loss of one hand or one foot, some  
 2 specified indemnity for any or all benefits under the policy unless  
 3 the indemnity so specified is equal to or greater than the total of  
 4 the benefit or benefits for which such specified indemnity is  
 5 substituted and which, assuming in all cases that the insured would  
 6 continue to live, could possibly accrue within four years from the  
 7 date of such dismemberment under all other provisions of the  
 8 policy applicable to the particular event or events (as distinguished  
 9 from character of physical injury or illness) causing the  
 10 dismemberment.

11 (B) Of substituting, upon the occurrence of any other  
 12 dismemberment some specified indemnity for any or all benefits  
 13 under the policy unless the indemnity so specified is equal to or  
 14 greater than one-fourth of the total of the benefit or benefits for  
 15 which the specified indemnity is substituted and which, assuming  
 16 in all cases that the insured would continue to live, could possibly  
 17 accrue within four years from the date of the dismemberment under  
 18 all other provisions of the policy applicable to the particular event  
 19 or events (as distinguished from character of physical injury or  
 20 illness) causing the dismemberment.

21 (C) Of substituting a specified indemnity upon the occurrence  
 22 of any dismemberment for any benefit of the policy which would  
 23 accrue prior to the time of dismemberment.

24 As used in this section, loss of a hand shall be severance at or  
 25 above the wrist joint, loss of a foot shall be severance at or above  
 26 the ankle joint, loss of an eye shall be the irrecoverable loss of the  
 27 entire sight thereof, loss of a finger shall mean at least one entire  
 28 phalanx thereof and loss of a toe the entire toe.

29 (9) If it contains provision, other than as provided in Section  
 30 10369.3, reducing any original benefit more than 50 percent on  
 31 account of age of the insured.

32 (10) If the insuring clause or clauses contain no reference to the  
 33 exceptions, limitations, and reductions (if any) or no specific  
 34 reference to, or brief statement of, each abnormally restrictive  
 35 exception, limitation, or reduction.

36 (11) If it contains benefit or benefits for loss or losses from  
 37 specified diseases only unless:

38 (A) All of the diseases so specified in each provision granting  
 39 the benefits fall within some general classification based upon the  
 40 following:

1 (i) The part or system of the human body principally subject to  
2 all such diseases.

3 (ii) The similarity in nature or cause of such diseases.

4 (iii) In case of diseases of an unusually serious nature and  
5 protracted course of treatment, the common characteristics of all  
6 such diseases with respect to severity of affliction and cost of  
7 treatment.

8 (B) The policy is entitled and each provision granting the  
9 benefits is separately captioned in clearly understandable words  
10 so as to accurately describe the classification of diseases covered  
11 and expressly point out, when that is the case, that not all diseases  
12 of the classification are covered.

13 (12) If it does not contain provision for a grace period of at least  
14 the number of days specified below for the payment of each  
15 premium falling due after the first premium, during which grace  
16 period the policy shall continue in force provided, that the grace  
17 period to be included in the policy shall be not less than seven days  
18 for policies providing for weekly payment of premium, not less  
19 than 10 days for policies providing for monthly payment of  
20 premium and not less than 31 days for all other policies.

21 (13) If it fails to conform in any respect with any law of this  
22 state.

23 (c) The commissioner shall not approve any disability policy  
24 covering hospital, medical, or surgical expenses unless the  
25 commissioner finds that the application conforms to ~~both~~ of the  
26 following requirements, *as applicable*:

27 (1) All applications for disability insurance covering hospital,  
28 medical, or surgical expenses, except that which is guaranteed  
29 issue, which include questions relating to medical conditions, shall  
30 contain clear and unambiguous questions designed to ascertain the  
31 health condition or history of the applicant.

32 (2) The application questions designed to ascertain the health  
33 condition or history of the applicant *in applications subject to*  
34 *paragraph (1)* shall be based on medical information that is  
35 reasonable and necessary for medical underwriting purposes. The  
36 application shall include a prominently displayed notice that states:

37  
38 “California law prohibits an HIV test from being required or  
39 used by health insurance companies as a condition of obtaining  
40 health insurance coverage.”

1  
 2 (3) *All applications for coverage subject to Chapter 8*  
 3 *(commencing with Section 10700) shall comply with paragraph*  
 4 *(2) of subdivision (j) of Section 10705.*

5 (d) Nothing in this section authorizes the commissioner to  
 6 establish or require a single or standard application form for  
 7 application questions.

8 (e) The commissioner may, from time to time as conditions  
 9 warrant, after notice and hearing, promulgate such reasonable rules  
 10 and regulations, and amendments and additions thereto, as are  
 11 necessary or convenient, to establish, in advance of the submission  
 12 of policies, the standard or standards conforming to subdivision  
 13 (b), by which he or she shall disapprove or withdraw approval of  
 14 any disability policy.

15 In promulgating any such rule or regulation the commissioner  
 16 shall give consideration to the criteria herein established and to  
 17 the desirability of approving for use in policies in this state uniform  
 18 provisions, nationwide or otherwise, and is hereby granted the  
 19 authority to consult with insurance authorities of any other state  
 20 and their representatives individually or by way of convention or  
 21 committee, to seek agreement upon those provisions.

22 Any such rule or regulation shall be promulgated in accordance  
 23 with the procedure provided in Chapter 3.5 (commencing with  
 24 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
 25 Code.

26 (f) The commissioner may withdraw approval of filing of any  
 27 policy or other document or matter required to be approved by the  
 28 commissioner, or filed with him or her, by this chapter when the  
 29 commissioner would be authorized to disapprove or refuse filing  
 30 of the same if originally submitted at the time of the action of  
 31 withdrawal.

32 Any such withdrawal shall be in writing and shall specify  
 33 reasons. An insurer adversely affected by any such withdrawal  
 34 may, within a period of 30 days following mailing or delivery of  
 35 the writing containing the withdrawal, by written request secure  
 36 a hearing to determine whether the withdrawal should be annulled,  
 37 modified, or confirmed. Unless, at any time, it is mutually agreed  
 38 to the contrary, a hearing shall be granted and commenced within  
 39 30 days following filing of the request and shall proceed with  
 40 reasonable dispatch to determination. Unless the commissioner in

1 writing in the withdrawal, or subsequent thereto, grants an  
2 extension, any such withdrawal shall, in the absence of any such  
3 request, be effective, prospectively and not retroactively, on the  
4 91st day following the mailing or delivery of the withdrawal, and,  
5 if request for the hearing is filed, on the 91st day following mailing  
6 or delivery of written notice of the commissioner's determination.

7 (g) No proceeding under this section is subject to Chapter 5  
8 (commencing with Section 11500) of Part 1 of Division 3 of Title  
9 2 of the Government Code.

10 (h) Except as provided in subdivision (k), any action taken by  
11 the commissioner under this section is subject to review by the  
12 courts of this state and proceedings on review shall be in  
13 accordance with the Code of Civil Procedure.

14 Notwithstanding any other provision of law to the contrary,  
15 petition for any such review may be filed at any time before the  
16 effective date of the action taken by the commissioner. No action  
17 of the commissioner shall become effective before the expiration  
18 of 20 days after written notice and a copy thereof are mailed or  
19 delivered to the person adversely affected, and any action so  
20 submitted for review shall not become effective for a further period  
21 of 15 days after the filing of the petition in court. The court may  
22 stay the effectiveness thereof for a longer period.

23 (i) This section shall be liberally construed to effectuate the  
24 purpose and intentions herein stated; but shall not be construed to  
25 grant the commissioner power to fix or regulate rates for disability  
26 insurance or prescribe a standard form of disability policy, except  
27 that the commissioner shall prescribe a standard supplementary  
28 disclosure form for presentation with all disability insurance  
29 policies, pursuant to Section 10603.

30 (j) This section shall be effective on and after July 1, 1950, as  
31 to all policies thereafter submitted and on and after January 1,  
32 1951, the commissioner may withdraw approval pursuant to  
33 subdivision (d) of any policy thereafter issued or delivered in this  
34 state irrespective of when its form may have been submitted or  
35 approved, and prior to those dates the provisions of law in effect  
36 on January 1, 1949, shall apply to those policies.

37 (k) Any such policy issued by an insurer to an insured on a form  
38 approved by the commissioner, and in accordance with the  
39 conditions, if any, contained in the approval, at a time when that  
40 approval is outstanding shall, as between the insurer and the

1 insured, or any person claiming under the policy, be conclusively  
 2 presumed to comply with, and conform to, this section.

3 *SEC. 16. Chapter 8 (commencing with Section 10700) is added*  
 4 *to Part 2 of Division 2 of the Insurance Code, to read:*

5  
 6 *CHAPTER 8. NONGRANDFATHERED SMALL EMPLOYER HEALTH*  
 7 *INSURANCE*

8  
 9 *Article 1. Definitions*

10  
 11 *10700. (a) “Agent or broker” means a person or entity*  
 12 *licensed under Chapter 5 (commencing with Section 1621) of Part*  
 13 *2 of Division 1.*

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

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

26 *(d) “Carrier” means a health insurer that writes, issues, or*  
 27 *administers health benefit plans that cover the employees of small*  
 28 *employers, regardless of the situs of the contract or master*  
 29 *policyholder.*

30 *(e) “Child” means a child described in Section 22775 of the*  
 31 *Government Code and subdivisions (n) to (p), inclusive, of Section*  
 32 *599.500 of Title 2 of the California Code of Regulations.*

33 *(f) “Dependent” means the spouse, domestic partner, or child*  
 34 *of an eligible employee, subject to applicable terms of the health*  
 35 *benefit plan covering the employee, and includes dependents of*  
 36 *guaranteed association members if the association elects to include*  
 37 *dependents under its health coverage at the same time it determines*  
 38 *its membership composition pursuant to subdivision (t).*

39 *(g) “Eligible employee” means either of the following:*

1 (1) Any permanent employee who is actively engaged on a  
2 full-time basis in the conduct of the business of the small employer  
3 with a normal workweek of an average of 30 hours per week over  
4 the course of a month, in the small employer's regular place of  
5 business, who has met any statutorily authorized applicable waiting  
6 period requirements. The term includes sole proprietors or partners  
7 of a partnership, if they are actively engaged on a full-time basis  
8 in the small employer's business, and they are included as  
9 employees under a health benefit plan of a small employer, but  
10 does not include employees who work on a part-time, temporary,  
11 or substitute basis. It includes any eligible employee, as defined  
12 in this paragraph, who obtains coverage through a guaranteed  
13 association. Employees of employers purchasing through a  
14 guaranteed association shall be deemed to be eligible employees  
15 if they would otherwise meet the definition except for the number  
16 of persons employed by the employer. A permanent employee who  
17 works at least 20 hours but not more than 29 hours is deemed to  
18 be an eligible employee if all four of the following apply:

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

21 (B) The employer offers the employee health coverage under a  
22 health benefit plan.

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

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

31 (2) Any member of a guaranteed association as defined in  
32 subdivision (t).

33 (h) "Enrollee" means an eligible employee or dependent who  
34 receives health coverage through the program from a participating  
35 carrier.

36 (i) "Exchange" means the California Health Benefit Exchange  
37 created by Section 100500 of the Government Code.

38 (j) "Financially impaired" means, for the purposes of this  
39 chapter, a carrier that, on or after the effective date of this chapter,  
40 is not insolvent and is either:

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

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

5 (k) “Health benefit plan” means a policy of health insurance,  
6 as defined in Section 106, that arranges or provides health care  
7 benefits for the covered eligible employees of a small employer  
8 and their dependents. The term does not include coverage of  
9 Medicare services pursuant to contracts with the United States  
10 government, Medicare supplement, long-term care insurance, or  
11 coverage consisting solely of excepted benefits, as described in  
12 Sections 2722 and 2791 of the federal Public Health Service Act,  
13 subject to Section 10701.

14 (l) “In force business” means an existing health benefit plan  
15 issued by the carrier to a small employer.

16 (m) “Late enrollee” means an eligible employee or dependent  
17 who has declined health coverage under a health benefit plan  
18 offered by a small employer at the time of the initial enrollment  
19 period provided under the terms of the health benefit plan  
20 consistent with the periods provided pursuant to Section 10705  
21 and who subsequently requests enrollment in a health benefit plan  
22 of that small employer, except where the employee or dependent  
23 qualifies for a special enrollment period provided pursuant to  
24 Section 10705. It also means any member of an association that  
25 is a guaranteed association as well as any other person eligible  
26 to purchase through the guaranteed association when that person  
27 has failed to purchase coverage during the initial enrollment period  
28 provided under the terms of the guaranteed association’s health  
29 benefit plan consistent with the periods provided pursuant to  
30 Section 10705 and who subsequently requests enrollment in the  
31 plan, except where the employee or dependent qualifies for a  
32 special enrollment period provided pursuant to Section 10705.

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

35 (o) “Preexisting condition provision” means a policy provision  
36 that excludes coverage for charges or expenses incurred during  
37 a specified period following the insured’s effective date of  
38 coverage, as to a condition for which medical advice, diagnosis,  
39 care, or treatment was recommended or received during a specified  
40 period immediately preceding the effective date of coverage.

1 (p) “Creditable coverage” means:

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

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

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

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

23 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
24 (Civilian Health and Medical Program of the Uniformed Services  
25 (CHAMPUS)).

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

28 (7) A health plan offered under 5 U.S.C. Chapter 89  
29 (commencing with Section 8901) (Federal Employees Health  
30 Benefits Program (FEHBP)).

31 (8) A public health plan as defined in federal regulations  
32 authorized by Section 2701(c)(1)(I) of the federal Public Health  
33 Service Act, as amended by Public Law 104-191, the federal Health  
34 Insurance Portability and Accountability Act of 1996.

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

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

1 (q) “Rating period” means the period for which premium rates  
2 established by a carrier are in effect and shall be from January 1  
3 to December 31, inclusive.

4 (r) (1) “Small employer” means either of the following:

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

1 *PPACA, except that the minimum requirement of one employee*  
2 *shall be implemented only to the extent required by PPACA.*

3 *(B) Any guaranteed association, as defined in subdivision (s),*  
4 *that purchases health coverage for members of the association.*

5 *(2) For plan years commencing on or after January 1, 2014,*  
6 *the definition of an employer, for purposes of determining whether*  
7 *an employer with one employee shall include sole proprietors,*  
8 *certain owners of “S” corporations, or other individuals, shall be*  
9 *consistent with Section 1304 of PPACA.*

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

38 *This subdivision applies regardless of whether a master policy*  
39 *by an admitted insurer is delivered directly to the association or*

1 a trust formed for or sponsored by an association to administer  
2 benefits for association members.

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

10 (t) “Members of a guaranteed association” means any  
11 individual or employer meeting the association’s membership  
12 criteria if that person is a member of the association and chooses  
13 to purchase health coverage through the association. At the  
14 association’s discretion, it may also include employees of  
15 association members, association staff, retired members, retired  
16 employees of members, and surviving spouses and dependents of  
17 deceased members. However, if an association chooses to include  
18 those persons as members of the guaranteed association, the  
19 association must so elect in advance of purchasing coverage from  
20 a plan. Health plans may require an association to adhere to the  
21 membership composition it selects for up to 12 months.

22 (u) “Affiliation period” means a period that, under the terms  
23 of the health benefit plan, must expire before health care services  
24 under the plan become effective.

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

27 (w) “Nongrandfathered health benefit plan” means a health  
28 benefit plan that is not a grandfathered health plan.

29 (x) “Plan year” has the meaning set forth in Section 144.103  
30 of Title 45 of the Code of Federal Regulations.

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

36 (z) “Waiting period” means a period that is required to pass  
37 with respect to the employee before the employee is eligible to be  
38 covered for benefits under the terms of the contract.

39 10701. (a) For purposes of this chapter, “health benefit plan”  
40 does not include policies or certificates of specified disease or

1 hospital confinement indemnity provided that the carrier offering  
2 those policies or certificates complies with the following:

3 (1) The carrier files, on or before March 1 of each year, a  
4 certification with the commissioner that contains the statement  
5 and information described in paragraph (2).

6 (2) The certification required in paragraph (1) shall contain  
7 the following:

8 (A) A statement from the carrier certifying that policies or  
9 certificates described in this section (i) are being offered and  
10 marketed as supplemental health insurance and not as a substitute  
11 for coverage that provides essential health benefits as defined by  
12 the state pursuant to Section 1302 of PPACA, (ii) the disclosure  
13 forms as described in Section 10603 contains the following  
14 statement prominently on the first page: “This is a supplement to  
15 health insurance. It is not a substitute for essential health benefits  
16 or minimum essential coverage as defined in federal law.  
17 Commencing January 1, 2014, you may be subject to a federal tax  
18 if you do not obtain minimum essential coverage,” and (iii) are  
19 not being offered, marketed, or sold in a manner that would make  
20 the purchase of the policies contingent upon the sale of any product  
21 sold under Sections 10700 and 10718, or under Section 1357 of  
22 the Health and Safety Code or the renewal of a product under  
23 Section 10755 or Section 1357.600 of the Health and Safety Code.

24 (B) A summary description of each policy or certificate  
25 described in this section, including the average annual premium  
26 rates, or range of premium rates in cases where premiums vary  
27 by age, gender, or other factors, charged for the policies and  
28 certificates in this state.

29 (3) In the case of a policy or certificate that is described in this  
30 section and that is offered for the first time in this state with respect  
31 to plan years on or after January 1, 2014, the carrier files with  
32 the commissioner the information and statement required in  
33 paragraph (2) at least 30 days prior to the date such a policy or  
34 certificate is issued or delivered in this state.

35 (b) As used in this section, “policies or certificates of specified  
36 disease” and “policies or certificates of hospital confinement  
37 indemnity” mean policies or certificates of insurance sold to an  
38 insured to supplement other health insurance coverage as specified  
39 in this section. An insurer issuing a “policy or certificate of  
40 specified disease” or a “policy or certificate of hospital

1 *confinement indemnity” shall require that the person to be insured*  
 2 *is covered by an individual or group policy or contract that*  
 3 *arranges or provides medical, hospital, and surgical coverage not*  
 4 *designed to supplement other private or governmental plans.*

5

6 *Article 2. Small Employer Carrier Requirements*

7

8 *10702. (a) This chapter shall apply only to nongrandfathered*  
 9 *health benefit plans and only with respect to plan years*  
 10 *commencing on or after January 1, 2014.*

11 *(b) All carriers writing, issuing, or administering health benefit*  
 12 *plans that cover employees of small employers shall be subject to*  
 13 *this chapter if any one of the following conditions are met:*

14 *(1) Any portion of the premium for any health benefit plan or*  
 15 *benefits is paid by a small employer, or any covered individual is*  
 16 *reimbursed, whether through wage adjustments or otherwise, by*  
 17 *a small employer for any portion of the premium.*

18 *(2) The health benefit plan is treated by the small employer or*  
 19 *any of the covered individuals as part of a plan or program for*  
 20 *the purposes of Section 106 or 162 of the Internal Revenue Code.*

21 *10702.1. Any person or entity subject to the requirements of*  
 22 *this chapter shall comply with the standards set forth in Chapter*  
 23 *7 (commencing with Section 3750) of Part 1 of Division 9 of the*  
 24 *Family Code and Section 14124.94 of the Welfare and Institutions*  
 25 *Code.*

26 *10703. The commissioner shall have the authority to determine*  
 27 *whether a health benefit plan is covered by this chapter, and to*  
 28 *determine whether an employer is a small employer within the*  
 29 *meaning of Section 10700.*

30 *10704. The commissioner may issue regulations that are*  
 31 *necessary to carry out the purposes of this chapter.*

32 *10705. (a) No group or individual policy or contract or*  
 33 *certificate of group insurance or statement of group coverage*  
 34 *providing benefits to employees of small employers as defined in*  
 35 *this chapter shall be issued or delivered by a carrier subject to the*  
 36 *jurisdiction of the commissioner regardless of the situs of the*  
 37 *contract or master policyholder or of the domicile of the carrier*  
 38 *nor, except as otherwise provided in Sections 10270.91 and*  
 39 *10270.92, shall a carrier provide coverage subject to this chapter*  
 40 *until a copy of the form of the policy, contract, certificate, or*

1 *statement of coverage is filed with and approved by the*  
2 *commissioner in accordance with Sections 10290 and 10291, and*  
3 *the carrier has complied with the requirements of Section 10717.*

4 *(b) (1) On and after October 1, 2013, each carrier shall fairly*  
5 *and affirmatively offer, market, and sell all of the carrier's health*  
6 *benefit plans that are sold to, offered through, or sponsored by,*  
7 *small employers or associations that include small employers to*  
8 *all small employers in each geographic region in which the carrier*  
9 *makes coverage available or provides benefits.*

10 *(2) A carrier that offers qualified health plans through the*  
11 *Exchange shall be deemed to be in compliance with paragraph*  
12 *(1) with respect to health benefit plans offered through the*  
13 *Exchange in those geographic regions in which the carrier offers*  
14 *plans through the Exchange.*

15 *(3) A carrier shall provide enrollment periods consistent with*  
16 *PPACA and set forth in Section 155.725 of Title 45 of the Code*  
17 *of Federal Regulations. A carrier shall provide special enrollment*  
18 *periods consistent with the special enrollment periods required in*  
19 *the individual nongrandfathered market in the state, except for the*  
20 *triggering events identified in paragraphs (d)(3) and (d)(6) of*  
21 *Section 155.420 of Title 45 of the Code of Federal Regulations*  
22 *with respect to health benefit plans offered through the Exchange.*

23 *(4) Nothing in this section shall be construed to require an*  
24 *association, or a trust established and maintained by an association*  
25 *to receive a master insurance policy issued by an admitted insurer*  
26 *and to administer the benefits thereof solely for association*  
27 *members, to offer, market or sell a benefit plan design to those*  
28 *who are not members of the association. However, if the*  
29 *association markets, offers or sells a benefit plan design to those*  
30 *who are not members of the association it is subject to the*  
31 *requirements of this section. This shall apply to an association*  
32 *that otherwise meets the requirements of paragraph (8) formed by*  
33 *merger of two or more associations after January 1, 1992, if the*  
34 *predecessor organizations had been in active existence on January*  
35 *1, 1992, and for at least five years prior to that date and met the*  
36 *requirements of paragraph (5).*

37 *(5) A carrier which (A) effective January 1, 1992, and at least*  
38 *20 years prior to that date, markets, offers, or sells benefit plan*  
39 *designs only to all members of one association and (B) does not*  
40 *market, offer or sell any other individual, selected group, or group*

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

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

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

21 (8) *For purposes of paragraphs (4) and (6), an association is*  
22 *a nonprofit organization comprised of a group of individuals or*  
23 *employers who associate based solely on participation in a*  
24 *specified profession or industry, accepting for membership any*  
25 *individual or small employer meeting its membership criteria,*  
26 *which do not condition membership directly or indirectly on the*  
27 *health or claims history of any person, which uses membership*  
28 *dues solely for and in consideration of the membership and*  
29 *membership benefits, except that the amount of the dues shall not*  
30 *depend on whether the member applies for or purchases insurance*  
31 *offered by the association, which is organized and maintained in*  
32 *good faith for purposes unrelated to insurance, which has been in*  
33 *active existence on January 1, 1992, and at least five years prior*  
34 *to that date, which has a constitution and bylaws, or other*  
35 *analogous governing documents which provide for election of the*  
36 *governing board of the association by its members, which has*  
37 *contracted with one or more carriers to offer one or more health*  
38 *benefit plans to all individual members and small employer*  
39 *members in this state.*

1 (c) On and after October 1, 2013, each carrier shall make  
2 available to each small employer all health benefit plans that the  
3 carrier offers or sells to small employers or to associations that  
4 include small employers. Notwithstanding subdivision (d) of Section  
5 10700, for purposes of this subdivision, companies that are  
6 affiliated companies or that are eligible to file a consolidated  
7 income tax return shall be treated as one carrier.

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

9 (1) Prepare a brochure that summarizes all of its health benefit  
10 plans and make this summary available to small employers, agents,  
11 and brokers upon request. The summary shall include for each  
12 plan information on benefits provided, a generic description of  
13 the manner in which services are provided, such as how access to  
14 providers is limited, benefit limitations, required copayments and  
15 deductibles, an explanation of how creditable coverage is  
16 calculated if a waiting or affiliation period is imposed, and a  
17 telephone number that can be called for more detailed benefit  
18 information. Carriers are required to keep the information  
19 contained in the brochure accurate and up to date, and, upon  
20 updating the brochure, send copies to agents and brokers  
21 representing the carrier. Any entity that provides administrative  
22 services only with regard to a health benefit plan written or issued  
23 by another carrier shall not be required to prepare a summary  
24 brochure which includes that benefit plan.

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

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

39 (4) Notwithstanding subdivision (d) of Section 10700, for  
40 purposes of this subdivision, companies that are affiliated

1 *companies or that are eligible to file a consolidated income tax*  
2 *return shall be treated as one carrier.*

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

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

9 *(A) Advise the small employer of the carrier's obligation to sell*  
10 *to any small employer any of the health benefit plans it offers to*  
11 *small employers, consistent with PPACA, and provide them, upon*  
12 *request, with the actual rates that would be charged to that*  
13 *employer for a given health benefit plan.*

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

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

22 *(D) Notify the small employer of the availability of coverage*  
23 *and the availability of tax credits for certain employers consistent*  
24 *with PPACA and state law, including any rules, regulations, or*  
25 *guidance issued in connection therewith.*

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

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

33 *(A) For each of the health benefit plans offered by the carrier*  
34 *whose health benefit plan the agent or broker is presenting, provide*  
35 *the small employer with the benefit summary required in paragraph*  
36 *(1) of subdivision (d) and the premium for that particular employer.*

37 *(B) Notify the small employer that, upon request, the agent or*  
38 *broker will provide the small employer with an evidence of*  
39 *coverage brochure for each health benefit plan the carrier offers.*

1 (C) Obtain a signed statement from the small employer  
2 acknowledging that the small employer has received the disclosures  
3 required by this paragraph and Section 10716.

4 (f) No carrier, agent, or broker shall induce or otherwise  
5 encourage a small employer to separate or otherwise exclude an  
6 eligible employee from a health benefit plan which, in the case of  
7 an eligible employee meeting the definition in paragraph (1) of  
8 subdivision (g) of Section 10700, is provided in connection with  
9 the employee's employment or which, in the case of an eligible  
10 employee as defined in paragraph (2) of subdivision (g) of Section  
11 10700, is provided in connection with a guaranteed association.

12 (g) No carrier shall reject an application from a small employer  
13 for a health benefit plan provided:

14 (1) The small employer as defined by subparagraph (A) of  
15 paragraph (1) of subdivision (r) of Section 10700 offers health  
16 benefits to 100 percent of its eligible employees as defined in  
17 paragraph (1) of subdivision (g) of Section 10700. Employees who  
18 waive coverage on the grounds that they have other group coverage  
19 shall not be counted as eligible employees.

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

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

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

29 (2) Encourage or direct small employers to seek coverage from  
30 another carrier because of the health status, claims experience,  
31 industry, occupation, or geographic location within the carrier's  
32 approved service area of the small employer or the small  
33 employer's employees.

34 (i) No carrier shall, directly or indirectly, enter into any  
35 contract, agreement, or arrangement with an agent or broker that  
36 provides for or results in the compensation paid to an agent or  
37 broker for a health benefit plan to be varied because of the health  
38 status, claims experience, industry, occupation, or geographic  
39 location of the small employer or the small employer's employees.  
40 This subdivision shall not apply with respect to a compensation

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

6 (j) (1) A health benefit plan offered to a small employer, as  
7 defined in Section 1304(b) of PPACA and in Section 10700, shall  
8 not establish rules for eligibility, including continued eligibility,  
9 of an individual, or dependent of an individual, to enroll under  
10 the terms of the plan based on any of the following health  
11 status-related factors:

12 (A) Health status.

13 (B) Medical condition, including physical and mental illnesses.

14 (C) Claims experience.

15 (D) Receipt of health care.

16 (E) Medical history.

17 (F) Genetic information.

18 (G) Evidence of insurability, including conditions arising out  
19 of acts of domestic violence.

20 (H) Disability.

21 (I) Any other health status-related factor as determined by any  
22 federal regulations, rules, or guidance issued pursuant to Section  
23 2705 of the federal Public Health Service Act.

24 (2) A carrier shall not require an eligible employee or dependent  
25 to fill out a health assessment or medical questionnaire prior to  
26 enrollment under a health benefit plan.

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

32 (l) (1) With respect to the obligation to provide coverage newly  
33 issued under subdivision (c), to the extent permitted by PPACA,  
34 the carrier may cease enrolling new small employer groups and  
35 new eligible employees as defined by paragraph (2) of subdivision  
36 (g) of Section 10700 if it certifies to the commissioner that the  
37 number of eligible employees and dependents, of the employers  
38 newly enrolled or insured during the current calendar year by the  
39 carrier equals or exceeds: (A) in the case of a carrier that  
40 administers any self-funded health benefits arrangement in

1 California, 10 percent of the total number of eligible employees,  
2 or eligible employees and dependents, respectively, enrolled or  
3 insured in California by that carrier as of December 31 of the  
4 preceding year, or (B) in the case of a carrier that does not  
5 administer any self-funded health benefit arrangements in  
6 California, 8 percent of the total number of eligible employees, or  
7 eligible employees and dependents, respectively, enrolled or  
8 insured by the carrier in California as of December 31 of the  
9 preceding year.

10 (2) Certification shall be deemed approved if not disapproved  
11 within 45 days after submission to the commissioner. If that  
12 certification is approved, the small employer carrier shall not offer  
13 coverage to any small employers under any health benefit plans  
14 during the remainder of the current year. If the certification is not  
15 approved, the carrier shall continue to issue coverage as required  
16 by subdivision (c) and be subject to administrative penalties as  
17 established in Section 10718.

18 10705.1. (a) For contracts expiring after July 1, 1994, 60 days  
19 prior to July 1, 1994, an association that meets the definition of  
20 guaranteed association, as set forth in Section 10700, except for  
21 the requirement that 1,000 persons be covered, shall be entitled  
22 to purchase small employer health coverage as if the association  
23 were a guaranteed association, except that the coverage shall be  
24 guaranteed only for those members of an association, as defined  
25 in Section 10700, (1) who were receiving coverage or had  
26 successfully applied for coverage through the association as of  
27 June 30, 1993, (2) who were receiving coverage through the  
28 association as of December 31, 1992, and whose coverage lapsed  
29 at any time thereafter because the employment through which  
30 coverage was received ended or an employer's contribution to  
31 health coverage ended, or (3) who were covered at any time  
32 between June 30, 1993, and July 1, 1994, under a contract that  
33 was in force on June 30 1993.

34 (b) An association obtaining health coverage for its members  
35 pursuant to this section shall otherwise be afforded all the rights  
36 of a guaranteed association under this chapter including, but not  
37 limited to, guaranteed renewability of coverage.

38 10706. Every carrier shall file with the commissioner the  
39 reasonable participation requirements and employer contribution  
40 requirements that are to be included in its health benefit plans.

1 *Participation requirements shall be applied uniformly among all*  
2 *small employer groups, except that a carrier may vary application*  
3 *of minimum employer participation requirements by the size of*  
4 *the small employer group and whether the employer contributes*  
5 *100 percent of the eligible employee's premium. Employer*  
6 *contribution requirements shall not vary by employer size. A*  
7 *carrier shall not establish a participation requirement that (1)*  
8 *requires a person who meets the definition of a dependent in*  
9 *subdivision (f) of Section 10700 to enroll as a dependent if he or*  
10 *she is otherwise eligible for coverage and wishes to enroll as an*  
11 *eligible employee and (2) allows a carrier to reject an otherwise*  
12 *eligible small employer because of the number of persons that*  
13 *waive coverage due to coverage through another employer.*  
14 *Members of an association eligible for health coverage eligible*  
15 *under subdivision (t) of Section 10700 but not electing any health*  
16 *coverage through the association shall not be counted as eligible*  
17 *employees for purposes of determining whether the guaranteed*  
18 *association meets a carrier's reasonable participation standards.*

19 *10706.5. (a) With respect to health benefit plans offered*  
20 *outside the Exchange, after a small employer submits a completed*  
21 *application, the carrier shall, within 30 days notify the employer*  
22 *of the employer's actual rates in accordance with Section 10714.*  
23 *The employer shall have 30 days in which to exercise the right to*  
24 *buy coverage at the quoted rates.*

25 *(b) (1) Except as required under paragraph (2), when a small*  
26 *employer submits a premium payment, based on the quoted rates,*  
27 *and that payment is delivered or postmarked, whichever occurs*  
28 *earlier, within the first 15 days of a month, coverage shall become*  
29 *effective no later than the first day of the following month. When*  
30 *that payment is neither delivered nor postmarked until after the*  
31 *15th day of a month, coverage shall become effective no later than*  
32 *the first day of the second month following delivery or postmark*  
33 *of the payment.*

34 *(2) A carrier shall apply coverage effective dates for health*  
35 *benefit plans subject to this chapter consistent with the coverage*  
36 *effective dates applicable to nongrandfathered individual health*  
37 *benefit plans.*

38 *(c) During the first 30 days of coverage, the small employer*  
39 *shall have the option of changing coverage to a different health*  
40 *benefit plan offered by the same carrier. If a small employer*

1 notifies the carrier of the change within the first 15 days of a  
2 month, coverage under the new health benefit plan shall become  
3 effective no later than the first day of the following month. If a  
4 small employer notifies the carrier of the change after the 15th  
5 day of a month, coverage under the new health benefit plan shall  
6 become effective no later than the first day of the second month  
7 following notification.

8 (d) All eligible employees and dependents listed on the small  
9 employer's completed application shall be covered on the effective  
10 date of the health benefit plan.

11 10708. (a) A health benefit plan shall not impose a preexisting  
12 condition provision upon any individual.

13 (b) A health benefit plan may apply a waiting period of up to  
14 60 days as a condition of employment if applied equally to all  
15 eligible employees and dependents and if consistent with PPACA.  
16 A health benefit plan offered through a health maintenance  
17 organization, as defined in Section 2791 of the federal Public  
18 Health Service Act, may impose an affiliation period not to exceed  
19 60 days. A waiting or affiliation period shall not be based on a  
20 preexisting condition of an employee or dependent, the health  
21 status of an employee or dependent, or any other factor listed in  
22 subdivision (j) of Section 10705. An affiliation period shall run  
23 concurrently with a waiting period. During the waiting or  
24 affiliation period, the health benefit plan is not required to provide  
25 health care services and no premium shall be charged to the  
26 policyholder or insureds.

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

1 *creditable coverage if the person becomes eligible for health*  
2 *coverage offered through employment or sponsored by an employer*  
3 *within 180 days, exclusive of any waiting or affiliation period, and*  
4 *applies for coverage under the succeeding health benefit plan*  
5 *within the applicable enrollment period.*

6 *(d) An individual's period of creditable coverage shall be*  
7 *certified pursuant to subsection (e) of Section 2704 of Title XXVII*  
8 *of the federal Public Health Service Act (42 U.S.C. Sec.*  
9 *300gg-3(e)).*

10 *10709. Nothing in this chapter shall be construed as prohibiting*  
11 *a carrier from restricting enrollment of late enrollees to open*  
12 *enrollment periods provided under Section 10705 as authorized*  
13 *under Section 2702 of the federal Public Health Service Act. No*  
14 *premium shall be charged to the late enrollee until the exclusion*  
15 *period has ended.*

16 *10711. To the extent permitted by PPACA, no carrier shall be*  
17 *required by the provisions of this chapter:*

18 *(a) To offer coverage to, or accept applications from, a small*  
19 *employer as defined in subparagraph (A) of paragraph (1) of*  
20 *subdivision (r) of Section 10700, where the small employer is not*  
21 *physically located in a carrier's approved service areas.*

22 *(b) To offer coverage to or accept applications from a small*  
23 *employer as defined in subparagraph (B) of paragraph (1) of*  
24 *subdivision (r) of Section 10700 where the small employer is*  
25 *seeking coverage for eligible employees who do not work or reside*  
26 *in a carrier's approved service areas.*

27 *(c) To include in a health benefit plan an otherwise eligible*  
28 *employee or dependent, when the eligible employee or dependent*  
29 *does not work or reside within a carrier's approved service area,*  
30 *except as provided in Section 10702.1.*

31 *(d) To offer coverage to, or accept applications from, a small*  
32 *employer for a benefits plan design within an area if the*  
33 *commissioner has found that the carrier will not have the capacity*  
34 *within the area in its network of providers to deliver service*  
35 *adequately to the eligible employees and dependents of that*  
36 *employee because of its obligations to existing group*  
37 *contractholders and enrollees and that the action is not*  
38 *unreasonable or clearly inconsistent with the intent of this chapter.*

39 *A carrier that cannot offer coverage to small employers in a*  
40 *specific service area because it is lacking sufficient capacity may*

1 *not offer coverage in the applicable area to new employer groups*  
2 *with more than 50 eligible employees until the carrier notifies the*  
3 *commissioner that it has regained capacity to deliver services to*  
4 *small employers, and certifies to the commissioner that from the*  
5 *date of the notice it will enroll all small groups requesting coverage*  
6 *from the carrier until the carrier has met the requirements of*  
7 *subdivision (h) of Section 10705.*

8 *(e) To offer coverage to a small employer, or an eligible*  
9 *employee as defined in paragraph (2) of subdivision (g) of Section*  
10 *10700, who within 12 months of application for coverage*  
11 *terminated from a health benefit plan offered by the carrier.*

12 *10712. (a) A carrier shall not be required to offer coverage*  
13 *or accept applications for benefit plan designs pursuant to this*  
14 *chapter where the commissioner determines that the acceptance*  
15 *of an application or applications would place the carrier in a*  
16 *financially impaired condition.*

17 *(b) The commissioner's determination shall follow an evaluation*  
18 *that includes a certification by the commissioner that the*  
19 *acceptance of an application or applications would place the*  
20 *carrier in a financially impaired condition.*

21 *(c) A carrier that has not offered coverage or accepted*  
22 *applications pursuant to this chapter shall not offer coverage or*  
23 *accept applications for any individual or group health benefit plan*  
24 *until the commissioner has determined that the carrier has ceased*  
25 *to be financially impaired.*

26 *10713. All health benefit plans subject to this chapter shall be*  
27 *renewable with respect to all eligible employees or dependents at*  
28 *the option of the policyholder, contractholder, or small employer*  
29 *except as follows:*

30 *(a) (1) For nonpayment of the required premiums by the*  
31 *policyholder, contractholder, or small employer, if the*  
32 *policyholder, contractholder, or small employer has been duly*  
33 *notified and billed for the charge and at least a 30-day grace*  
34 *period has elapsed since the date of notification or, if longer, the*  
35 *period of time required for notice and any other requirements*  
36 *pursuant to Section 2703, 2712, or 2742 of the federal Public*  
37 *Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and*  
38 *300gg-42) and any subsequent rules or regulations has elapsed.*

39 *(2) An insurer shall continue to provide coverage as required*  
40 *by the policyholder's, contractholder's, or small employer's policy*

1 during the period described in paragraph (1). Nothing in this  
2 section shall be construed to affect or impair the policyholder's,  
3 contractholder's, small employer's, or insurer's other rights and  
4 responsibilities pursuant to the subscriber contract.

5 (b) If the insurer demonstrates fraud or an intentional  
6 misrepresentation of material fact under the terms of the policy  
7 by the policyholder, contractholder, or small employer or, with  
8 respect to coverage of individual enrollees, the enrollees or their  
9 representative.

10 (c) Violation of a material contract provision relating to  
11 employer contribution or group participation rates by the  
12 policyholder, contractholder, or small employer.

13 (d) When the carrier ceases to write, issue, or administer new  
14 or existing grandfathered or nongrandfathered small employer  
15 health benefit plans in this state, provided, however, that the  
16 following conditions are satisfied:

17 (1) Notice of the decision to cease writing, issuing, or  
18 administering new or existing small employer health benefits plans  
19 in this state is provided to the commissioner, and to either the  
20 policyholder, contractholder, or small employer at least 180 days  
21 prior to the discontinuation of the coverage.

22 (2) Small employer health benefit plans subject to this chapter  
23 shall not be canceled for 180 days after the date of the notice  
24 required under paragraph (1). For that business of a carrier that  
25 remains in force, any carrier that ceases to write, issue, or  
26 administer new or existing health benefit plans shall continue to  
27 be governed by this chapter.

28 (3) Except in the case where a certification has been approved  
29 pursuant to subdivision (l) of Section 10705 or the commissioner  
30 has made a determination pursuant to subdivision (a) of Section  
31 10712, a carrier that ceases to write, issue, or administer new  
32 health benefit plans to small employers in this state after the  
33 passage of this chapter shall be prohibited from writing, issuing,  
34 or administering new health benefit plans to small employers in  
35 this state for a period of five years from the date of notice to the  
36 commissioner.

37 (e) When a carrier withdraws a benefit plan design from the  
38 small employer market, provided that the carrier notifies all  
39 affected policyholders, contractholders, or small employers and  
40 the commissioner at least 90 days prior to the discontinuation of

1 *those contracts, and that the carrier makes available to the small*  
2 *employer all small employer benefit plan designs which it markets.*

3 *(f) If coverage is made available through a bona fide association*  
4 *pursuant to subdivision (r) of Section 10700 or a guaranteed*  
5 *association pursuant to subdivision (s) of Section 10700, the*  
6 *membership of the employer or the individual, respectively, ceases,*  
7 *but only if that coverage is terminated under this subdivision*  
8 *uniformly without regard to any health status-related factor of*  
9 *covered individuals.*

10 *10714. (a) The premium rate for a health benefit plan issued,*  
11 *amended, or renewed on after January 1, 2014, shall vary with*  
12 *respect to the particular coverage involved only by the following:*

13 *(1) Age, as described in regulations adopted by the department*  
14 *in conjunction with the Department of Managed Health Care that*  
15 *do not prevent the application of PPACA. Rates based on age shall*  
16 *be determined based on the individual's birthday. A carrier shall*  
17 *not use any age bands for rating purposes that are inconsistent*  
18 *with the age bands established by the United States Secretary of*  
19 *Health and Human Services pursuant to Section 2701(a)(3) of the*  
20 *federal Public Health Service Act (42 U.S.C. Sec. 300gg (a)(3)).*

21 *(2) Geographic region. The geographic regions for purposes*  
22 *of rating shall be the following:*

23 *(A) Region 1 shall consist of the Counties of Alpine, Del Norte,*  
24 *Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama,*  
25 *Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter,*  
26 *Yuba, Colusa, Amador, Calaveras, and Tuolumne.*

27 *(B) Region 2 shall consist of the Counties of Napa, Sonoma,*  
28 *Solano, and Marin.*

29 *(C) Region 3 shall consist of the Counties of Sacramento, Placer,*  
30 *El Dorado, and Yolo.*

31 *(D) Region 4 shall consist of the Counties of San Francisco,*  
32 *Contra Costa, Alameda, Santa Clara, and San Mateo.*

33 *(E) Region 5 shall consist of the Counties of Santa Cruz,*  
34 *Monterey, and San Benito.*

35 *(F) Region 6 shall consist of the Counties of San Joaquin,*  
36 *Stanislaus, Merced, Mariposa, Madera, Fresno, Kings, and Tulare.*

37 *(G) Region 7 shall consist of the Counties of San Luis Obispo,*  
38 *Santa Barbara, and Ventura.*

39 *(H) Region 8 shall consist of the Counties of Mono, Inyo, Kern,*  
40 *and Imperial.*

1     (I) Region 9 shall consist of the ZIP Codes in Los Angeles  
2 County starting with 906 to 912, inclusive, 915, 917, 918, and 935.  
3     (J) Region 10 shall consist of the ZIP Codes in Los Angeles  
4 County other than those identified in subparagraph (I).  
5     (K) Region 11 shall consist of the Counties of San Bernardino  
6 and Riverside.  
7     (L) Region 12 shall consist of the County of Orange.  
8     (M) Region 13 shall consist of the County of San Diego.  
9     (3) Whether the health benefit plan covers an individual or  
10 family.  
11     (b) The rate for a health benefit plan subject to this section shall  
12 not vary by any factor not described in this section.  
13     (c) The rating period for rates subject to this section shall be  
14 from January 1 to December 31, inclusive.  
15     (d) (1) Notwithstanding the Administrative Procedure Act  
16 (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
17 Division 3 of Title 2 of the Government Code), the department may  
18 implement and administer this section through insurer letters or  
19 similar instruction from the department until regulations are  
20 adopted.  
21     (2) The department shall adopt emergency regulations  
22 implementing this section no later than August 31, 2013. The  
23 department may readopt any emergency regulation authorized by  
24 this section that is the same as or substantially equivalent to an  
25 emergency regulation previously adopted under this section.  
26     (3) The initial adoption of emergency regulations implementing  
27 this section and the one readoption of emergency regulations  
28 authorized by this section shall be deemed an emergency and  
29 necessary for the immediate preservation of the public peace,  
30 health, safety, or general welfare. Initial emergency regulations  
31 and the one readoption of emergency regulations authorized by  
32 this section shall be exempt from review by the Office of  
33 Administrative Law. The initial emergency regulations and the  
34 one readoption of emergency regulations authorized by this section  
35 shall be submitted to the Office of Administrative Law for filing  
36 with the Secretary of State and each shall remain in effect for no  
37 more than 180 days, by which time final regulations may be  
38 adopted.  
39     10716. In connection with the offering for sale of a health  
40 benefit plan subject to this chapter to small employers:

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

3 (a) The provisions concerning the carrier's ability to change  
4 premium rates and the factors other than claim experience which  
5 affect changes in premium rates.

6 (b) Provisions relating to the guaranteed issue of policies and  
7 contracts.

8 (c) A statement that no preexisting condition provisions shall  
9 be allowed.

10 (d) Provisions relating to the small employer's right to apply  
11 for any health benefit plan written, issued, or administered by the  
12 carrier at the time of application for a new health benefit plan, or  
13 at the time of renewal of a health benefit plan.

14 (e) The availability, upon request, of a listing of all the carrier's  
15 benefit plan designs offered, both inside and outside the Exchange,  
16 including the rates for each benefit plan design.

17 10717. (a) No carrier shall provide or renew coverage subject  
18 to this chapter until a statement has been filed with the  
19 commissioner listing all of the carrier's health benefit plans  
20 currently in force that are offered or proposed to be offered for  
21 sale in this state, identified by form number, and, if previously  
22 approved by the commissioner, the date approved by the  
23 commissioner.

24 (b) No carrier shall issue, deliver, renew, or revise a health  
25 benefit plan lawfully provided pursuant to subdivision (a) until all  
26 of the following requirements are met:

27 (1) The carrier files with the commissioner a statement of the  
28 factors used to establish rates for the plan.

29 (2) Either:

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

34 (B) Prior to that time the commissioner gives the carrier written  
35 notice that the carrier's rating factors as filed comply with the  
36 requirements of this chapter.

37 (c) If the commissioner notifies the carrier, in writing, that the  
38 carrier's rating factors do not comply with the requirements of  
39 this chapter, specifying the reasons for his or her opinion, it is  
40 unlawful for the carrier, at any time after the receipt of such notice,

1 *to utilize the noncomplying health benefit plan or rating factors*  
2 *in conjunction with the health benefit plans or benefit plan designs*  
3 *for which the filing was made.*

4 *(d) Each carrier shall maintain at its principal place of business*  
5 *copies of all information required to be filed with the commissioner*  
6 *pursuant to this section.*

7 *(e) Each carrier shall make the information and documentation*  
8 *described in this section available to the commissioner upon*  
9 *request.*

10 *(f) Nothing in this section shall be construed to permit the*  
11 *commissioner to establish or approve the rates charged to*  
12 *policyholders for health benefit plans.*

13 *10718. (a) In addition to any other remedy permitted by law,*  
14 *the commissioner shall have the administrative authority to assess*  
15 *penalties against carriers, insurance producers, and other entities*  
16 *engaged in the business of insurance or other persons or entities*  
17 *for violations of this chapter.*

18 *(b) Upon a showing of a violation of this chapter in any civil*  
19 *action, a court may also assess the penalties described in this*  
20 *chapter, in addition to any other remedies provided by law.*

21 *(c) Any production agent or other person or entity engaged in*  
22 *the business of insurance, other than a carrier, that violates this*  
23 *chapter is liable for administrative penalties of not more than two*  
24 *hundred fifty dollars (\$250) for the first violation.*

25 *(d) Any production agent or other person or entity engaged in*  
26 *the business of insurance, other than a carrier, that engages in*  
27 *practices prohibited by this chapter a second or subsequent time,*  
28 *or who commits a knowing violation of this chapter, is liable for*  
29 *administrative penalties of not less than one thousand dollars*  
30 *(\$1,000) and not more than two thousand five hundred dollars*  
31 *(\$2,500) for each violation.*

32 *(e) Any carrier that violates this chapter is liable for*  
33 *administrative penalties of not more than two thousand five*  
34 *hundred dollars (\$2,500) for the first violation and not more than*  
35 *five thousand dollars (\$5,000) for each subsequent violation.*

36 *(f) Any carrier that violates this chapter with a frequency that*  
37 *indicates a general business practice or commits a knowing*  
38 *violation of this chapter, is liable for administrative penalties of*  
39 *not less than fifteen thousand dollars (\$15,000) and not more than*  
40 *one hundred thousand dollars (\$100,000) for each violation.*

1 (g) An act or omission that is inadvertent and that results in  
2 incorrect premium rates being charged to more than one  
3 policyholder shall be a single violation for the purpose of this  
4 section.

5 10718.5. (a) (1) In addition to any other remedy permitted  
6 by law, whenever the commissioner shall have reason to believe  
7 that any carrier, production agent, or other person or entity  
8 engaged in the business of insurance has violated this chapter,  
9 and that a proceeding by the commissioner in respect thereto would  
10 be in the interest of the public, the commissioner may issue and  
11 serve upon that entity an order to show cause containing a  
12 statement of the charges, a statement of the entity's potential  
13 liability under this chapter, and a notice of a public hearing  
14 thereon before the Administrative Law Bureau of the department  
15 to be held at a time and place fixed therein, which shall not be less  
16 than 30 days after the service thereof, for the purpose of  
17 determining whether the commissioner should issue an order to  
18 that entity to pay the penalty imposed by this chapter and such  
19 order or orders as shall be reasonably necessary to correct,  
20 eliminate, or remedy the alleged violations of this chapter,  
21 including, but not limited to, an order to cease and desist from the  
22 specified violations of this chapter.

23 (2) The hearings provided by this subdivision shall be conducted  
24 in accordance with the Administrative Procedure Act (Chapter 5  
25 (commencing with Section 11500) of Part 1 of Division 3 of Title  
26 2 of the Government Code), and the commissioner shall have all  
27 the powers granted therein.

28 (b) (1) Whenever it appears to the commissioner that irreparable  
29 loss and injury has occurred or may occur to an insured, employer,  
30 employee, or other member of the public because a carrier,  
31 production agent, or other person or entity engaged in the business  
32 of insurance has violated this chapter, the commissioner may,  
33 before hearing, but after notice and opportunity to submit relevant  
34 information, issue and cause to be served upon the entity such  
35 order or orders as shall be reasonably necessary to correct,  
36 eliminate, or remedy the alleged violations of this chapter,  
37 including, but not limited to, an order requiring the entity to  
38 forthwith cease and desist from engaging further in the violations  
39 which are causing or may cause such irreparable injury.

1     (2) *At the same time an order is served pursuant to paragraph*  
 2 *(1) of this subdivision, the commissioner shall issue and also serve*  
 3 *upon the person a notice of public hearing before the*  
 4 *Administrative Law Bureau of the department to be held at a time*  
 5 *and place fixed therein, which shall not be less than 30 days after*  
 6 *the service thereof.*

7     (3) *The hearings provided by this subdivision shall be conducted*  
 8 *in accordance with the Administrative Procedure Act (Chapter 5*  
 9 *(commencing with Section 11500) of Part 1 of Division 3 of Title*  
 10 *2 of the Government Code), and the commissioner shall have all*  
 11 *the powers granted therein.*

12     (4) *At any time prior to the commencement of a hearing as*  
 13 *provided in this subdivision, the entity against which the*  
 14 *commissioner has served an order may waive the hearing and*  
 15 *have judicial review of the order by means of any remedy afforded*  
 16 *by law without first exhausting administrative remedies or*  
 17 *procedures.*

18     (c) *If, after hearing as provided by subdivision (a) or (b), the*  
 19 *charges, or any of them, that an entity has violated this chapter*  
 20 *are found to be justified, the commissioner shall issue and cause*  
 21 *to be served upon that entity an order requiring that entity to pay*  
 22 *the penalty imposed by this chapter and such order or orders as*  
 23 *shall be reasonably necessary to correct, eliminate, or remedy the*  
 24 *alleged violations of this chapter, including, but not limited to, an*  
 25 *order to cease and desist from the specified violations of this*  
 26 *chapter.*

27     (d) *In addition to any other penalty provided by law or the*  
 28 *availability of any administrative procedure, if a carrier, after*  
 29 *notice and hearing, is found to have violated this chapter knowingly*  
 30 *or as a general business practice the commissioner may suspend*  
 31 *the carrier's certificate of authority to transact disability insurance.*  
 32 *The order of suspension shall prescribe the period of such*  
 33 *suspension. The proceedings shall be conducted in accordance*  
 34 *with the Administrative Procedure Act, Chapter 5 (commencing*  
 35 *with Section 11500) of Part 1 of Division 3 of Title 2 of the*  
 36 *Government Code and the commissioner shall have all the powers*  
 37 *granted therein.*

38     10718.55. (a) *Carriers may enter into contractual agreements*  
 39 *with qualified associations, as defined in subdivision (b), under*  
 40 *which these qualified associations may assume responsibility for*

1 performing specific administrative services, as defined in this  
2 section, for qualified association members. Carriers that enter  
3 into agreements with qualified associations for assumption of  
4 administrative services shall establish uniform definitions for the  
5 administrative services that may be provided by a qualified  
6 association or its third-party administrator. The carrier shall  
7 permit all qualified associations to assume one or more of these  
8 functions when the carrier determines the qualified association  
9 demonstrates that it has the administrative capacity to assume  
10 these functions.

11 For the purposes of this section, administrative services provided  
12 by qualified associations or their third-party administrators shall  
13 be services pertaining to eligibility determination, enrollment,  
14 premium collection, sales, or claims administration on a per-claim  
15 basis that would otherwise be provided directly by the carrier or  
16 through a third-party administrator on a commission basis or an  
17 agent or solicitor workforce on a commission basis.

18 Each carrier that enters into an agreement with any qualified  
19 association for the provision of administrative services shall offer  
20 all qualified associations with which it contracts the same premium  
21 discounts for performing those services the carrier has permitted  
22 the qualified association or its third-party administrator to assume.  
23 The carrier shall apply these uniform discounts to the carrier's  
24 rates pursuant to Section 10714. The carrier shall report to the  
25 department its schedule of discounts for each administrative  
26 service.

27 In no instance may a carrier provide discounts to qualified  
28 associations that are in any way intended to, or materially result  
29 in, a reduction in premium charges to the qualified association  
30 due to the health status of the membership of the qualified  
31 association. In addition to any other remedies available to the  
32 commissioner to enforce this chapter, the commissioner may  
33 declare a contract between a carrier and a qualified association  
34 for administrative services pursuant to this section null and void  
35 if the commissioner determines any discounts provided to the  
36 qualified association are intended to, or materially result in, a  
37 reduction in premium charges to the qualified association due to  
38 the health status of the membership of the qualified association.

39 (b) For the purposes of this section, a qualified association is  
40 a nonprofit corporation comprised of a group of individuals or

1 employers who associate based solely on participation in a  
2 specified profession or industry, that conforms to all of the  
3 following requirements:

4 (1) It accepts for membership any individual or small employer  
5 meeting its membership criteria.

6 (2) It does not condition membership, directly or indirectly, on  
7 the health or claims history of any person.

8 (3) It uses membership dues solely for and in consideration of  
9 the membership and membership benefits, except that the amount  
10 of the dues shall not depend on whether the member applies for  
11 or purchases insurance offered by the association.

12 (4) It is organized and maintained in good faith for purposes  
13 unrelated to insurance.

14 (5) It existed on January 1, 1972, and has been in continuous  
15 existence since that date.

16 (6) It has a constitution and bylaws or other analogous  
17 governing documents that provide for election of the governing  
18 board of the association by its members.

19 (7) It offered, marketed, or sold health coverage to its members  
20 for 20 continuous years prior to January 1, 1993.

21 (8) It agrees to offer any plan contract only to association  
22 members.

23 (9) It agrees to include any member choosing to enroll in the  
24 plan contract offered by the association, provided that the member  
25 agrees to make required premium payments.

26 (10) It complies with all provisions of this article.

27 (11) It had at least 10,000 enrollees covered by  
28 association-sponsored plans immediately prior to enactment of  
29 Chapter 1128 of the Statutes of 1992.

30 (12) It applies any administrative cost at an equal rate to all  
31 members purchasing coverage through the qualified association.

32 (c) A qualified association shall comply with the requirements  
33 set forth in Section 10198.9.

34 10718.7. Notwithstanding any other provision of law, no  
35 provision of this chapter shall be construed to limit the applicability  
36 of any other provision of the Insurance Code unless such provision  
37 is in conflict with the requirements of this chapter.

38 SEC. 17. Section 10702 of the Insurance Code is amended to  
39 read:

1 10702. (a) All carriers writing, issuing, or administering health  
2 benefit plans with respect to plan years commencing prior to  
3 January 1, 2014, that cover employees of small employers shall  
4 be subject to this chapter if any one of the following conditions  
5 are met:

6 (a)

7 (1) Any portion of the premium for any health benefit plan or  
8 benefits is paid by a small employer, or any covered individual is  
9 reimbursed, whether through wage adjustments or otherwise, by  
10 a small employer for any portion of the premium.

11 (b)

12 (2) The health benefit plan is treated by the small employer or  
13 any of the covered individuals as part of a plan or program for the  
14 purposes of Section 106 or 162 of the Internal Revenue Code.

15 (b) For purposes of this section, "plan year" has the meaning  
16 provided in Section 144.103 of Title 45 of the Code of Federal  
17 Regulations.

18 SEC. 18. Section 10750 is added to the Insurance Code, to  
19 read:

20 10750. This chapter shall remain in effect only until January  
21 1, 2014, and as of that date is repealed, unless a later enacted  
22 statute, that is enacted before January 1, 2014, deletes or extends  
23 that date.

24 SEC. 19. Chapter 8.01 (commencing with Section 10755) is  
25 added to Part 2 of Division 2 of the Insurance Code, to read:

26

27 CHAPTER 8.01. GRANDFATHERED SMALL EMPLOYER HEALTH  
28 INSURANCE

29

30 Article 1. Definitions

31

32 10755. As used in this chapter, the following definitions shall  
33 apply:

34 (a) "Agent or broker" means a person or entity licensed under  
35 Chapter 5 (commencing with Section 1621) of Part 2 of Division  
36 1.

37 (b) "Benefit plan design" means a specific health coverage  
38 product issued by a carrier to small employers, to trustees of  
39 associations that include small employers, or to individuals if the  
40 coverage is offered through employment or sponsored by an

1 employer. It includes services covered and the levels of copayment  
2 and deductibles, and it may include the professional providers  
3 who are to provide those services and the sites where those services  
4 are to be provided. A benefit plan design may also be an integrated  
5 system for the financing and delivery of quality health care services  
6 which has significant incentives for the covered individuals to use  
7 the system.

8 (c) “Carrier” means any disability insurance company or any  
9 other entity that writes, issues, or administers health benefit plans  
10 that cover the employees of small employers, regardless of the  
11 situs of the contract or master policyholder.

12 (d) “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 (e) “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 who  
35 works at least 20 hours but not more than 29 hours is deemed to  
36 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 (f) “Enrollee” means an eligible employee or dependent who  
12 receives health coverage through the program from a participating  
13 carrier.

14 (g) “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 (h) “Health benefit plan” means a policy or contract written  
22 or administered by a carrier that arranges or provides health care  
23 benefits for the covered eligible employees of a small employer  
24 and their dependents. The term does not include accident only,  
25 credit, disability income, coverage of Medicare services pursuant  
26 to contracts with the United States government, Medicare  
27 supplement, long-term care insurance, dental, vision, coverage  
28 issued as a supplement to liability insurance, automobile medical  
29 payment insurance, or insurance under which benefits are payable  
30 with or without regard to fault and that is statutorily required to  
31 be contained in any liability insurance policy or equivalent  
32 self-insurance.

33 (i) “In force business” means an existing health benefit plan  
34 issued by the carrier to a small employer.

35 (j) “Late enrollee” means an eligible employee or dependent  
36 who has declined health coverage under a health benefit plan  
37 offered by a small employer at the time of the initial enrollment  
38 period provided under the terms of the health benefit plan and  
39 who subsequently requests enrollment in a health benefit plan of  
40 that small employer, provided that the initial enrollment period

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

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

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

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

28 (C) He or she has lost or will lose coverage under another  
29 employer health benefit plan as a result of termination of  
30 employment of the individual or of a person through whom the  
31 individual was covered as a dependent, change in employment  
32 status of the individual, or of a person through whom the individual  
33 was covered as a dependent, the termination of the other plan's  
34 coverage, cessation of an employer's contribution toward an  
35 employee or dependent's coverage, death of the person through  
36 whom the individual was covered as a dependent, legal separation,  
37 or divorce; or he or she has lost or will lose coverage under the  
38 Healthy Families Program, the AIM Program, the Medi-Cal  
39 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 offered through the California Health  
7 Benefit 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) In the case of an eligible employee as defined in  
14 paragraph (1) of subdivision (f), the carrier cannot produce a  
15 written statement from the employer stating that the individual or  
16 the person through whom an individual was eligible to be covered  
17 as a dependent, prior to declining coverage, was provided with,  
18 and signed acknowledgment of, an explicit written notice in  
19 boldface type specifying that failure to elect coverage during the  
20 initial enrollment period permits the carrier to impose, at the time  
21 of the individual's later decision to elect coverage, an exclusion  
22 from coverage for a period of 12 months as well as a six-month  
23 preexisting condition exclusion unless the individual meets the  
24 criteria specified in paragraph (1), (2), or (3).

25 (B) In the case of an eligible employee who is a guaranteed  
26 association member, the plan cannot produce a written statement  
27 from the guaranteed association stating that the association sent  
28 a written notice in boldface type to all potentially eligible  
29 association members at their last known address prior to the initial  
30 enrollment period informing members that failure to elect coverage  
31 during the initial enrollment period permits the plan to impose, at  
32 the time of the member's later decision to elect coverage, an  
33 exclusion from coverage for a period of 12 months as well as a  
34 six-month preexisting condition exclusion unless the member can  
35 demonstrate that he or she meets the requirements of  
36 subparagraphs (A), (C), and (D) of paragraph (1) or meets the  
37 requirements of paragraph (2) or (3).

38 (C) In the case of an employer or person who is not a member  
39 of an association, was eligible to purchase coverage through a  
40 guaranteed association, and did not do so, and would not be

1 eligible to purchase guaranteed coverage unless purchased through  
2 a guaranteed association, the employer or person can demonstrate  
3 that he or she meets the requirements of subparagraphs (A), (C),  
4 and (D) of paragraph (1), or meets the requirements of paragraph  
5 (2) or (3), or that he or she recently had a change in status that  
6 would make him or her eligible and that application for coverage  
7 was made within 30 days of the change.

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

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

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

36 (8) The individual is an eligible employee who has declined  
37 coverage for himself or herself or his or her dependents during a  
38 previous enrollment period because his or her dependents were  
39 covered by another employer health benefit plan, including a plan  
40 offered through the California Health Benefit Exchange, at the

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

14 *(k) "Preexisting condition provision" means a policy provision*  
15 *that excludes coverage for charges or expenses incurred during*  
16 *a specified period following the insured's effective date of*  
17 *coverage, as to a condition for which medical advice, diagnosis,*  
18 *care, or treatment was recommended or received during a specified*  
19 *period immediately preceding the effective date of coverage.*

20 *(l) "Creditable coverage" means:*

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

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

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

- 1     (4) Any other publicly sponsored program, provided in this state
- 2     or elsewhere, of medical, hospital, and surgical care.
- 3     (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
- 4     (Civilian Health and Medical Program of the Uniformed Services
- 5     (CHAMPUS)).
- 6     (6) A medical care program of the Indian Health Service or of
- 7     a tribal organization.
- 8     (7) A health plan offered under 5 U.S.C. Chapter 89
- 9     (commencing with Section 8901) (Federal Employees Health
- 10    Benefits Program (FEHBP)).
- 11    (8) A public health plan as defined in federal regulations
- 12    authorized by Section 2701(c)(1)(I) of the federal Public Health
- 13    Service Act, as amended by Public Law 104-191, the federal Health
- 14    Insurance Portability and Accountability Act of 1996.
- 15    (9) A health benefit plan under Section 5(e) of the federal Peace
- 16    Corps Act (22 U.S.C. Sec. 2504(e)).
- 17    (10) Any other creditable coverage as defined by subdivision
- 18    (c) of Section 2704 of Title XXVII of the federal Public Health
- 19    Service Act (42 U.S.C. Sec. 300gg-3(c)).
- 20    (m) "Rating period" means the period for which premium rates
- 21    established by a carrier are in effect and shall be no less than 12
- 22    months from the date of issuance or renewal of the health benefit
- 23    plan.
- 24    (n) "Risk adjusted employee risk rate" means the rate
- 25    determined for an eligible employee of a small employer in a
- 26    particular risk category after applying the risk adjustment factor.
- 27    (o) "Risk adjustment factor" means the percent adjustment to
- 28    be applied equally to each standard employee risk rate for a
- 29    particular small employer, based upon any expected deviations
- 30    from standard claims. This factor may not be more than 110
- 31    percent or less than 90 percent.
- 32    (p) "Risk category" means the following characteristics of an
- 33    eligible employee: age, geographic region, and family size of the
- 34    employee, plus the benefit plan design selected by the small
- 35    employer.
- 36    (1) No more than the following age categories may be used in
- 37    determining premium rates:
- 38    Under 30
- 39    30-39
- 40    40-49

- 1 50–54
- 2 55–59
- 3 60–64
- 4 65 and over

5 *However, for the 65 and over age category, separate premium*  
6 *rates may be specified depending upon whether coverage under*  
7 *the health benefit plan will be primary or secondary to benefits*  
8 *provided by the federal Medicare Program pursuant to Title XVIII*  
9 *of the federal Social Security Act.*

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

- 12 (A) *Single.*
- 13 (B) *Married couple.*
- 14 (C) *One adult and child or children.*
- 15 (D) *Married couple and child or children.*

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

27 (B) *In determining rates for small employers, a carrier that*  
28 *does not operate statewide shall use no more than the number of*  
29 *geographic regions in the state than is determined by the following*  
30 *formula: the population, as determined in the last federal census,*  
31 *of all counties which are included in their entirety in a carrier’s*  
32 *service area divided by the total population of the state, as*  
33 *determined in the last federal census, multiplied by nine. The*  
34 *resulting number shall be rounded to the nearest whole integer.*  
35 *No region may be smaller than an area in which the first three*  
36 *digits of all its ZIP Codes are in common within a county and no*  
37 *county may be divided into more than two regions. The area*  
38 *encompassed in a geographic region shall be separate and distinct*  
39 *from areas encompassed in other geographic regions. Geographic*

1 regions may be noncontiguous. No carrier shall have less than  
2 one geographic area.

3 (q) (1) “Small employer” means either of the following:

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

1 *PPACA, except that the minimum requirement of one employee*  
2 *shall be implemented only to the extent required by PPACA.*

3 *(B) Any guaranteed association, as defined in subdivision (y),*  
4 *that purchases health coverage for members of the association.*

5 *(2) For plan years commencing on or after January 1, 2014,*  
6 *the definition of an employer, for purposes of determining whether*  
7 *an employer with one employee shall include sole proprietors,*  
8 *certain owners of “S” corporations, or other individuals, shall be*  
9 *consistent with Section 1304 of PPACA.*

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

13 *(s) “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 which (1) includes one or more small*  
18 *employers as defined in paragraph (1) of subdivision (w), (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 by 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 been offering health insurance to its members for at least*  
28 *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 benefit plan design that is purchased to all individual*  
32 *members and employer members in this state, (9) includes any*  
33 *member choosing to enroll in the benefit plan design offered to*  
34 *the 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 carrier with which it contracts. The requirement of 1,000*  
37 *persons may be met if component chapters of a statewide*  
38 *association contracting separately with the same carrier cover at*  
39 *least 1,000 persons in the aggregate.*

1     *This subdivision applies regardless of whether a master policy*  
2 *by an admitted insurer is delivered directly to the association or*  
3 *a trust formed for or sponsored by an association to administer*  
4 *benefits for association members.*

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

12     *(t) “Members of a guaranteed association” means any*  
13 *individual or employer meeting the association’s membership*  
14 *criteria if that person is a member of the association and chooses*  
15 *to purchase health coverage through the association. At the*  
16 *association’s discretion, it may also include employees of*  
17 *association members, association staff, retired members, retired*  
18 *employees of members, and surviving spouses and dependents of*  
19 *deceased members. However, if an association chooses to include*  
20 *those persons as members of the guaranteed association, the*  
21 *association must so elect in advance of purchasing coverage from*  
22 *a plan. Health plans may require an association to adhere to the*  
23 *membership composition it selects for up to 12 months.*

24     *(u) “Affiliation period” means a period that, under the terms*  
25 *of the health benefit plan, must expire before health care services*  
26 *under the plan become effective.*

27     *(v) “Grandfathered health benefit plan” means a health benefit*  
28 *plan that constitutes a grandfathered health plan.*

29     *(w) “Grandfathered health plan” has the meaning set forth in*  
30 *Section 1251 of PPACA.*

31     *(x) “Nongrandfathered health benefit plan” means a health*  
32 *benefit plan that is not a grandfathered health plan.*

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

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

1 (aa) “Waiting period” means a period that is required to pass  
2 with respect to the employee before the employee is eligible to be  
3 covered for benefits under the terms of the contract.

4 10755.01. (a) For purposes of this chapter, “health benefit  
5 plan” does not include policies or certificates of specified disease  
6 or hospital confinement indemnity provided that the carrier offering  
7 those policies or certificates complies with the following:

8 (1) The carrier files, on or before March 1 of each year, a  
9 certification with the commissioner that contains the statement  
10 and information described in paragraph (2).

11 (2) The certification required in paragraph (1) shall contain  
12 the following:

13 (A) A statement from the carrier certifying that policies or  
14 certificates described in this section (i) are being offered and  
15 marketed as supplemental health insurance and not as a substitute  
16 for coverage that provides essential health benefits as defined by  
17 the state pursuant to Section 1302 of PPACA, (ii) contain the  
18 disclosure forms as described in Section 10603 with the following  
19 statement prominently on the first page: “This is a supplement to  
20 health insurance. It is not a substitute for essential health benefits  
21 or minimum essential coverage as required under federal law.  
22 Commencing January 1, 2014, you may be subject to a tax if you  
23 do not obtain minimum essential coverage,” and (iii) are not being  
24 offered, marketed, or sold in a manner that would make the  
25 purchase of the policies contingent upon the sale of any product  
26 sold under Sections 10700 and 10718, or under Section 1357 of  
27 the Health and Safety Code or the renewal of a product under  
28 Section 10755 or Section 1357.600 of the Health and Safety Code.

29 (B) A summary description of each policy or certificate  
30 described in this section, including the average annual premium  
31 rates, or range of premium rates in cases where premiums vary  
32 by age, gender, or other factors, charged for the policies and  
33 certificates in this state.

34 (3) In the case of a policy or certificate that is described in this  
35 section and that is offered for the first time in this state for plan  
36 years on or after January 1, 2014, the carrier files with the  
37 commissioner the information and statement required in paragraph  
38 (2) at least 30 days prior to the date such a policy or certificate is  
39 issued or delivered in this state.

1 (b) As used in this section, “policies or certificates of specified  
 2 disease” and “policies or certificates of hospital confinement  
 3 indemnity” mean policies or certificates of insurance sold to an  
 4 insured to supplement other health insurance coverage as specified  
 5 in this section. An insurer issuing a “policy or certificate of  
 6 specified disease” or a “policy or certificate of hospital  
 7 confinement indemnity” shall require that the person to be insured  
 8 is covered by an individual or group policy or contract that  
 9 arranges or provides medical, hospital, and surgical coverage not  
 10 designed to supplement other private or governmental plans.

11  
 12 *Article 2. Small Employer Carrier Requirements*

13  
 14 10755.02. (a) This chapter shall apply only to grandfathered  
 15 health benefit plans and only with respect to plan years  
 16 commencing on or after January 1, 2014.

17 (b) All carriers administering health benefit plans that cover  
 18 employees of small employers shall be subject to this chapter if  
 19 any one of the following conditions are met:

20 (1) Any portion of the premium for any health benefit plan or  
 21 benefits is paid by a small employer, or any covered individual is  
 22 reimbursed, whether through wage adjustments or otherwise, by  
 23 a small employer for any portion of the premium.

24 (2) The health benefit plan is treated by the small employer or  
 25 any of the covered individuals as part of a plan or program for  
 26 the purposes of Section 106 or 162 of the Internal Revenue Code.

27 10755.02.1. Any person or entity subject to the requirements  
 28 of this chapter shall comply with the standards set forth in Chapter  
 29 7 (commencing with Section 3750) of Part 1 of Division 9 of the  
 30 Family Code and Section 14124.94 of the Welfare and Institutions  
 31 Code.

32 10755.03. The commissioner shall have the authority to  
 33 determine whether a health benefit plan is covered by this chapter,  
 34 and to determine whether an employer is a small employer within  
 35 the meaning of Section 10755.

36 10755.04. (a) The department may issue regulations that are  
 37 necessary to carry out the purposes of this chapter.

38 (b) Notwithstanding the Administrative Procedure Act (Chapter  
 39 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
 40 Title 2 of the Government Code), the department may implement

1 *and administer this chapter through insurer letters or similar*  
2 *instruction from the department until regulations are adopted.*

3 *(c) The department shall adopt emergency regulations*  
4 *implementing this chapter no later than August 31, 2013. The*  
5 *department may readopt any emergency regulation authorized by*  
6 *this section that is the same as or substantially equivalent to an*  
7 *emergency regulation previously adopted under this section.*

8 *(d) The initial adoption of emergency regulations implementing*  
9 *this section and the one readoption of emergency regulations*  
10 *authorized by this section shall be deemed an emergency and*  
11 *necessary for the immediate preservation of the public peace,*  
12 *health, safety, or general welfare. Initial emergency regulations*  
13 *and the one readoption of emergency regulations authorized by*  
14 *this section shall be exempt from review by the Office of*  
15 *Administrative Law. The initial emergency regulations and the*  
16 *one readoption of emergency regulations authorized by this section*  
17 *shall be submitted to the Office of Administrative Law for filing*  
18 *with the Secretary of State and each shall remain in effect for no*  
19 *more than 180 days, by which time final regulations may be*  
20 *adopted.*

21 *(e) This section shall become operative on January 1, 2013.*

22 *10755.05. (a) (1) Each carrier, except a self-funded employer,*  
23 *shall fairly and affirmatively renew all of the carrier's health*  
24 *benefit plans that are sold to small employers or associations that*  
25 *include small employers.*

26 *(2) Nothing in this section shall be construed to require an*  
27 *association, or a trust established and maintained by an association*  
28 *to receive a master insurance policy issued by an admitted insurer*  
29 *and to administer the benefits thereof solely for association*  
30 *members, to offer, market or sell a benefit plan design to those*  
31 *who are not members of the association. However, if the*  
32 *association markets, offers or sells a benefit plan design to those*  
33 *who are not members of the association it is subject to the*  
34 *requirements of this section. This shall apply to an association*  
35 *that otherwise meets the requirements of paragraph (6) formed by*  
36 *merger of two or more associations after January 1, 1992, if the*  
37 *predecessor organizations had been in active existence on January*  
38 *1, 1992, and for at least five years prior to that date and met the*  
39 *requirements of paragraph (3).*

1     (3) A carrier which (A) effective January 1, 1992, and at least  
2 20 years prior to that date, markets, offers, or sells benefit plan  
3 designs only to all members of one association and (B) does not  
4 market, offer or sell any other individual, selected group, or group  
5 policy or contract providing medical, hospital and surgical benefits  
6 shall not be required to market, offer, or sell to those who are not  
7 members of the association. However, if the carrier markets, offers  
8 or sells any benefit plan design or any other individual, selected  
9 group, or group policy or contract providing medical, hospital  
10 and surgical benefits to those who are not members of the  
11 association it is subject to the requirements of this section.

12     (4) Each carrier that sells health benefit plans to members of  
13 one association pursuant to paragraph (3) shall submit an annual  
14 statement to the commissioner which states that the carrier is  
15 selling health benefit plans pursuant to paragraph (3) and which,  
16 for the one association, lists all the information required by  
17 paragraph (5).

18     (5) Each carrier that sells health benefit plans to members of  
19 any association shall submit an annual statement to the  
20 commissioner which lists each association to which the carrier  
21 sells health benefit plans, the industry or profession which is served  
22 by the association, the association's membership criteria, a list of  
23 officers, the state in which the association is organized, and the  
24 site of its principal office.

25     (6) For purposes of paragraphs (2) and (3), an association is  
26 a nonprofit organization comprised of a group of individuals or  
27 employers who associate based solely on participation in a  
28 specified profession or industry, accepting for membership any  
29 individual or small employer meeting its membership criteria,  
30 which do not condition membership directly or indirectly on the  
31 health or claims history of any person, which uses membership  
32 dues solely for and in consideration of the membership and  
33 membership benefits, except that the amount of the dues shall not  
34 depend on whether the member applies for or purchases insurance  
35 offered by the association, which is organized and maintained in  
36 good faith for purposes unrelated to insurance, which has been in  
37 active existence on January 1, 1992, and at least five years prior  
38 to that date, which has a constitution and bylaws, or other  
39 analogous governing documents which provide for election of the  
40 governing board of the association by its members, which has

1 *contracted with one or more carriers to offer one or more health*  
2 *benefit plans to all individual members and small employer*  
3 *members in this state.*

4 *(b) Each carrier shall make available to each small employer*  
5 *all nongrandfathered health benefit plans that the carrier offers*  
6 *or sells to small employers or to associations that include small*  
7 *employers. Notwithstanding subdivision (d) of Section 10700, for*  
8 *purposes of this subdivision, companies that are affiliated*  
9 *companies or that are eligible to file a consolidated income tax*  
10 *return shall be treated as one carrier.*

11 *(c) Each carrier shall do all of the following:*

12 *(1) Prepare a brochure that summarizes all of its health benefit*  
13 *plans and make this summary available to small employers, agents,*  
14 *and brokers upon request. The summary shall include for each*  
15 *health benefit plan information on benefits provided, a generic*  
16 *description of the manner in which services are provided, such as*  
17 *how access to providers is limited, benefit limitations, required*  
18 *copayments and deductibles, standard employee risk rates, an*  
19 *explanation of how creditable coverage is calculated if a waiting*  
20 *or affiliation period is imposed, and a telephone number that can*  
21 *be called for more detailed benefit information. Carriers are*  
22 *required to keep the information contained in the brochure*  
23 *accurate and up to date, and, upon updating the brochure, send*  
24 *copies to agents and brokers representing the carrier. Any entity*  
25 *that provides administrative services only with regard to a benefit*  
26 *plan design written or issued by another carrier shall not be*  
27 *required to prepare a summary brochure which includes that*  
28 *benefit plan design.*

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

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

1 *requesting this information, small employers, solicitors, and*  
2 *solicitor firms shall provide the plan with the information the plan*  
3 *needs to determine the small employer's risk adjusted employee*  
4 *risk rate.*

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

10 *(5) Notwithstanding subdivision (c) of Section 10755, for*  
11 *purposes of this subdivision, companies that are affiliated*  
12 *companies or that are eligible to file a consolidated income tax*  
13 *return shall be treated as one carrier.*

14 *(e) No carrier, agent, or broker shall induce or otherwise*  
15 *encourage a small employer to separate or otherwise exclude an*  
16 *eligible employee from a health benefit plan which, in the case of*  
17 *an eligible employee meeting the definition in paragraph (1) of*  
18 *subdivision (e) of Section 10755, is provided in connection with*  
19 *the employee's employment or which, in the case of an eligible*  
20 *employee as defined in paragraph (2) of subdivision (e) of Section*  
21 *10755, is provided in connection with a guaranteed association.*

22 *(f) No carrier or agent or broker shall, directly or indirectly,*  
23 *engage in the following activities:*

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

29 *(2) Encourage or direct small employers to seek coverage from*  
30 *another carrier or the California Health Benefit Exchange because*  
31 *of the health status, claims experience, industry, occupation, or*  
32 *geographic location within the carrier's approved service area of*  
33 *the small employer or the small employer's employees.*

34 *(g) No carrier shall, directly or indirectly, enter into any*  
35 *contract, agreement, or arrangement with an agent or broker that*  
36 *provides for or results in the compensation paid to an agent or*  
37 *broker for a health benefit plan to be varied because of the health*  
38 *status, claims experience, industry, occupation, or geographic*  
39 *location of the small employer or the small employer's employees.*  
40 *This subdivision shall not apply with respect to a compensation*

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

6 (h) A policy or contract that covers a small employer, as defined  
7 in Section 1304(b) of PPACA and in subdivision (q) of Section  
8 10755 shall not establish rules for eligibility, including continued  
9 eligibility, of an individual, or dependent of an individual, to enroll  
10 under the terms of the plan based on any of the following health  
11 status-related factors:

12 (1) Health status.

13 (2) Medical condition, including physical and mental illnesses.

14 (3) Claims experience.

15 (4) Receipt of health care.

16 (5) Medical history.

17 (6) Genetic information.

18 (7) Evidence of insurability, including conditions arising out  
19 of acts of domestic violence.

20 (8) Disability.

21 (9) Any other health status-related factor as determined by any  
22 federal regulations, rules, or guidance issued pursuant to Section  
23 2705 of the federal Public Health Service Act.

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

29 10755.05.1. (a) For contracts expiring after July 1, 1994, 60  
30 days prior to July 1, 1994, an association that meets the definition  
31 of guaranteed association, as set forth in Section 10755, except  
32 for the requirement that 1,000 persons be covered, shall be entitled  
33 to purchase small employer health coverage as if the association  
34 were a guaranteed association, except that the coverage shall be  
35 guaranteed only for those members of an association, as defined  
36 in Section 10755, (1) who were receiving coverage or had  
37 successfully applied for coverage through the association as of  
38 June 30, 1993, (2) who were receiving coverage through the  
39 association as of December 31, 1992, and whose coverage lapsed  
40 at any time thereafter because the employment through which

1 coverage was received ended or an employer's contribution to  
 2 health coverage ended, or (3) who were covered at any time  
 3 between June 30, 1993, and July 1, 1994, under a contract that  
 4 was in force on June 30 1993.

5 (b) An association obtaining health coverage for its members  
 6 pursuant to this section shall otherwise be afforded all the rights  
 7 of a guaranteed association under this chapter including, but not  
 8 limited to, guaranteed renewability of coverage.

9 10755.06. Every carrier shall file with the commissioner the  
 10 reasonable participation requirements that will be required in  
 11 renewing its health benefit plans. Participation requirements of a  
 12 health benefit plan shall be applied uniformly among all small  
 13 employer groups, except that a carrier may vary application of  
 14 minimum employer participation requirements by the size of the  
 15 small employer group and whether the employer contributes 100  
 16 percent of the eligible employee's premium. Employer contribution  
 17 requirements of a health benefit plan shall not vary by employer  
 18 size. A carrier shall not establish a participation requirement that  
 19 (1) requires a person who meets the definition of a dependent in  
 20 subdivision (d) of Section 10755 to enroll as a dependent if he or  
 21 she is otherwise eligible for coverage and wishes to enroll as an  
 22 eligible employee and (2) allows a carrier to reject an otherwise  
 23 eligible small employer because of the number of persons that  
 24 waive coverage due to coverage through another employer.  
 25 Members of an association eligible for health coverage eligible  
 26 under subdivision (t) of Section 10755 but not electing any health  
 27 coverage through the association shall not be counted as eligible  
 28 employees for purposes of determining whether the guaranteed  
 29 association meets a carrier's reasonable participation standards.

30 10755.08. (a) A health benefit plan shall not impose a  
 31 preexisting condition provision upon any individual.

32 (b) A health benefit plan may apply a waiting period of up to  
 33 60 days as a condition of employment if applied equally to all  
 34 eligible employees and dependents and if consistent with PPACA.  
 35 A health benefit plan offered through a health maintenance  
 36 organization, as defined in Section 2791 of the federal Public  
 37 Health Service Act, may impose an affiliation period not to exceed  
 38 60 days. A waiting or affiliation period shall not be based on a  
 39 preexisting condition of an employee or dependent, the health  
 40 status of an employee or dependent, or any other factor listed in

1 *subdivision (j) of Section 10705. An affiliation period shall run*  
2 *concurrently with a waiting period. During the waiting or*  
3 *affiliation period, the health benefit plan is not required to provide*  
4 *health care services and no premium shall be charged to the*  
5 *policyholder or insureds.*

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

25 *(d) A carrier providing aggregate or specific stop loss coverage*  
26 *or any other assumption of risk with reference to a health benefit*  
27 *plan shall provide that the plan meets all requirements of this*  
28 *section concerning waiting or affiliation periods. The requirements*  
29 *of this subdivision shall only be exercised to the extent they are*  
30 *not preempted by ERISA.*

31 *(e) An individual's period of creditable coverage shall be*  
32 *certified pursuant to subsection (e) of Section 2704 of Title XXVII*  
33 *of the federal Public Health Service Act (42 U.S.C. Sec.*  
34 *300gg-3(e)).*

35 *10755.09. Nothing in this chapter shall be construed as*  
36 *prohibiting a carrier from restricting enrollment of late enrollees*  
37 *to open enrollment periods consistent with federal law. No premium*  
38 *shall be charged to the late enrollee until the exclusion period has*  
39 *ended.*

1 10755.11. No carrier shall be required by the provisions of  
2 this chapter:

3 (a) To include in a health benefit plan an otherwise eligible  
4 employee or dependent, when the eligible employee or dependent  
5 does not work or reside within a carrier's approved service area,  
6 except as provided in Section 10755.02.1.

7 (b) To offer coverage to an eligible employee, as defined in  
8 paragraph (2) of subdivision (e) of Section 10755, who within 12  
9 months of application for coverage terminated from a health benefit  
10 plan offered by the carrier.

11 10755.13. All grandfathered health benefit plans shall be  
12 renewable with respect to all eligible employees or dependents at  
13 the option of the policyholder, contractholder, or small employer  
14 except as follows:

15 (a) (1) For nonpayment of the required premiums by the  
16 policyholder, contractholder, or small employer, if the  
17 policyholder, contractholder, or small employer has been duly  
18 notified and billed for the charge and at least a 30-day grace  
19 period has elapsed since the date of notification or, if longer, the  
20 period of time required for notice and any other requirements  
21 pursuant to Section 2703, 2712, or 2742 of the federal Public  
22 Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and  
23 300gg-42) and any subsequent rules or regulations has elapsed.

24 (2) An insurer shall continue to provide coverage as required  
25 by the policyholder's, contractholder's, or small employer's policy  
26 during the period described in paragraph (1). Nothing in this  
27 section shall be construed to affect or impair the policyholder's,  
28 contractholder's, small employer's, or insurer's other rights and  
29 responsibilities pursuant to the subscriber contract.

30 (b) If the insurer demonstrates fraud or an intentional  
31 misrepresentation of material fact under the terms of the policy  
32 by the policyholder, contractholder, or small employer or, with  
33 respect to coverage of individual enrollees, the enrollees or their  
34 representative.

35 (c) Violation of a material contract provision relating to  
36 employer contribution or group participation rates by the  
37 policyholder, contractholder, or small employer.

38 (d) When the carrier ceases to write, issue, or administer new  
39 or existing grandfathered or nongrandfathered small employer

1 health benefit plans in this state, provided, however, that the  
2 following conditions are satisfied:

3 (1) Notice of the decision to cease writing, issuing, or  
4 administering new or existing small employer health benefits plans  
5 in this state is provided to the commissioner, and to either the  
6 policyholder, contractholder, or small employer at least 180 days  
7 prior to the discontinuation of the coverage.

8 (2) Small employer health benefit plans subject to this chapter  
9 shall not be canceled for 180 days after the date of the notice  
10 required under paragraph (1). For that business of a carrier that  
11 remains in force, any carrier that ceases to write, issue, or  
12 administer new or existing health benefit plans shall continue to  
13 be governed by this chapter.

14 (3) A carrier that ceases to write, issue, or administer new health  
15 benefit plans to small employers in this state after the passage of  
16 this chapter shall be prohibited from writing, issuing, or  
17 administering new health benefit plans to small employers in this  
18 state for a period of five years from the date of notice to the  
19 commissioner.

20 (e) When a carrier withdraws a health benefit plan from the  
21 small employer market, provided that the carrier notifies all  
22 affected policyholders, contractholders, or small employers and  
23 the commissioner at least 90 days prior to the discontinuation of  
24 those contracts, and that the carrier makes available to the small  
25 employer all nongrandfathered small employer health benefit plans  
26 which it markets and satisfies the requirements of Section 10714.

27 (f) If coverage is made available through a bona fide association  
28 pursuant to subdivision (q) of Section 10755 or a guaranteed  
29 association pursuant to subdivision (s) of Section 10755, the  
30 membership of the employer or the individual, respectively, ceases,  
31 but only if that coverage is terminated under this subdivision  
32 uniformly without regard to any health status-related factor of  
33 covered individuals.

34 10755.14. Premiums for grandfathered health benefit plans  
35 written or administered by carriers on or after the January 1,  
36 2014, shall be subject to the following requirements:

37 (a) (1) The premium for new business shall be determined for  
38 an eligible employee in a particular risk category after applying  
39 a risk adjustment factor to the carrier's standard employee risk

1 rates. The risk adjusted employee risk rate may not be more than  
2 110 percent or less than 90 percent.

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 (3) The standard employee risk rates applied to a small employer  
6 for new business shall be in effect for no less than 12 months.

7 (b) (1) The premium for in force business shall be determined  
8 for an eligible employee in a particular risk category after applying  
9 a risk adjustment factor to the carrier's standard employee risk  
10 rates. The risk adjusted employee risk rate may not be more than  
11 110 percent or less than 90 percent. The risk adjustment factor  
12 applied to a small employer may not increase by more than 10  
13 percentage points from the risk adjustment factor applied in the  
14 prior rating period. The risk adjustment factor for a small employer  
15 may not be modified more frequently than every 12 months.

16 (2) The premium charged a small employer for in force business  
17 shall be equal to the sum of the risk adjusted employee risk rates.  
18 The standard employee risk rates shall be in effect for 12 months.

19 (c) (1) For any small employer, a carrier may, with the consent  
20 of the small employer, establish composite employee and dependent  
21 rates for renewal of in force business. The composite rates shall  
22 be determined as the average of the risk adjusted employee risk  
23 rates for the small employer, as determined in accordance with  
24 the requirements of subdivisions (a) and (b). The sum of the  
25 composite rates so determined shall be equal to the sum of the risk  
26 adjusted employee risk rates for the small employer.

27 (2) The composite rates shall be used for all employees and  
28 dependents covered throughout a rating period of 12 months,  
29 except that a carrier may reserve the right to redetermine the  
30 composite rates if the enrollment under the health benefit plan  
31 changes by more than a specified percentage during the rating  
32 period. Any redetermination of the composite rates shall be based  
33 on the same risk adjusted employee risk rates used to determine  
34 the initial composite rates for the rating period. If a carrier  
35 reserves the right to redetermine the rates and the enrollment  
36 changes more than the specified percentage, the carrier shall  
37 redetermine the composite rates if the redetermined rates would  
38 result in a lower premium for the small employer. A carrier  
39 reserving the right to redetermine the composite rates based upon  
40 a change in enrollment shall use the same specified percentage to

1 *measure that change with respect to all small employers electing*  
2 *composite rates.*

3 *10755.15. Carrier shall apply standard employee risk rates*  
4 *consistently with respect to all small employers.*

5 *10755.16. In connection with the renewal of any grandfathered*  
6 *health benefit plan to small employers:*

7 *Each carrier shall make a reasonable disclosure, as part of its*  
8 *solicitation and sales materials, of the following:*

9 *(a) The extent to which the premium rates for a specified small*  
10 *employer are established or adjusted in part based upon the actual*  
11 *or expected variation in claims costs or actual or expected*  
12 *variation in health conditions of the employees and dependents of*  
13 *the small employer.*

14 *(b) The provisions concerning the carrier's ability to change*  
15 *premium rates and the factors other than claim experience which*  
16 *affect changes in premium rates.*

17 *(c) Provisions relating to the guaranteed issue of policies and*  
18 *contracts.*

19 *(d) Provisions relating to the effect of any preexisting condition*  
20 *provision.*

21 *(e) Provisions relating to the small employer's right to apply*  
22 *for any nongrandfathered health benefit plan written, issued, or*  
23 *administered by the carrier, at the time of application for a new*  
24 *health benefit plan, or at the time of renewal of a health benefit*  
25 *plan, consistent with the requirements of PPACA.*

26 *(f) The availability, upon request, of a listing of all the carrier's*  
27 *nongrandfathered health benefit plans, offered inside or outside*  
28 *the California Health Benefit Exchange, including the rates for*  
29 *each benefit plan design.*

30 *10755.17. (a) No carrier shall renew coverage subject to this*  
31 *chapter until it has done all of the following:*

32 *(1) A statement has been filed with the commissioner listing all*  
33 *of the carrier's grandfathered health benefit plans currently in*  
34 *force in this state, identified by form number, and, if previously*  
35 *approved by the commissioner, the date approved by the*  
36 *commissioner as well as the standard employee risk rate for each*  
37 *risk category for each benefit plan design and the highest and*  
38 *lowest risk adjustment factors that the carrier intends to use in*  
39 *determining rates for each benefit plan design. When filing a new*  
40 *benefit plan design pursuant to Section 10755.05, carriers may*

1 *submit both the policy form and the standard employee risk rates*  
2 *for each risk category at the same time.*

3 *(2) Either:*

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

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

12 *(b) No carrier shall renew or revise a grandfathered health*  
13 *benefit plan lawfully provided pursuant to subdivision (a), and no*  
14 *carrier shall change the risk categories, risk adjustment factors,*  
15 *or standard employee risk rates for a grandfathered health benefit*  
16 *plan until all of the following requirements are met:*

17 *(1) The carrier files with the commissioner a statement of the*  
18 *specific changes which the carrier proposes in the risk categories,*  
19 *risk adjustment factors, or standard employee risk rates.*

20 *(2) Either:*

21 *(A) Thirty days expires after such statement is filed without*  
22 *written notice from the commissioner specifying the reasons for*  
23 *his or her opinion that the carrier's risk categories or risk*  
24 *adjustment factors do not comply with the requirements of this*  
25 *chapter.*

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

29 *(c) Notwithstanding any provision to the contrary, when a*  
30 *carrier is changing the standard employee risk rates of a health*  
31 *benefit plan lawfully provided under subdivision (a) or (b) but is*  
32 *not changing the risk categories or risk adjustment factors which*  
33 *have been previously authorized, the carrier need not comply with*  
34 *the requirements of paragraph (2) of subdivision (b), but instead*  
35 *shall submit the revised standard employee risk rates for the health*  
36 *benefit plan prior to renewing the health benefit plan.*

37 *(d) When submitting filings under subdivision (a), (b), or (c), a*  
38 *carrier may also file with the commissioner at the time of the filings*  
39 *a statement of the standard employee risk rate for each risk*  
40 *category the carrier intends to use for each month in the 12 months*

1 subsequent to the date of the filing. Once the requirements of the  
2 applicable subdivision (a), (b), or (c), have been met, these rates  
3 shall be used by the carrier for the 12-month period unless the  
4 carrier is otherwise informed by the commissioner in his or her  
5 response to the filings submitted under subdivision (a), (b), or (c),  
6 provided that any subsequent change in the standard employee  
7 risk rates charged by the carrier which differ from those previously  
8 filed with the commissioner must be newly filed in accordance  
9 with this subdivision and provided that the carrier does not change  
10 the risk categories or risk adjustment factors for the health benefit  
11 plan.

12 (e) If the commissioner notifies the carrier, in writing, that the  
13 carrier's risk categories or risk adjustment factors do not comply  
14 with the requirements of this chapter, specifying the reasons for  
15 his or her opinion, it is unlawful for the carrier, at any time after  
16 the receipt of such notice, to utilize the noncomplying health benefit  
17 plan, benefit plan design, risk categories, or risk adjustment factors  
18 in conjunction with the health benefit plans or benefit plan designs  
19 for which the filing was made.

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

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

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

29 10755.18. (a) In addition to any other remedy permitted by  
30 law, the commissioner shall have the administrative authority to  
31 assess penalties against carriers, insurance producers, and other  
32 entities engaged in the business of insurance or other persons or  
33 entities for violations of this chapter.

34 (b) Upon a showing of a violation of this chapter in any civil  
35 action, a court may also assess the penalties described in this  
36 chapter, in addition to any other remedies provided by law.

37 (c) Any production agent or other person or entity engaged in  
38 the business of insurance, other than a carrier, that violates this  
39 chapter is liable for administrative penalties of not more than two  
40 hundred fifty dollars (\$250) for the first violation.

1 (d) Any production agent or other person or entity engaged in  
2 the business of insurance, other than a carrier, that engages in  
3 practices prohibited by this chapter a second or subsequent time,  
4 or who commits a knowing violation of this chapter, is liable for  
5 administrative penalties of not less than one thousand dollars  
6 (\$1,000) and not more than two thousand five hundred dollars  
7 (\$2,500) for each violation.

8 (e) Any carrier that violates this chapter is liable for  
9 administrative penalties of not more than two thousand five  
10 hundred dollars (\$2,500) for the first violation and not more than  
11 five thousand dollars (\$5,000) for each subsequent violation.

12 (f) Any carrier that violates this chapter with a frequency that  
13 indicates a general business practice or commits a knowing  
14 violation of this chapter, is liable for administrative penalties of  
15 not less than fifteen thousand dollars (\$15,000) and not more than  
16 one hundred thousand dollars (\$100,000) for each violation.

17 (g) An act or omission that is inadvertent and that results in  
18 incorrect premium rates being charged to more than one  
19 policyholder shall be a single violation for the purpose of this  
20 section.

21 10755.18.5. (a) (1) In addition to any other remedy permitted  
22 by law, whenever the commissioner shall have reason to believe  
23 that any carrier, production agent, or other person or entity  
24 engaged in the business of insurance has violated this chapter,  
25 and that a proceeding by the commissioner in respect thereto would  
26 be in the interest of the public, the commissioner may issue and  
27 serve upon that entity an order to show cause containing a  
28 statement of the charges, a statement of the entity's potential  
29 liability under this chapter, and a notice of a public hearing  
30 thereon before the Administrative Law Bureau of the department  
31 to be held at a time and place fixed therein, which shall not be less  
32 than 30 days after the service thereof, for the purpose of  
33 determining whether the commissioner should issue an order to  
34 that entity to pay the penalty imposed by this chapter and such  
35 order or orders as shall be reasonably necessary to correct,  
36 eliminate, or remedy the alleged violations of this chapter,  
37 including, but not limited to, an order to cease and desist from the  
38 specified violations of this chapter.

39 (2) The hearings provided by this subdivision shall be conducted  
40 in accordance with the Administrative Procedure Act, Chapter 5

1 (commencing with Section 11500) of Part 1 of Division 3 of Title  
2 2 of the Government Code, and the commissioner shall have all  
3 the powers granted therein.

4 (b) (1) Whenever it appears to the commissioner that  
5 irreparable loss and injury has occurred or may occur to an  
6 insured, employer, employee, or other member of the public  
7 because a carrier, production agent, or other person or entity  
8 engaged in the business of insurance has violated this chapter, the  
9 commissioner may, before hearing, but after notice and opportunity  
10 to submit relevant information, issue and cause to be served upon  
11 the entity such order or orders as shall be reasonably necessary  
12 to correct, eliminate, or remedy the alleged violations of this  
13 chapter, including, but not limited to, an order requiring the entity  
14 to forthwith cease and desist from engaging further in the violations  
15 which are causing or may cause such irreparable injury.

16 (2) At the same time an order is served pursuant to paragraph  
17 (1) of this subdivision, the commissioner shall issue and also serve  
18 upon the person a notice of public hearing before the  
19 Administrative Law Bureau of the department to be held at a time  
20 and place fixed therein, which shall not be less than 30 days after  
21 the service thereof.

22 (3) The hearings provided by this subdivision shall be conducted  
23 in accordance with the Administrative Procedure Act, Chapter 5  
24 (commencing with Section 11500) of Part 1 of Division 3 of Title  
25 2 of the Government Code, and the commissioner shall have all  
26 the powers granted therein.

27 (4) At any time prior to the commencement of a hearing as  
28 provided in this subdivision, the entity against which the  
29 commissioner has served an order may waive the hearing and  
30 have judicial review of the order by means of any remedy afforded  
31 by law without first exhausting administrative remedies or  
32 procedures.

33 (c) If, after hearing as provided by subdivision (a) or (b), the  
34 charges, or any of them, that an entity has violated this chapter  
35 are found to be justified, the commissioner shall issue and cause  
36 to be served upon that entity an order requiring that entity to pay  
37 the penalty imposed by this chapter and such order or orders as  
38 shall be reasonably necessary to correct, eliminate, or remedy the  
39 alleged violations of this chapter, including, but not limited to, an

1 *order to cease and desist from the specified violations of this*  
2 *chapter.*

3 *(d) In addition to any other penalty provided by law or the*  
4 *availability of any administrative procedure, if a carrier, after*  
5 *notice and hearing, is found to have violated this chapter knowingly*  
6 *or as a general business practice the commissioner may suspend*  
7 *the carrier's certificate of authority to transact disability insurance.*  
8 *The order of suspension shall prescribe the period of such*  
9 *suspension. The proceedings shall be conducted in accordance*  
10 *with the Administrative Procedure Act, Chapter 5 (commencing*  
11 *with Section 11500) of Part 1 of Division 3 of Title 2 of the*  
12 *Government Code and the commissioner shall have all the powers*  
13 *granted therein.*

14 *10755.18.6. (a) Carriers may enter into contractual*  
15 *agreements with qualified associations, as defined in subdivision*  
16 *(b), under which these qualified associations may assume*  
17 *responsibility for performing specific administrative services, as*  
18 *defined in this section, for qualified association members. Carriers*  
19 *that enter into agreements with qualified associations for*  
20 *assumption of administrative services shall establish uniform*  
21 *definitions for the administrative services that may be provided*  
22 *by a qualified association or its third-party administrator. The*  
23 *carrier shall permit all qualified associations to assume one or*  
24 *more of these functions when the carrier determines the qualified*  
25 *association demonstrates that it has the administrative capacity*  
26 *to assume these functions.*

27 *For the purposes of this section, administrative services provided*  
28 *by qualified associations or their third-party administrators shall*  
29 *be services pertaining to eligibility determination, enrollment,*  
30 *premium collection, sales, or claims administration on a per-claim*  
31 *basis that would otherwise be provided directly by the carrier or*  
32 *through a third-party administrator on a commission basis or an*  
33 *agent or solicitor workforce on a commission basis.*

34 *Each carrier that enters into an agreement with any qualified*  
35 *association for the provision of administrative services shall offer*  
36 *all qualified associations with which it contracts the same premium*  
37 *discounts for performing those services the carrier has permitted*  
38 *the qualified association or its third-party administrator to assume.*  
39 *The carrier shall apply these uniform discounts to the carrier's*  
40 *risk adjusted employee risk rates after the carrier has determined*

1 *the qualified association's risk adjusted employee risk rates*  
2 *pursuant to Section 10755.14. The carrier shall report to the*  
3 *department its schedule of discounts for each administrative*  
4 *service.*

5 *In no instance may a carrier provide discounts to qualified*  
6 *associations that are in any way intended to, or materially result*  
7 *in, a reduction in premium charges to the qualified association*  
8 *due to the health status of the membership of the qualified*  
9 *association. In addition to any other remedies available to the*  
10 *commissioner to enforce this chapter, the commissioner may*  
11 *declare a contract between a carrier and a qualified association*  
12 *for administrative services pursuant to this section null and void*  
13 *if the commissioner determines any discounts provided to the*  
14 *qualified association are intended to, or materially result in, a*  
15 *reduction in premium charges to the qualified association due to*  
16 *the health status of the membership of the qualified association.*

17 *(b) For the purposes of this section, a qualified association is*  
18 *a nonprofit corporation comprised of a group of individuals or*  
19 *employers who associate based solely on participation in a*  
20 *specified profession or industry, that conforms to all of the*  
21 *following requirements:*

22 *(1) It accepts for membership any individual or small employer*  
23 *meeting its membership criteria.*

24 *(2) It does not condition membership, directly or indirectly, on*  
25 *the health or claims history of any person.*

26 *(3) It uses membership dues solely for and in consideration of*  
27 *the membership and membership benefits, except that the amount*  
28 *of the dues shall not depend on whether the member applies for*  
29 *or purchases insurance offered by the association.*

30 *(4) It is organized and maintained in good faith for purposes*  
31 *unrelated to insurance.*

32 *(5) It existed on January 1, 1972, and has been in continuous*  
33 *existence since that date.*

34 *(6) It has a constitution and bylaws or other analogous*  
35 *governing documents that provide for election of the governing*  
36 *board of the association by its members.*

37 *(7) It offered, marketed, or sold health coverage to its members*  
38 *for 20 continuous years prior to January 1, 1993.*

39 *(8) It agrees to offer any plan contract only to association*  
40 *members.*

1 (9) *It agrees to include any member choosing to enroll in the*  
 2 *plan contract offered by the association, provided that the member*  
 3 *agrees to make required premium payments.*

4 (10) *It complies with all provisions of this article.*

5 (11) *It had at least 10,000 enrollees covered by*  
 6 *association-sponsored plans immediately prior to enactment of*  
 7 *Chapter 1128 of the Statutes of 1992.*

8 (12) *It applies any administrative cost at an equal rate to all*  
 9 *members purchasing coverage through the qualified association.*

10 (c) *A qualified association shall comply with the requirements*  
 11 *set forth in Section 10198.9.*

12 10755.18.7. *Notwithstanding any other provision of law, no*  
 13 *provision of this chapter shall be construed to limit the applicability*  
 14 *of any other provision of the Insurance Code unless such provision*  
 15 *is in conflict with the requirements of this chapter.*

16 10755.19. (a) *On or before October 1, 2013, and annually*  
 17 *thereafter, a carrier shall issue the following notice to all insureds*  
 18 *enrolled in a grandfathered health benefit plan:*

19  
 20 “*Beginning on and after January 1, 2014, new improved health*  
 21 *insurance options are available in California. You currently have*  
 22 *health insurance that is exempt from many of the new requirements.*  
 23 *You have the option to remain in your current plan or switch to a*  
 24 *new plan. Under the new rules, a health insurance company cannot*  
 25 *deny your application based on any health conditions you may*  
 26 *have. For more information about your options, please contact*  
 27 *the California Health Benefit Exchange, the Office of Patient*  
 28 *Advocate, your plan or policy representative, an insurance broker,*  
 29 *or a health care navigator.”*

30  
 31 (b) *A carrier shall include the notice described in subdivision*  
 32 *(a) in any marketing material of the individual grandfathered*  
 33 *health plan.*

34 SEC. 20. *Nothing in this act shall preclude the Legislature*  
 35 *from considering and adopting future legislation to allow premium*  
 36 *ratings based on tobacco use and wellness incentives, to the extent*  
 37 *permitted under the federal Patient Protection and Affordable*  
 38 *Care Act (Public Law 111-148) and any rules, regulations, or*  
 39 *guidance issued consistent with that law.*

1     *SEC. 21. This act shall be implemented to the extent consistent*  
2 *with the federal Patient Protection and Affordable Care Act (Public*  
3 *Law 111-148), as amended by the federal Health Care and*  
4 *Education Reconciliation Act of 2010 (Public Law 111-152), and*  
5 *any rules, regulations, or guidance issued pursuant to that law,*  
6 *except to the extent that this act provides greater consumer*  
7 *protections.*

8     *SEC. 22. No reimbursement is required by this act pursuant*  
9 *to Section 6 of Article XIII B of the California Constitution because*  
10 *the only costs that may be incurred by a local agency or school*  
11 *district will be incurred because this act creates a new crime or*  
12 *infraction, eliminates a crime or infraction, or changes the penalty*  
13 *for a crime or infraction, within the meaning of Section 17556 of*  
14 *the Government Code, or changes the definition of a crime within*  
15 *the meaning of Section 6 of Article XIII B of the California*  
16 *Constitution.*

17  
18  
19     **All matter omitted in this version of the bill**  
20 **appears in the bill as amended in the**  
21 **Senate, September 2, 2011. (JR11)**  
22