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AMENDED IN ASSEMBLY MAY 10, 2011  
AMENDED IN ASSEMBLY MARCH 29, 2011  
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 ~~1357.01~~, 1385.01, ~~1389~~, and 1393.6 of, to add ~~Section~~ *Sections* 1348.95, 1357.19, and 1357.55 to, to add *Article 3.16 (commencing with Section 1357.500) and 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~~ *Section* 10181, ~~10291.5~~, and ~~10702~~ of, to add Sections 10127.19, 10198.10, and 10750 to, to add *Chapter 8.01 (commencing with 10753)*

~~and Chapter 8.01 8.02~~ (commencing with Section 10755) to Part 2 of Division 2 of, ~~and 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 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 insurers by the Department of Insurance. Existing law provides for the regulation of health care service plans and health insurers that offer health benefit plans to small employers with regard to eligible employees, 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.

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 and grandfathered plans with respect to plan years on or after January 1, 2014, consistent with PPACA. 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 the bill's provisions regarding grandfathered plans by August 31, 2012 2013, as specified. The bill would make certain of these provisions inoperative if the corresponding provisions of PPACA are repealed and would make other related conforming changes.~~ 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, *by product type*, as of  
 9 December 31 of the prior year, that receive health care coverage  
 10 under a health care service plan contract that covers individuals,  
 11 small groups, ~~groups of 51-100, groups of 101 or more~~ *large*  
 12 *groups*, or administrative services only business lines. Health care  
 13 service plans shall include the ~~unduplicated~~ enrollment data in  
 14 specific product ~~lines~~ *types* as determined by the department,  
 15 including, but not limited to, HMO, point-of-service, PPO,  
 16 ~~Medicare excluding Medicare supplement, grandfathered, and~~  
 17 ~~Medi-Cal managed care, and traditional indemnity non-PPO health~~  
 18 ~~insurance~~. The department shall publicly report the data provided  
 19 by each health care service plan pursuant to this section, including,  
 20 but not limited to, posting the data on the department’s Internet  
 21 Web site. The department shall consult with the Department of  
 22 Insurance to ensure that the data reported is comparable and  
 23 consistent, *does not duplicate existing reporting requirements, and*  
 24 *utilizes existing reporting formats.*  
 25 SEC. 2. Section 1357.19 is added to the Health and Safety  
 26 Code, to read:

1 1357.19. *This article shall not apply to a health care service*  
2 *plan contract that is subject to Article 3.16 (commencing with*  
3 *Section 1357.500) or Article 3.17 (commencing with Section*  
4 *1357.600), except as otherwise provided in those articles.*

5 ~~SEC. 2.~~

6 ~~SEC. 3.~~ Article ~~3.1~~ 3.16 (commencing with Section ~~1357~~)  
7 1357.500) is added to Chapter 2.2 of Division 2 of the Health and  
8 Safety Code, to read:

9  
10 Article ~~3.1~~ 3.16. Nongrandfathered Small Employer Plans

11  
12 ~~1357.~~

13 1357.500. As used in this article, the following definitions shall  
14 apply:

15 (a) “Child” means a child described in Section 22775 of the  
16 Government Code and subdivisions (n) to (p), inclusive, of Section  
17 599.500 of Title 2 of the California Code of Regulations.

18 (b) “Dependent” means the spouse; *or registered* domestic  
19 partner, or child, of an eligible employee, subject to applicable  
20 terms of the health care service plan contract covering the  
21 employee, and includes dependents of guaranteed association  
22 members if the association elects to include dependents under its  
23 health coverage at the same time it determines its membership  
24 composition pursuant to subdivision (m).

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

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

1 of persons employed by the employer. Permanent employees who  
2 work at least 20 hours but not more than 29 hours are deemed to  
3 be eligible employees if all four of the following apply:

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

6 (B) The employer offers the employees health coverage under  
7 a health benefit plan.

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

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

16 (2) Any member of a guaranteed association as defined in  
17 subdivision (m).

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

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

22 (f) “Late enrollee” means an eligible employee or dependent  
23 who has declined enrollment in a health benefit plan offered by a  
24 small employer at the time of the initial enrollment period provided  
25 under the terms of the health benefit plan consistent with the  
26 periods provided pursuant to Section ~~1357.03~~ 1357.503 and who  
27 subsequently requests enrollment in a health benefit plan of that  
28 small employer, except where the employee or dependent qualifies  
29 for a special enrollment period provided pursuant to Section  
30 ~~1357.03~~ 1357.503. It also means any member of an association  
31 that is a guaranteed association as well as any other person eligible  
32 to purchase through the guaranteed association when that person  
33 has failed to purchase coverage during the initial enrollment period  
34 provided under the terms of the guaranteed association’s plan  
35 contract consistent with the periods provided pursuant to Section  
36 ~~1357.03~~ 1357.503 and who subsequently requests enrollment in  
37 the plan, except where that member or person qualifies for a special  
38 enrollment period provided pursuant to Section ~~1357.03~~ 1357.503.

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

1 (h) “Preexisting condition provision” means a contract provision  
2 that excludes coverage for charges or expenses incurred during a  
3 specified period following the enrollee’s effective date of coverage,  
4 as to a condition for which medical advice, diagnosis, care, or  
5 treatment was recommended or received during a specified period  
6 immediately preceding the effective date of coverage. No health  
7 care service plan shall limit or exclude coverage for any individual  
8 based on a preexisting condition whether or not any medical advice,  
9 diagnosis, care, or treatment was recommended or received before  
10 that date.

11 (i) “Creditable coverage” means:

12 (1) Any individual or group policy, contract, or program that is  
13 written or administered by a disability insurer, health care service  
14 plan, fraternal benefits society, self-insured employer plan, or any  
15 other entity, in this state or elsewhere, and that arranges or provides  
16 medical, hospital, and surgical coverage not designed to supplement  
17 other private or governmental plans. The term includes continuation  
18 or conversion coverage but does not include accident only, credit,  
19 coverage for onsite medical clinics, disability income, Medicare  
20 supplement, long-term care, dental, vision, coverage issued as a  
21 supplement to liability insurance, insurance arising out of a  
22 workers’ 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 Medicare Program pursuant to Title XVIII of the federal  
28 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 Public Health Service  
3 Act, as amended by Public Law 104-191, the Health Insurance  
4 Portability and Accountability Act of 1996.

5 (9) A health benefit plan under Section 5(e) of the Peace Corps  
6 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 (j) “Rating period” means the period for which premium rates  
11 established by a plan are in effect and shall be ~~from January 1 to~~  
12 ~~December 31, inclusive.~~ *no less than 12 months from the date of*  
13 *issuance or renewal of the plan contract.*

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

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

1 pursuant to this article, and for the purpose of determining  
2 eligibility, the size of a small employer shall be determined  
3 annually. Except as otherwise specifically provided in this article,  
4 provisions of this article that apply to a small employer shall  
5 continue to apply until the plan contract anniversary following the  
6 date the employer no longer meets the requirements of this  
7 definition. It includes any small employer as defined in this  
8 paragraph who purchases coverage through a guaranteed  
9 association, and any employer purchasing coverage for employees  
10 through a guaranteed association. This ~~paragraph~~ *subparagraph*  
11 shall be implemented to the extent consistent with PPACA, except  
12 that the minimum requirement of one employee shall be  
13 implemented only to the extent required by PPACA.

14 (B) Any guaranteed association, as defined in subdivision (l),  
15 that purchases health coverage for members of the association.

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

21 (l) “Guaranteed association” means a nonprofit organization  
22 comprised of a group of individuals or employers who associate  
23 based solely on participation in a specified profession or industry,  
24 accepting for membership any individual or employer meeting its  
25 membership criteria, and that (1) includes one or more small  
26 employers as defined in subparagraph (A) of paragraph (1) of  
27 subdivision (k), (2) does not condition membership directly or  
28 indirectly on the health or claims history of any person, (3) uses  
29 membership dues solely for and in consideration of the membership  
30 and membership benefits, except that the amount of the dues shall  
31 not depend on whether the member applies for or purchases  
32 insurance offered to the association, (4) is organized and  
33 maintained in good faith for purposes unrelated to insurance, (5)  
34 has been in active existence on January 1, 1992, and for at least  
35 five years prior to that date, (6) has included health insurance as  
36 a membership benefit for at least five years prior to January 1,  
37 1992, (7) has a constitution and bylaws, or other analogous  
38 governing documents that provide for election of the governing  
39 board of the association by its members, (8) offers any plan contract  
40 that is purchased to all individual members and employer members

1 in this state, (9) includes any member choosing to enroll in the  
2 plan contracts offered to the association provided that the member  
3 has agreed to make the required premium payments, and (10)  
4 covers at least 1,000 persons with the health care service plan with  
5 which it contracts. The requirement of 1,000 persons may be met  
6 if component chapters of a statewide association contracting  
7 separately with the same carrier cover at least 1,000 persons in the  
8 aggregate.

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

12 For purposes of this subdivision, an association formed by a  
13 merger of two or more associations after January 1, 1992, and  
14 otherwise meeting the criteria of this subdivision shall be deemed  
15 to have been in active existence on January 1, 1992, if its  
16 predecessor organizations had been in active existence on January  
17 1, 1992, and for at least five years prior to that date and otherwise  
18 met the criteria of this subdivision.

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

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

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

37 (p) “Nongrandfathered small employer health care service plan  
38 contract” means a small employer health care service plan contract  
39 that is not a grandfathered health plan.

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

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

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

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

13 (u) “Registered domestic partner” means a person who has  
14 established a domestic partnership as described in Section 297 of  
15 the Family Code.

16 ~~1357.01.~~

17 *1357.501.* This article shall apply only to nongrandfathered  
18 small employer health care service plan contracts and only with  
19 respect to plan years beginning on or after January 1, 2014.

20 ~~1357.02.~~

21 *1357.502.* (a) A health care service plan providing or arranging  
22 for the provision of essential health benefits, as defined by the  
23 state pursuant to Section 1302 of PPACA, to small employers shall  
24 be subject to this article if either of the following conditions is  
25 met:

26 (1) Any portion of the premium is paid by a small employer, or  
27 any covered individual is reimbursed, whether through wage  
28 adjustments or otherwise, by a small employer for any portion of  
29 the premium.

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

33 (b) This article shall not apply to health care service plan  
34 contracts for coverage of Medicare services pursuant to contracts  
35 with the United States government, Medicare supplement,  
36 Medi-Cal contracts with the State Department of Health Care  
37 Services, long-term care coverage, or specialized health care  
38 service plan contracts.

1 ~~1357.025.~~

2 1357.502.5. Nothing in this article shall be construed to  
3 preclude the application of this chapter to either of the following:

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

6 (b) An association, trust, or other organization or person  
7 presenting information regarding a health care service plan to  
8 persons who may be interested in subscribing or enrolling in the  
9 plan.

10 ~~1357.03.~~

11 1357.503. (a) (1) On and after October 1, 2013, a plan shall  
12 fairly and affirmatively offer, market, and sell all of the plan’s  
13 small employer health care service plan contracts *for plan years*  
14 *on or after January 1, 2014*, to all small employers in each service  
15 area in which the plan provides or arranges for the provision of  
16 health care services.

17 (2) On and after October 1, 2013, a plan shall make available  
18 to each small employer all small employer health care service plan  
19 contracts that the plan offers and sells to small employers or to  
20 associations that include small employers in this state *for plan*  
21 *years on or after January 1, 2014*.

22 (3) A plan that offers qualified health plans through the  
23 Exchange shall be deemed to be in compliance with paragraphs  
24 (1) and (2) with respect to small employer health care service plan  
25 contracts offered through the Exchange in those geographic regions  
26 in which the plan offers plan contracts through the Exchange.

27 (b) A plan shall provide enrollment periods consistent with  
28 PPACA and set forth in Section 155.725 of Title 45 of the Code  
29 of Federal Regulations. A plan shall provide special enrollment  
30 periods consistent with the special enrollment periods required in  
31 the individual nongrandfathered market in the state *under Section*  
32 *1399.849*, except for the triggering events identified in paragraphs  
33 (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of  
34 Federal Regulations with respect to plan contracts offered through  
35 the Exchange.

36 (c) No plan or solicitor shall induce or otherwise encourage a  
37 small employer to separate or otherwise exclude an eligible  
38 employee from a health care service plan contract that is provided  
39 in connection with employee’s employment or membership in a  
40 guaranteed association.

1 (d) Every plan shall file with the director the reasonable  
2 employee participation requirements and employer contribution  
3 requirements that will be applied in offering its plan contracts.  
4 Participation requirements shall be applied uniformly among all  
5 small employer groups, except that a plan may vary application  
6 of minimum employee participation requirements by the size of  
7 the small employer group and whether the employer contributes  
8 100 percent of the eligible employee's premium. Employer  
9 contribution requirements shall not vary by employer size. A health  
10 care service plan shall not establish a participation requirement  
11 that (1) requires a person who meets the definition of a dependent  
12 in Section ~~1357~~ 1357.500 to enroll as a dependent if he or she is  
13 otherwise eligible for coverage and wishes to enroll as an eligible  
14 employee and (2) allows a plan to reject an otherwise eligible small  
15 employer because of the number of persons that waive coverage  
16 due to coverage through another employer. Members of an  
17 association eligible for health coverage under subdivision (m) of  
18 Section ~~1357~~ 1357.500, but not electing any health coverage  
19 through the association, shall not be counted as eligible employees  
20 for purposes of determining whether the guaranteed association  
21 meets a plan's reasonable participation standards.

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

25 (1) The small employer offers health benefits to 100 percent of  
26 its eligible employees. Employees who waive coverage on the  
27 grounds that they have other group coverage shall not be counted  
28 as eligible employees.

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

31 (3) The small employer agrees to inform the small employer's  
32 employees of the availability of coverage and the provision that  
33 those not electing coverage must wait until the next open  
34 enrollment or a special enrollment period to obtain coverage  
35 through the group if they later decide they would like to have  
36 coverage.

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

1 (f) No plan or solicitor shall, directly or indirectly, engage in  
2 the following activities:

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

8 (2) Encourage or direct small employers to seek coverage from  
9 another plan because of the health status, claims experience,  
10 industry, occupation of the small employer, or geographic location  
11 provided that it is within the plan’s approved service area.

12 (g) A plan shall not, directly or indirectly, enter into any  
13 contract, agreement, or arrangement with a solicitor that provides  
14 for or results in the compensation paid to a solicitor for the sale of  
15 a health care service plan contract to be varied because of the health  
16 status, claims experience, industry, occupation, or geographic  
17 location of the small employer. This subdivision does not apply  
18 to a compensation arrangement that provides compensation to a  
19 solicitor on the basis of percentage of premium, provided that the  
20 percentage shall not vary because of the health status, claims  
21 experience, industry, occupation, or geographic area of the small  
22 employer.

23 (h) (1) A policy or contract that covers a small employer, as  
24 defined in Section 1304(b) of PPACA and in Section ~~1357~~  
25 *1357.500*, shall not establish rules for eligibility, including  
26 continued eligibility, of an individual, or dependent of an  
27 individual, to enroll under the terms of the ~~plan~~ *policy or contract*  
28 based on any of the following health status-related factors:

- 29 (A) Health status.
- 30 (B) Medical condition, including physical and mental illnesses.
- 31 (C) Claims experience.
- 32 (D) Receipt of health care.
- 33 (E) Medical history.
- 34 (F) Genetic information.
- 35 (G) Evidence of insurability, including conditions arising out  
36 of acts of domestic violence.
- 37 (H) Disability.
- 38 (I) Any other health status-related factor as determined by any  
39 federal regulations, rules, or guidance issued pursuant to Section  
40 2705 of the federal Public Health Service Act.

1 (2) ~~A~~ *Notwithstanding Section 1389.1, a health care service*  
2 *plan shall not require an eligible employee or dependent to fill out*  
3 *a health assessment or medical questionnaire prior to enrollment*  
4 *under a small employer health care service plan contract. A health*  
5 *care service plan shall not acquire or request information that*  
6 *relates to a health status-related factor from the applicant or his*  
7 *or her dependent or any other source prior to enrollment of the*  
8 *individual.*

9 (i) A plan shall comply with the requirements of Section 1374.3.

10 (j) *(1) Except as provided in paragraph (2), this section shall*  
11 *become inoperative if Section 2702 of the federal Public Health*  
12 *Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201*  
13 *of PPACA, is repealed, in which case health care services plans*  
14 *subject to this section shall instead be governed by Section 1357.03*  
15 *to the extent permitted by federal law, and all references in this*  
16 *article to this section shall instead refer to Section 1357.03 except*  
17 *for purposes of paragraph (2).*

18 (2) *Subdivision (b) of this section shall remain operative with*  
19 *respect to health care service plan contracts offered through the*  
20 *Exchange.*

21 ~~1357.035.~~

22 *1357.503.035.* (a) For plan contracts subject to this article, an  
23 association that meets the definition of a guaranteed association,  
24 as set forth in Section ~~1357~~ *1357.500*, except for the requirement  
25 that 1,000 persons be covered, shall be entitled to purchase small  
26 employer health coverage as if the association were a guaranteed  
27 association, except that the coverage shall be guaranteed only for  
28 those members of an association, as defined in subdivision (m) of  
29 Section ~~1357~~ *1357.500*, (1) who were receiving coverage or had  
30 successfully applied for coverage through the association as of  
31 June 30, 1993, (2) who were receiving coverage through the  
32 association as of December 31, 1992, and whose coverage lapsed  
33 at any time thereafter because the employment through which  
34 coverage was received ended or an employer's contribution to  
35 health coverage ended, or (3) who were covered at any time  
36 between June 30, 1993, and July 1, 1994, under a contract that was  
37 in force on June 30, 1993.

38 (b) An association obtaining health coverage for its members  
39 pursuant to this section shall otherwise be afforded all the rights

1 of a guaranteed association under this chapter, including, but not  
2 limited to, guaranteed renewability of coverage.

3 ~~1357.04.~~

4 *1357.504.* (a) With respect to small employer health care  
5 service plan contracts offered outside the Exchange, after a small  
6 employer submits a completed application form for a plan contract,  
7 the health care service plan shall, within 30 days, notify the  
8 employer of the employer’s actual premium charges for that plan  
9 contract established in accordance with Section~~1357.12~~ *1357.512.*  
10 The employer shall have 30 days in which to exercise the right to  
11 buy coverage at the quoted premium charges.

12 (b) (1) Except as provided in paragraph (2), when a small  
13 employer submits a premium payment, based on the quoted  
14 premium charges, and that payment is delivered or postmarked,  
15 whichever occurs earlier, within the first 15 days of the month,  
16 coverage under the plan contract shall become effective no later  
17 than the first day of the following month. When that payment is  
18 neither delivered nor postmarked until after the 15th day of a  
19 month, coverage shall become effective no later than the first day  
20 of the second month following delivery or postmark of the  
21 payment.

22 (2) A health care service plan shall apply coverage effective  
23 dates for plan contracts subject to this article consistent with the  
24 coverage effective dates applicable to nongrandfathered individual  
25 health care service plan contracts *pursuant to Section 1399.849.*

26 (c) During the first 30 days after the effective date of the plan  
27 contract, the small employer shall have the option of changing  
28 coverage to a different plan contract offered by the same health  
29 care service plan. If a small employer notifies the plan of the  
30 change within the first 15 days of a month, coverage under the  
31 new plan contract shall become effective no later than the first day  
32 of the following month. If a small employer notifies the plan of  
33 the change after the 15th day of a month, coverage under the new  
34 plan contract shall become effective no later than the first day of  
35 the second month following notification.

36 ~~1357.06.~~

37 *1357.506.* (a) A small employer health care service plan  
38 contract shall not impose a preexisting condition provision upon  
39 any individual.

1 (b) A plan contract may apply a waiting period of up to 60 days  
2 as a condition of employment if applied equally to all eligible  
3 employees and dependents and if consistent with PPACA. A plan  
4 contract through a health maintenance organization, as defined in  
5 Section 2791 of the federal Public Health Service Act, may impose  
6 an affiliation period not to exceed 60 days. A waiting or affiliation  
7 period shall not be based on a preexisting condition of an employee  
8 or dependent, the health status of an employee or dependent, or  
9 any other factor listed in subdivision (h) of Section ~~1357.03~~  
10 *1357.503*. An affiliation period shall run concurrently with a  
11 waiting period. During the waiting or affiliation period, the plan  
12 is not required to provide health care services and no premium  
13 shall be charged to the subscriber or enrollees.

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

33 (d) An individual's period of creditable coverage shall be  
34 certified pursuant to subsection (e) of Section 2704 of Title XXVII  
35 of the federal Public Health Service Act (42 U.S.C. Sec.  
36 300gg-3(e)).

37 ~~1357.07.~~

38 *1357.507.* Nothing in this article shall be construed as  
39 prohibiting a health care service plan from restricting enrollment  
40 of late enrollees to open enrollment periods provided under Section

1 ~~1357.03~~ 1357.503 as authorized under Section 2702 of the federal  
2 Public Health Service Act. ~~No premium shall be charged to the~~  
3 ~~late enrollee until the exclusion period has ended.~~

4 ~~1357.08:~~

5 1357.508. A small employer health care service plan contract  
6 shall provide to subscribers and enrollees at least all of the essential  
7 health benefits as defined by the state pursuant to Section 1302 of  
8 PPACA.

9 ~~1357.09:~~

10 1357.509. To the extent permitted by PPACA, no plan shall  
11 be required to offer a health care service plan contract or accept  
12 applications for the contract pursuant to this article in the case of  
13 any of the following:

14 (a) To a small employer, if the small employer is not physically  
15 located in a plan’s approved service areas, or if an eligible  
16 employee and dependents who are to be covered by the plan  
17 contract do not work or reside within a plan’s approved service  
18 areas.

19 (b) (1) Within a specific service area or portion of a service  
20 area, if a plan reasonably anticipates and demonstrates to the  
21 satisfaction of the director that it will not have sufficient health  
22 care delivery resources to ensure that health care services will be  
23 available and accessible to the eligible employee and dependents  
24 of the employee because of its obligations to existing enrollees.

25 (2) A plan that cannot offer a health care service plan contract  
26 to small employers because it is lacking in sufficient health care  
27 delivery resources within a service area or a portion of a service  
28 area may not offer a contract in the area in which the plan is not  
29 offering coverage to small employers to new employer groups  
30 with more than 50 eligible employees until the plan notifies the  
31 director that it has the ability to deliver services to small employer  
32 groups, and certifies to the director that from the date of the notice  
33 it will enroll all small employer groups requesting coverage in that  
34 area from the plan unless the plan has met the requirements of  
35 subdivision (d).

36 (3) Nothing in this article shall be construed to limit the  
37 director’s authority to develop and implement a plan of  
38 rehabilitation for a health care service plan whose financial viability  
39 or organizational and administrative capacity has become impaired.

1 (c) Offer coverage to a small employer or an eligible employee  
2 as defined in paragraph (2) of subdivision (c) of Section ~~1357~~  
3 *1357.500* that, within 12 months of application for coverage,  
4 disenrolled from a plan contract offered by the plan.

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

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

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

19 (2) If a health care service plan treats an affiliate or subsidiary  
20 as a separate carrier for the purpose of this article because one  
21 health care service plan is qualified under the federal Health  
22 Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and  
23 does not offer coverage to small employers, while the affiliate or  
24 subsidiary offers a plan contract that is not qualified under the  
25 federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e  
26 et seq.) and offers plan contracts to small employers, the health  
27 care service plan offering coverage to small employers shall enroll  
28 new eligible employees and dependents, equal to the applicable  
29 percentage of the total enrollment of both the health care service  
30 plan qualified under the federal Health Maintenance Organization  
31 Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.

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

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

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

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

1 (B) The director shall, within 45 days, approve or disapprove  
2 the certified statement. If the certified statement is disapproved,  
3 the plan shall continue to issue coverage as required by Section  
4 ~~1357.03~~ 1357.503 and be subject to disciplinary action as set forth  
5 in Article 7 (commencing with Section 1386).

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

10 (f) A social health maintenance organization, as described in  
11 subsection (a) of Section 2355 of the federal Deficit Reduction  
12 Act of 1984 (Public Law 98-369), that, as of December 31 of the  
13 prior year, had a total enrollment of fewer than 100,000 and has  
14 50 percent or more of the organization’s total enrollment premiums  
15 paid by the Medi-Cal program or Medicare Program, or by a  
16 combination of Medi-Cal and Medicare. In no event shall this  
17 exemption be based upon enrollment in Medicare supplement  
18 contracts, as described in Article 3.5 (commencing with Section  
19 1358).

20 ~~1357.10.~~

21 1357.510. The director may require a plan to discontinue the  
22 offering of contracts or acceptance of applications from any small  
23 employer or group upon a determination by the director that the  
24 plan does not have sufficient financial viability, or organizational  
25 and administrative capacity to ensure the delivery of health care  
26 services to its enrollees. In determining whether the conditions of  
27 this section have been met, the director shall consider, but not be  
28 limited to, the plan’s compliance with the requirements of Section  
29 1367, Article 6 (commencing with Section 1375), and the rules  
30 adopted thereunder.

31 ~~1357.12.~~

32 1357.512. (a) The premium rate for a small employer health  
33 care service plan contract shall vary with respect to the particular  
34 coverage involved only by the following:

35 (1) Age, ~~as described in regulations adopted by the department~~  
36 ~~in conjunction with the Department of Insurance that do not prevent~~  
37 ~~the application of PPACA pursuant to the age bands established~~  
38 ~~by the United States Secretary of Health and Human Services~~  
39 ~~pursuant to Section 2701(a)(3) of the federal Public Health Service~~  
40 ~~Act (42 U.S.C. Sec. 300gg(a)(3)).~~ Rates based on age shall be

1 determined based on the individual's birthday *and shall not vary*  
2 *by more than three to one for adults.* ~~A plan shall not use any age~~  
3 ~~bands for rating purposes that are inconsistent with the age bands~~  
4 ~~established by the United States Secretary of Health and Human~~  
5 ~~Services pursuant to Section 2701(a)(3) of the federal Public Health~~  
6 ~~Service Act (42 U.S.C. Sec. 300gg(a)(3)).~~

7 (2) (A) Geographic region. The geographic regions for purposes  
8 of rating shall be the following:

9 (A)

10 (i) Region 1 shall consist of the Counties of Alpine, Del Norte,  
11 Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama,  
12 Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter,  
13 Yuba, Colusa, Amador, Calaveras, and Tuolumne.

14 (B)

15 (ii) Region 2 shall consist of the Counties of Napa, Sonoma,  
16 Solano, and Marin.

17 (C)

18 (iii) Region 3 shall consist of the Counties of Sacramento,  
19 Placer, El Dorado, and Yolo.

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

22 (iv) *Region 4 shall consist of the County of San Francisco.*

23 (v) *Region 5 shall consist of the County of Contra Costa.*

24 (vi) *Region 6 shall consist of the County of Alameda.*

25 (vii) *Region 7 shall consist of the County of Santa Clara.*

26 (viii) *Region 8 shall consist of the County of San Mateo.*

27 (E)

28 (ix) ~~Region 5~~ 9 shall consist of the Counties of Santa Cruz,  
29 Monterey, and San Benito.

30 (F)

31 (x) ~~Region 6~~ 10 shall consist of the Counties of San Joaquin,  
32 Stanislaus, Merced, Mariposa, ~~Madera, Fresno, Kings,~~ and Tulare.

33 (xi) *Region 11 shall consist of the Counties of Madera, Fresno,*  
34 *and Kings.*

35 (G)

36 (xii) ~~Region 7~~ 12 shall consist of the Counties of San Luis  
37 Obispo, Santa Barbara, and Ventura.

38 (H)

39 (xiii) ~~Region 8~~ 13 shall consist of the Counties of Mono, Inyo,  
40 ~~Kern,~~ and Imperial.

1     (xiv) *Region 14 shall consist of the County of Kern.*  
 2     ~~(I)~~  
 3     (xv) *Region-9 15 shall consist of the ZIP Codes in Los Angeles*  
 4 *County starting with 906 to 912, inclusive, 915, 917, 918, and 935.*  
 5     ~~(J)~~  
 6     (xvi) *Region-10 16 shall consist of the ZIP Codes in Los Angeles*  
 7 *County other than those identified in-subparagraph (I) clause (xv).*  
 8     ~~(K)~~  
 9     (xvii) *Region-11 17 shall consist of the Counties of San*  
 10 *Bernardino and Riverside.*  
 11     ~~(L)~~  
 12     (xviii) *Region-12 18 shall consist of the County of Orange.*  
 13     ~~(M)~~  
 14     (xix) *Region-13 19 shall consist of the County of San Diego.*  
 15     *(B) No later than June 1, 2017, the department, in collaboration*  
 16 *with the Exchange and the Department of Insurance, shall review*  
 17 *the geographic rating regions specified in this paragraph and the*  
 18 *impacts of those regions on the health care coverage market in*  
 19 *California, and submit a report to the appropriate policy*  
 20 *committees of the Legislature.*  
 21     (3) Whether the contract covers an individual or family, *as*  
 22 *described in PPACA.*  
 23     (b) The rate for a health care service plan contract subject to  
 24 this section shall not vary by any factor not described in this  
 25 section.  
 26     (c) The rating period for rates subject to this section shall be  
 27 ~~from January 1 to December 31, inclusive~~ *no less than 12 months*  
 28 *from the date of issuance or renewal of the plan contract.*  
 29     ~~(d) (1) Notwithstanding the Administrative Procedure Act~~  
 30 ~~(Chapter 3.5 (commencing with Section 11340) of Part 1 of~~  
 31 ~~Division 3 of Title 2 of the Government Code), the department~~  
 32 ~~may implement and administer this section through plan letters or~~  
 33 ~~similar instruction from the department until regulations are~~  
 34 ~~adopted.~~  
 35     ~~(2)~~  
 36 ~~The department shall adopt emergency regulations~~  
 37 ~~implementing this section no later than August 31, 2013. The~~  
 38 ~~department may readopt any emergency regulation authorized by~~  
 39 ~~this section that is the same as or substantially equivalent to an~~  
 40 ~~emergency regulation previously adopted under this section.~~

1 (3)

2 ~~The initial adoption of emergency regulations implementing~~  
3 ~~this section and the one readoption of emergency regulations~~  
4 ~~authorized by this section shall be deemed an emergency and~~  
5 ~~necessary for the immediate preservation of the public peace,~~  
6 ~~health, safety, or general welfare. Initial emergency regulations~~  
7 ~~and the one readoption of emergency regulations authorized by~~  
8 ~~this section shall be exempt from review by the Office of~~  
9 ~~Administrative Law. The initial emergency regulations and the~~  
10 ~~one readoption of emergency regulations authorized by this section~~  
11 ~~shall be submitted to the Office of Administrative Law for filing~~  
12 ~~with the Secretary of State and each shall remain in effect for no~~  
13 ~~more than 180 days, by which time final regulations may be~~  
14 ~~adopted.~~

15 *(d) This section shall become inoperative if Section 2701 of the*  
16 *federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added*  
17 *by Section 1201 of PPACA, is repealed, in which case rates for*  
18 *health care service plan contracts subject to this section shall*  
19 *instead be subject to Section 1357.12, to the extent permitted by*  
20 *federal law, and all references to this section shall be deemed to*  
21 *be references to Section 1357.12.*

22 ~~1357.14.~~

23 *1357.514.* In connection with the offering for sale of a small  
24 employer health care service plan contract subject to this article,  
25 each plan shall make a reasonable disclosure, as part of its  
26 solicitation and sales materials, of the following:

27 (a) The provisions concerning the plan's right to change  
28 premium rates and the factors other than provision of services  
29 experience that affect changes in premium rates. *The plan shall*  
30 *disclose that claims experience cannot be used.*

31 (b) Provisions relating to the guaranteed issue and renewal of  
32 contracts.

33 (c) A statement that no preexisting condition provisions shall  
34 be allowed.

35 (d) Provisions relating to the small employer's right to apply  
36 for any small employer health care service plan contract written,  
37 issued, or administered by the plan at the time of application for  
38 a new health care service plan contract, or at the time of renewal  
39 of a health care service plan contract, consistent with the  
40 requirements of PPACA.

1 (e) The availability, upon request, of a listing of all the plan's  
2 contracts and benefit plan designs offered, both inside and outside  
3 the Exchange, to small employers, including the rates for each  
4 contract.

5 (f) At the time it offers a contract to a small employer, each plan  
6 shall provide the small employer with a statement of all of its small  
7 employer health care service plan contracts, including the rates  
8 for each plan contract, in the service area in which the employer's  
9 employees and eligible dependents who are to be covered by the  
10 plan contract work or reside. For purposes of this subdivision,  
11 plans that are affiliated plans or that are eligible to file a  
12 consolidated income tax return shall be treated as one health plan.

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

14 (1) Prepare a brochure that summarizes all of its plan contracts  
15 offered to small employers and to make this summary available  
16 to any small employer and to solicitors upon request. The summary  
17 shall include for each contract information on benefits provided,  
18 a generic description of the manner in which services are provided,  
19 such as how access to providers is limited, benefit limitations,  
20 required copayments and deductibles, an explanation of the manner  
21 in which creditable coverage is calculated if a waiting or affiliation  
22 period is imposed, and a phone number that can be called for more  
23 detailed benefit information. Plans are required to keep the  
24 information contained in the brochure accurate and up to date and,  
25 upon updating the brochure, send copies to solicitors and solicitor  
26 firms with whom the plan contracts to solicit enrollments or  
27 subscriptions.

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

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

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

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

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

7 (A) Advise the small employer of the plan's obligation to sell  
8 to any small employer any small employer health care service plan  
9 contract, consistent with PPACA, and provide the small employer,  
10 upon request, with the actual rates that would be charged to that  
11 employer for a given contract.

12 (B) Notify the small employer that the solicitor or solicitor firm  
13 will procure rate and benefit information for the small employer  
14 on any plan contract offered by a plan whose contract the solicitor  
15 sells.

16 (C) Notify the small employer that upon request the solicitor or  
17 solicitor firm will provide the small employer with the summary  
18 brochure required under paragraph (1) of subdivision (g) for any  
19 plan contract offered by a plan with which the solicitor or solicitor  
20 firm has contracted to solicit enrollments or subscriptions.

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

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

30 (3) Prior to filing an application for a small employer for a  
31 particular contract:

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

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

4 ~~1357.15.~~

5 *1357.515.* (a) At least 20 business days prior to renewing or  
6 amending a plan contract subject to this article which will be in  
7 force on the operative date of this article, a plan shall file a notice  
8 of material modification with the director in accordance with the  
9 provisions of Section 1352. The notice of material modification  
10 shall include a statement certifying that the plan is in compliance  
11 *with Section ~~1357.12~~ 1357.512.* Any action by the director, as  
12 permitted under Section 1352, to disapprove, suspend, or postpone  
13 the plan’s use of a plan contract shall be in writing, specifying the  
14 reasons that the plan contract does not comply with the  
15 requirements of this chapter.

16 (b) At least 20 business days prior to offering a plan contract  
17 subject to this article, all plans shall file a notice of material  
18 modification with the director in accordance with the provisions  
19 of Section 1352. The notice of material modification shall include  
20 a statement certifying that the plan is in compliance with Section  
21 ~~1357.12~~ *1357.512.* Plans that will be offering to a small employer  
22 plan contracts approved by the director prior to the effective date  
23 of this article shall file a notice of material modification in  
24 accordance with this subdivision. Any action by the director, as  
25 permitted under Section 1352, to disapprove, suspend, or postpone  
26 the plan’s use of a plan contract shall be in writing, specifying the  
27 reasons that the plan contract does not comply with the  
28 requirements of this chapter.

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

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

35 ~~1357.16.~~

36 *1357.516.* (a) Health care service plans may enter into  
37 contractual agreements with qualified associations, as defined in  
38 subdivision (b), under which these qualified associations may  
39 assume responsibility for performing specific administrative  
40 services, as defined in this section, for qualified association

1 members. Health care service plans that enter into agreements with  
2 qualified associations for assumption of administrative services  
3 shall establish uniform definitions for the administrative services  
4 that may be provided by a qualified association or its third-party  
5 administrator. The health care service plan shall permit all qualified  
6 associations to assume one or more of these functions when the  
7 health care service plan determines the qualified association  
8 demonstrates the administrative capacity to assume these functions.

9 For the purposes of this section, administrative services provided  
10 by qualified associations or their third-party administrators shall  
11 be services pertaining to eligibility determination, enrollment,  
12 premium collection, sales, or claims administration on a per-claim  
13 basis that would otherwise be provided directly by the health care  
14 service plan or through a third-party administrator on a commission  
15 basis or an agent or solicitor workforce on a commission basis.  
16 Each health care service plan that enters into an agreement with  
17 any qualified association for the provision of administrative  
18 services shall offer all qualified associations with which it contracts  
19 the same premium discounts for performing those services the  
20 health care service plan has permitted the qualified association or  
21 its third-party administrator to assume. The health care service  
22 plan shall report to the department its schedule of discounts for  
23 each administrative service.

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

36 (b) For the purposes of this section, a qualified association is a  
37 nonprofit corporation comprised of a group of individuals or  
38 employers who associate based solely on participation in a  
39 specified profession or industry that conforms to all of the  
40 following requirements:

- 1 (1) It accepts for membership any individual or small employer
- 2 meeting its membership criteria.
- 3 (2) It does not condition membership directly or indirectly on
- 4 the health or claims history of any person.
- 5 (3) It uses membership dues solely for and in consideration of
- 6 the membership and membership benefits, except that the amount
- 7 of the dues shall not depend on whether the member applies for
- 8 or purchases insurance offered by the association.
- 9 (4) It is organized and maintained in good faith for purposes
- 10 unrelated to insurance.
- 11 (5) It existed on January 1, 1972, and has been in continuous
- 12 existence since that date.
- 13 (6) It has a constitution and bylaws or other analogous governing
- 14 documents that provide for election of the governing board of the
- 15 association by its members.
- 16 (7) It offered, marketed, or sold health coverage to its members
- 17 for 20 continuous years prior to January 1, 1993.
- 18 (8) It agrees to offer only to association members any plan
- 19 contract.
- 20 (9) It agrees to include any member choosing to enroll in the
- 21 plan contract offered by the association, provided that the member
- 22 agrees to make required premium payments.
- 23 (10) It complies with all provisions of this article.
- 24 (11) It had at least 10,000 enrollees covered by association
- 25 sponsored plans immediately prior to enactment of Chapter 1128
- 26 of the Statutes of 1992.
- 27 (12) It applies any administrative cost at an equal rate to all
- 28 members purchasing coverage through the qualified association.
- 29 (c) A qualified association shall comply with Section 1357.52.
- 30 ~~SEC. 3. Section 1357.01 of the Health and Safety Code is~~
- 31 ~~amended to read:~~
- 32 ~~1357.01. Every health care service plan offering plan contracts~~
- 33 ~~to small employer groups shall in addition to complying with the~~
- 34 ~~provisions of this chapter and the rules adopted thereunder comply~~
- 35 ~~with the provisions of this article. This article shall only apply with~~
- 36 ~~respect to plan years commencing prior to January 1, 2014. For~~
- 37 ~~purposes of this section, "plan year" has the meaning provided in~~
- 38 ~~Section 144.03 of Title 45 of the Code of Federal Regulations.~~
- 39 ~~SEC. 4. Section 1357.19 is added to the Health and Safety~~
- 40 ~~Code, to read:~~

1 ~~1357.19. This article shall remain in effect only until January~~  
2 ~~1, 2014, and as of that date is repealed, unless a later enacted~~  
3 ~~statute, that is enacted before January 1, 2014, deletes or extends~~  
4 ~~that date.~~

5 ~~SEC. 5.~~

6 *SEC. 4.* Article 3.15 (commencing with Section 1357.50) is  
7 added to Chapter 2.2 of Division 2 of the Health and Safety Code,  
8 to read:

9  
10 Article 3.15. Preexisting Condition Provisions

11  
12 1357.50. (a) For purposes of this article, the following  
13 definitions shall apply:

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

27 (2) “Preexisting condition provision” means a contract provision  
28 that excludes coverage for charges or expenses incurred during a  
29 specified period following the enrollee’s effective date of coverage,  
30 as to a condition for which medical advice, diagnosis, care, or  
31 treatment was recommended or received during a specified period  
32 immediately preceding the effective date of coverage.

33 (3) “Creditable coverage” means:

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

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

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

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

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

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

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

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

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

30 (J) 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 (4) "Waivered condition *provision*" means a contract provision  
34 that excludes coverage for charges or expenses incurred during a  
35 specified period of time for one or more specific, identified,  
36 medical conditions.

37 (5) "Affiliation period" means a period that, under the terms of  
38 the health benefit plan, must expire before health care services  
39 under the plan become effective.

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

4 (7) “Grandfathered health benefit plan” means a health benefit  
5 plan that is a grandfathered health plan, as defined in Section 1251  
6 of PPACA.

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

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

15 1357.51. (a) A nongrandfathered health benefit plan for group  
16 or individual coverage or a grandfathered health benefit plan for  
17 group coverage shall not impose any preexisting condition or  
18 waived condition upon any enrollee.

19 (b) A grandfathered health benefit plan for individual coverage  
20 shall not exclude coverage on the basis of a waived condition  
21 *provision* or preexisting condition provision for a period greater  
22 than 12 months following the enrollee’s effective date of coverage,  
23 nor limit or exclude coverage for a specific enrollee by type of  
24 illness, treatment, medical condition, or accident, except for  
25 satisfaction of a preexisting condition clause *or waived condition*  
26 *provision* pursuant to this article. ~~Waived-conditions condition~~  
27 *provisions* or preexisting condition provisions contained in  
28 individual grandfathered health benefit plans may relate only to  
29 conditions for which medical advice, diagnosis, care, or treatment,  
30 including use of prescription drugs, was recommended or received  
31 from a licensed health practitioner during the 12 months  
32 immediately preceding the effective date of coverage.

33 (c) (1) A health benefit plan for group coverage may apply a  
34 waiting period of up to 60 days as a condition of employment if  
35 applied equally to all eligible employees and dependents and if  
36 consistent with PPACA. A health benefit plan for group coverage  
37 through a health maintenance organization, as defined in Section  
38 2791 of the federal Public Health Service Act, shall not impose  
39 any affiliation period that exceeds 60 days. A waiting or affiliation  
40 period shall not be based on a preexisting condition of an employee

1 or dependent, the health status of an employee or dependent, or  
 2 any other factor listed in Section 1357.52. An affiliation period  
 3 shall run concurrently with a waiting period. During the waiting  
 4 or affiliation period, the plan is not required to provide health care  
 5 services and no premium shall be charged to the subscriber or  
 6 enrollees.

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

9 (d) In determining whether a preexisting condition provision,  
 10 a waived condition *provision*, or a waiting or affiliation period  
 11 applies to an enrollee, a plan shall credit the time the enrollee was  
 12 covered under creditable coverage, provided that the enrollee  
 13 becomes eligible for coverage under the succeeding plan contract  
 14 within 62 days of termination of prior coverage, exclusive of any  
 15 waiting or affiliation period, and applies for coverage under the  
 16 succeeding plan within the applicable enrollment period. A plan  
 17 shall also credit any time that an eligible employee must wait  
 18 before enrolling in the plan, including any postenrollment or  
 19 employer-imposed waiting or affiliation period.

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

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

32 1357.52. A health benefit plan for group coverage shall not  
 33 establish rules for eligibility, including continued eligibility, of an  
 34 individual, or dependent of an individual, to enroll under the terms  
 35 of the plan based on any of the following health status-related  
 36 factors:

- 37 (a) Health status.
- 38 (b) Medical condition, including physical and mental illnesses.
- 39 (c) Claims experience.
- 40 (d) Receipt of health care.

- 1 (e) Medical history.
- 2 (f) Genetic information.
- 3 (g) Evidence of insurability, including conditions arising out of
- 4 acts of domestic violence.
- 5 (h) Disability.
- 6 (i) Any other health status-related factor as determined by any
- 7 federal regulations, rules, or guidance issued pursuant to Section
- 8 2705 of the Public Health Service Act.

9 1357.55. This article shall become operative on January 1,

10 2014.

11 ~~SEC. 6.~~

12 *SEC. 5.* Section 1357.55 is added to the Health and Safety

13 Code, to read:

14 1357.55. This article shall remain in effect only until January

15 1, 2014, and as of that date is repealed, unless a later enacted

16 statute, that is enacted before January 1, 2014, deletes or extends

17 that date.

18 ~~SEC. 7.~~

19 *SEC. 6.* Article 3.17 (commencing with Section 1357.600) is

20 added to Chapter 2.2 of Division 2 of the Health and Safety Code,

21 to read:

22

23 Article 3.17. Grandfathered Small Employer Plans

24

25 1357.600. As used in this article, the following definitions shall

26 apply:

27 (a) “Dependent” means the spouse *or registered domestic*

28 *partner*, or child, of an eligible employee, subject to applicable

29 terms of the health care service plan contract covering the

30 employee, and includes dependents of guaranteed association

31 members if the association elects to include dependents under its

32 health coverage at the same time it determines its membership

33 composition pursuant to subdivision (n).

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

35 (1) Any permanent employee who is actively engaged on a

36 full-time basis in the conduct of the business of the small employer

37 with a normal workweek of an average of 30 hours per week over

38 the course of a month, at the small employer’s regular places of

39 business, who has met any statutorily authorized applicable waiting

40 period requirements. The term includes sole proprietors or partners

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

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

15 (B) The employer offers the employees health coverage under  
16 a health benefit plan.

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

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

25 (2) Any member of a guaranteed association as defined in  
26 subdivision (n).

27 (c) "In force business" means an existing health benefit plan  
28 contract issued by the plan to a small employer.

29 (d) "Late enrollee" means an eligible employee or dependent  
30 who has declined enrollment in a health benefit plan offered by a  
31 small employer at the time of the initial enrollment period provided  
32 under the terms of the health benefit plan and who subsequently  
33 requests enrollment in a health benefit plan of that small employer,  
34 provided that the initial enrollment period shall be a period of at  
35 least 30 days. It also means any member of an association that is  
36 a guaranteed association as well as any other person eligible to  
37 purchase through the guaranteed association when that person has  
38 failed to purchase coverage during the initial enrollment period  
39 provided under the terms of the guaranteed association's plan  
40 contract and who subsequently requests enrollment in the plan,

1 provided that the initial enrollment period shall be a period of at  
2 least 30 days. However, an eligible employee, any other person  
3 eligible for coverage through a guaranteed association pursuant to  
4 subdivision (n), or an eligible dependent shall not be considered  
5 a late enrollee if any of the following is applicable:

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

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

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

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

35 (D) He or she requests enrollment within 30 days after  
36 termination of coverage or employer contribution toward coverage  
37 provided under another employer health benefit plan, or requests  
38 enrollment within 60 days after termination of Medi-Cal program  
39 coverage, AIM Program coverage, Healthy Families Program

1 coverage, or coverage through the California Health Benefit  
2 Exchange.

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

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

7 (4) (A) In the case of an eligible employee, as defined in  
8 paragraph (1) of subdivision (b), the plan cannot produce a written  
9 statement from the employer stating that the individual or the  
10 person through whom the individual was eligible to be covered as  
11 a dependent, prior to declining coverage, was provided with, and  
12 signed, acknowledgment of an explicit written notice in boldface  
13 type specifying that failure to elect coverage during the initial  
14 enrollment period permits the plan to impose, at the time of the  
15 individual's later decision to elect coverage, a waiting period of  
16 no longer than 60 days, unless the individual meets the criteria  
17 specified in paragraph (1), (2), or (3).

18 (B) In the case of an association member who did not purchase  
19 coverage through a guaranteed association, the plan cannot produce  
20 a written statement from the association stating that the association  
21 sent a written notice in boldface type to all potentially eligible  
22 association members at their last known address prior to the initial  
23 enrollment period informing members that failure to elect coverage  
24 during the initial enrollment period permits the plan to impose, at  
25 the time of the member's later decision to elect coverage, a waiting  
26 period of no longer than 60 days, unless the individual meets the  
27 requirements of subparagraphs (A), (C), and (D) of paragraph (1)  
28 or meets the requirements of paragraph (2) or (3).

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

39 (5) The individual is an employee or dependent who meets the  
40 criteria described in paragraph (1) and was under a COBRA

1 continuation provision and the coverage under that provision has  
2 been exhausted. For purposes of this section, the definition of  
3 “COBRA” set forth in subdivision (e) of Section 1373.621 shall  
4 apply.

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

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

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

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

6 (e) “Preexisting condition provision” means a contract provision  
7 that excludes coverage for charges or expenses incurred during a  
8 specified period following the enrollee’s effective date of coverage,  
9 as to a condition for which medical advice, diagnosis, care, or  
10 treatment was recommended or received during a specified period  
11 immediately preceding the effective date of coverage. No health  
12 care service plan shall limit or exclude coverage for any individual  
13 based on a preexisting condition whether or not any medical advice,  
14 diagnosis, care, or treatment was recommended or received before  
15 that date.

16 (f) “Creditable coverage” means:

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

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

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

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

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

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

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

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

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

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

15 (g) “Rating period” means the period for which premium rates  
16 established by a plan are in effect and shall be no less than 12  
17 months from the date of issuance or renewal of the health care  
18 service plan contract.

19 (h) “Risk adjusted employee risk rate” means the rate determined  
20 for an eligible employee of a small employer in a particular risk  
21 category after applying the risk adjustment factor.

22 (i) “Risk adjustment factor” means the percentage adjustment  
23 to be applied equally to each standard employee risk rate for a  
24 particular small employer, based upon any expected deviations  
25 from standard cost of services. This factor may not be more than  
26 110 percent or less than 90 percent.

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

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

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

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

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

9 (A) Single.

10 (B) Married couple *or registered domestic partners*.

11 (C) One adult and child or children.

12 (D) Married couple *or registered domestic partners* and child  
13 or children.

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

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

1 (ii) If the formula in clause (i) results in a plan that operates in  
2 more than one county having only one geographic region, then the  
3 formula in clause (i) shall not apply and the plan may have two  
4 geographic regions, provided that no county is divided into more  
5 than one region.

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

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

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

1 date the employer no longer meets the requirements of this  
2 definition. It includes any small employer as defined in this  
3 subparagraph who purchases coverage through a guaranteed  
4 association, and any employer purchasing coverage for employees  
5 through a guaranteed association. This subparagraph shall be  
6 implemented to the extent consistent with PPACA, except that the  
7 minimum requirement of one employee shall be implemented only  
8 to the extent required by PPACA.

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

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

16 (l) “Standard employee risk rate” means the rate applicable to  
17 an eligible employee in a particular risk category in a small  
18 employer group.

19 (m) “Guaranteed association” means a nonprofit organization  
20 comprised of a group of individuals or employers who associate  
21 based solely on participation in a specified profession or industry,  
22 accepting for membership any individual or employer meeting its  
23 membership criteria, and that (1) includes one or more small  
24 employers as defined in subparagraph (A) of paragraph (1) of  
25 subdivision (k), (2) does not condition membership directly or  
26 indirectly on the health or claims history of any person, (3) uses  
27 membership dues solely for and in consideration of the membership  
28 and membership benefits, except that the amount of the dues shall  
29 not depend on whether the member applies for or purchases  
30 insurance offered to the association, (4) is organized and  
31 maintained in good faith for purposes unrelated to insurance, (5)  
32 has been in active existence on January 1, 1992, and for at least  
33 five years prior to that date, (6) has included health insurance as  
34 a membership benefit for at least five years prior to January 1,  
35 1992, (7) has a constitution and bylaws, or other analogous  
36 governing documents that provide for election of the governing  
37 board of the association by its members, (8) offers any plan contract  
38 that is purchased to all individual members and employer members  
39 in this state, (9) includes any member choosing to enroll in the  
40 plan contracts offered to the association provided that the member

1 has agreed to make the required premium payments, and (10)  
2 covers at least 1,000 persons with the health care service plan with  
3 which it contracts. The requirement of 1,000 persons may be met  
4 if component chapters of a statewide association contracting  
5 separately with the same carrier cover at least 1,000 persons in the  
6 aggregate.

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

10 For purposes of this subdivision, an association formed by a  
11 merger of two or more associations after January 1, 1992, and  
12 otherwise meeting the criteria of this subdivision shall be deemed  
13 to have been in active existence on January 1, 1992, if its  
14 predecessor organizations had been in active existence on January  
15 1, 1992, and for at least five years prior to that date and otherwise  
16 met the criteria of this subdivision.

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

29 (o) “Affiliation period” means a period that, under the terms of  
30 the health care service plan contract, must expire before health  
31 care services under the contract become effective.

32 (p) “Grandfathered small employer health care service plan  
33 contract” means a small employer health care service plan contract  
34 that constitutes a grandfathered health plan.

35 (q) “Grandfathered health plan” has the meaning set forth in  
36 Section 1251 of PPACA.

37 (r) “Nongrandfathered small employer health care service plan  
38 contract” means a small employer health care service plan contract  
39 that is not a grandfathered health plan.

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

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

8 (u) “Registered domestic partner” means a person who has  
9 established a domestic partnership as described in Section 297 of  
10 the Family Code.

11 (v)  
12 (v) “Small employer health care service plan contract” means  
13 a health care service plan contract issued to a small employer.

14 (w)  
15 (w) “Waiting period” means a period that is required to pass  
16 with respect to an employee before the employee is eligible to be  
17 covered for benefits under the terms of the contract.

18 1357.601. This article shall apply only to grandfathered small  
19 group health care service plan contracts and only with respect to  
20 plan years commencing on or after January 1, 2014.

21 1357.602. (a) A health care service plan providing or arranging  
22 for the provision of basic health care services to small employers  
23 shall be subject to this article if either of the following conditions  
24 are met:

25 (1) Any portion of the premium is paid by a small employer, or  
26 any covered individual is reimbursed, whether through wage  
27 adjustments or otherwise, by a small employer for any portion of  
28 the premium.

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

32 (b) This article shall not apply to health care service plan  
33 contracts for coverage of Medicare services pursuant to contracts  
34 with the United States government, Medicare supplement,  
35 Medi-Cal contracts with the State Department of Health Care  
36 Services, long-term care coverage, or specialized health care  
37 service plan contracts.

38 1357.603. Nothing in this article shall be construed to preclude  
39 the application of this chapter to either of the following:

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

3 (b) An association, trust, or other organization or person  
4 presenting information regarding a health care service plan to  
5 persons who may be interested in subscribing or enrolling in the  
6 plan.

7 1357.604. (a) (1) A plan shall fairly and affirmatively renew  
8 a grandfathered health plan contract with a small employer.

9 (2) Each plan shall make available to each small employer all  
10 nongrandfathered small employer health care service plan contracts  
11 that the plan offers and sells to small employers or to associations  
12 that include small employers in this state consistent with Article  
13 3.1 (commencing with Section 1357).

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

19 (b) Every plan shall file with the director the reasonable  
20 employee participation requirements and employer contribution  
21 requirements that will be applied in renewing its grandfathered  
22 health care service plan contracts. Participation requirements shall  
23 be applied uniformly among all small employer groups, except  
24 that a plan may vary application of minimum employee  
25 participation requirements by the size of the small employer group  
26 and whether the employer contributes 100 percent of the eligible  
27 employee’s premium. Employer contribution requirements shall  
28 not vary by employer size. A health care service plan shall not  
29 establish a participation requirement that (1) requires a person who  
30 meets the definition of a dependent in subdivision (a) of Section  
31 1357.600 to enroll as a dependent if he or she is otherwise eligible  
32 for coverage and wishes to enroll as an eligible employee and (2)  
33 allows a plan to reject an otherwise eligible small employer because  
34 of the number of persons that waive coverage due to coverage  
35 through another employer. Members of an association eligible for  
36 health coverage under subdivision (n) of Section 1357.600, but  
37 not electing any health coverage through the association, shall not  
38 be counted as eligible employees for purposes of determining  
39 whether the guaranteed association meets a plan’s reasonable  
40 participation standards.

- 1 (c) No plan or solicitor shall, directly or indirectly, engage in
- 2 the following activities:
- 3 (1) Encourage or direct small employers to refrain from filing
- 4 an application for coverage or renewal of coverage with a plan
- 5 because of the health status, claims experience, industry,
- 6 occupation of the small employer, or geographic location provided
- 7 that it is within the plan’s approved service area.
- 8 (2) Encourage or direct small employers to seek coverage from
- 9 another plan, or coverage offered through the California Health
- 10 Benefit Exchange, because of the health status, claims experience,
- 11 industry, occupation of the small employer, or geographic location
- 12 provided that it is within the plan’s approved service area.
- 13 (d) A plan shall not, directly or indirectly, enter into any
- 14 contract, agreement, or arrangement with a solicitor that provides
- 15 for or results in the compensation paid to a solicitor for the sale of
- 16 a health care service plan contract to be varied because of the health
- 17 status, claims experience, industry, occupation, or geographic
- 18 location of the small employer. This subdivision does not apply
- 19 to a compensation arrangement that provides compensation to a
- 20 solicitor on the basis of percentage of premium, provided that the
- 21 percentage shall not vary because of the health status, claims
- 22 experience, industry, occupation, or geographic area of the small
- 23 employer or small employer’s employees.
- 24 (e) A policy or contract that covers a small employer, as defined
- 25 in Section 1304(b) of PPACA and in subdivision (k) of Section
- 26 1357.600 shall not establish rules for eligibility, including
- 27 continued eligibility, of an individual, or dependent of an
- 28 individual, to enroll under the terms of the plan based on any of
- 29 the following health status-related factors:
- 30 (1) Health status.
- 31 (2) Medical condition, including physical and mental illnesses.
- 32 (3) Claims experience.
- 33 (4) Receipt of health care.
- 34 (5) Medical history.
- 35 (6) Genetic information.
- 36 (7) Evidence of insurability, including conditions arising out of
- 37 acts of domestic violence.
- 38 (8) Disability.

1 (9) Any other health status-related factor as determined by any  
2 federal regulations, rules, or guidance issued pursuant to Section  
3 2705 of the federal Public Health Service Act.

4 (f) A plan shall comply with the requirements of Section 1374.3.

5 1357.606. (a) For plan contracts expiring after July 1, 1994,  
6 60 days prior to July 1, 1994, an association that meets the  
7 definition of a guaranteed association, as set forth in Section  
8 1357.600, except for the requirement that 1,000 persons be covered,  
9 shall be entitled to renew grandfathered small employer health  
10 care service plan contracts as if the association were a guaranteed  
11 association, except that the coverage shall be guaranteed only for  
12 those members of an association, as defined in Section 1357.600,  
13 (1) who were receiving coverage or had successfully applied for  
14 coverage through the association as of June 30, 1993, (2) who were  
15 receiving coverage through the association as of December 31,  
16 1992, and whose coverage lapsed at any time thereafter because  
17 the employment through which coverage was received ended or  
18 an employer's contribution to health coverage ended, or (3) who  
19 were covered at any time between June 30, 1993, and July 1, 1994,  
20 under a contract that was in force on June 30, 1993.

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

25 1357.607. (a) A small employer health care service plan  
26 contract shall not impose a preexisting condition provision upon  
27 any individual.

28 (b) A plan contract may apply a waiting period of up to 60 days  
29 as a condition of employment if applied equally to all eligible  
30 employees and dependents and if consistent with PPACA. A plan  
31 contract through a health maintenance organization, as defined in  
32 Section 2791 of the federal Public Health Service Act, may impose  
33 an affiliation period not to exceed 60 days. A waiting or affiliation  
34 period shall not be based on a preexisting condition of an employee  
35 or dependent, the health status of an employee or dependent, or  
36 any other factor listed in subdivision (e) of Section 1357.604. An  
37 affiliation period shall run concurrently with a waiting period.  
38 During the waiting or affiliation period, the plan is not required to  
39 provide health care services and no premium shall be charged to  
40 the subscriber or enrollees.

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

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

24 1357.608. Nothing in this article shall be construed as  
 25 prohibiting a health care service plan from restricting enrollment  
 26 of late enrollees to open enrollment periods consistent with federal  
 27 law. ~~No premium shall be charged to the late enrollee until the~~  
 28 ~~exclusion period has ended.~~

29 1357.609. All grandfathered small employer health care service  
 30 plan contracts shall provide to subscribers and enrollees at least  
 31 all of the basic health care services included in subdivision (b) of  
 32 Section 1345, and in Section 1300.67 of the California Code of  
 33 Regulations.

34 1357.610. (a) No plan shall be required by the provisions of  
 35 this article:

36 (1) ~~To include in a small employer health care service plan~~  
 37 ~~contract offer coverage under a small employer’s health care~~  
 38 ~~service plan contract to an otherwise eligible employee or~~  
 39 dependent, when the eligible employee or dependent does not work  
 40 or reside within *the* plan’s approved service area, except as

1 provided in ~~Section~~ Chapter 7 (commencing with Section 3750)  
2 of Part 1 of Division 9 of the Family Code.

3 (2) ~~To include in a small employer health care service plan~~  
4 ~~contract offer coverage under a small employer's health care~~  
5 ~~service plan contract to an eligible employee, as defined in~~  
6 paragraph (2) of subdivision (b) of Section 1357.600, who within  
7 12 months of application for coverage terminated from a small  
8 employer health care service plan contract offered by the plan.

9 (b) Nothing in this article shall be construed to limit the  
10 director's authority to develop and implement a plan of  
11 rehabilitation for a health care service plan whose financial viability  
12 or organizational and administrative capacity has become impaired.

13 1357.611. (a) The director may require a plan to discontinue  
14 the renewal of grandfathered small employer health care service  
15 plan contracts or the offering or acceptance of applications from  
16 any group upon a determination by the director that the plan does  
17 not have sufficient financial viability, or organizational and  
18 administrative capacity to ensure the delivery of health care  
19 services to its enrollees. In determining whether the conditions of  
20 this section have been met, the director shall consider, but not be  
21 limited to, the plan's compliance with the requirements of Section  
22 1367, Article 6 (commencing with Section 1375), and the rules  
23 adopted thereunder.

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

28 1357.612. Premiums for grandfathered contracts renewed by  
29 plans on or after January 1, 2014, shall be subject to the following  
30 requirements:

31 (a) (1) The premium for in force business shall be determined  
32 for an eligible employee in a particular risk category after applying  
33 a risk adjustment factor to the plan's standard employee risk rates.  
34 The risk adjusted employee risk rates may not be more than 110  
35 percent or less than 90 percent. The risk adjustment factor applied  
36 to a small employer may not increase by more than 10 percentage  
37 points from the risk adjustment factor applied in the prior rating  
38 period. The risk adjustment factor for a small employer may not  
39 be modified more frequently than every 12 months.

1 (2) The premium charged a small employer for in force business  
 2 shall be equal to the sum of the risk adjusted employee risk rates.  
 3 The standard employee risk rates shall be in effect for no less than  
 4 12 months.

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

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

28 1357.613. Plans shall apply standard employee risk rates  
 29 consistently with respect to all small employers.

30 1357.614. In connection with the renewal of a grandfathered  
 31 small employer health care service plan contract, each plan shall  
 32 make a reasonable disclosure, as part of its solicitation and sales  
 33 materials, of the following:

34 (a) The extent to which premium rates for a specified small  
 35 employer are established or adjusted in part based upon the actual  
 36 or expected variation in service costs ~~or actual or expected variation~~  
 37 ~~in health condition~~ of the employees and dependents of the small  
 38 employer.

1 (b) The provisions concerning the plan’s right to change  
2 premium rates and the factors other than provision of services  
3 experience that affect changes in premium rates.

4 (c) Provisions relating to the guaranteed issue and renewal of  
5 contracts.

6 (d) Provisions relating to the effect of any waiting or affiliation  
7 provision.

8 (e) Provisions relating to the small employer’s right to apply  
9 for any nongrandfathered small employer health care service plan  
10 contract written, issued, or administered by the plan at the time of  
11 application for a new health care service plan contract, or at the  
12 time of renewal of a health care service plan contract, consistent  
13 with the requirements of PPACA.

14 (f) The availability, upon request, of a listing of all the plan’s  
15 nongrandfathered small employer health care service plan contracts  
16 and benefit plan designs offered, both inside and outside the  
17 California Health Benefit Exchange, including the rates for each  
18 contract.

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

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

29 (1) Prepare a brochure that summarizes all of its small employer  
30 health care service plan contracts and to make this summary  
31 available to any small employer and to solicitors upon request.  
32 The summary shall include for each contract information on  
33 benefits provided, a generic description of the manner in which  
34 services are provided, such as how access to providers is limited,  
35 benefit limitations, required copayments and deductibles, standard  
36 employee risk rates, an explanation of the manner in which  
37 creditable coverage is calculated if a waiting or affiliation period  
38 is imposed, and a phone number that can be called for more  
39 detailed benefit information. Plans are required to keep the  
40 information contained in the brochure accurate and up to date and,

1 upon updating the brochure, send copies to solicitors and solicitor  
2 firms with which the plan contracts to solicit enrollments or  
3 subscriptions.

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

9 (3) Provide to small employers and solicitors, upon request, for  
10 any given small employer the sum of the standard employee risk  
11 rates and the sum of the risk adjusted employee risk rates. When  
12 requesting this information, small employers, solicitors, and  
13 solicitor firms shall provide the plan with the information the plan  
14 needs to determine the small employer's risk adjusted employee  
15 risk rate.

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

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

22 1357.615. (a) At least 20 business days prior to renewing or  
23 amending a small employer health care service plan contract subject  
24 to this article, a plan shall file a notice of material modification  
25 with the director in accordance with the provisions of Section  
26 1352. The notice of material modification shall include a statement  
27 certifying that the plan is in compliance with subdivision (i) of  
28 Section 1357.600 and Section 1357.612. The certified statement  
29 shall set forth the standard employee risk rate for each risk category  
30 and the highest and lowest risk adjustment factors that will be used  
31 in setting the rates at which the contract will be renewed or  
32 amended. Any action by the director, as permitted under Section  
33 1352, to disapprove, suspend, or postpone the plan's use of a plan  
34 contract shall be in writing, specifying the reasons that the plan  
35 contract does not comply with the requirements of this chapter.

36 (b) Prior to making any changes in the risk categories, risk  
37 adjustment factors or standard employee risk rates filed with the  
38 director pursuant to subdivision (a), the plan shall file as an  
39 amendment a statement setting forth the changes and certifying  
40 that the plan is in compliance with subdivision (i) of Section

1 1357.600 and Section 1357.612. A plan may commence utilizing  
2 the changed risk categories set forth in the certified statement on  
3 the 31st day from the date of the filing, or at an earlier time  
4 determined by the director, unless the director disapproves the  
5 amendment by written notice, stating the reasons therefor. If only  
6 the standard employee risk rate is being changed, and not the risk  
7 categories or risk adjustment factors, a plan may commence  
8 utilizing the changed standard employee risk rate upon filing the  
9 certified statement unless the director disapproves the amendment  
10 by written notice.

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

15 (d) Each plan shall maintain at its principal place of business  
16 all of the information required to be filed with the director pursuant  
17 to this section.

18 (e) Each plan shall make available to the director, on request,  
19 the risk adjustment factor used in determining the rate for any  
20 particular small employer.

21 (f) Nothing in this section shall be construed to limit the  
22 director's authority to enforce the rating practices set forth in this  
23 article.

24 1357.616. (a) Health care service plans may enter into  
25 contractual agreements with qualified associations, as defined in  
26 subdivision (b), under which these qualified associations may  
27 assume responsibility for performing specific administrative  
28 services, as defined in this section, for qualified association  
29 members. Health care service plans that enter into agreements with  
30 qualified associations for assumption of administrative services  
31 shall establish uniform definitions for the administrative services  
32 that may be provided by a qualified association or its third-party  
33 administrator. The health care service plan shall permit all qualified  
34 associations to assume one or more of these functions when the  
35 health care service plan determines the qualified association  
36 demonstrates the administrative capacity to assume these functions.

37 For the purposes of this section, administrative services provided  
38 by qualified associations or their third-party administrators shall  
39 be services pertaining to eligibility determination, enrollment,  
40 premium collection, sales, or claims administration on a per-claim

1 basis that would otherwise be provided directly by the health care  
2 service plan or through a third-party administrator on a commission  
3 basis or an agent or solicitor workforce on a commission basis.

4 Each health care service plan that enters into an agreement with  
5 any qualified association for the provision of administrative  
6 services shall offer all qualified associations with which it contracts  
7 the same premium discounts for performing those services the  
8 health care service plan has permitted the qualified association or  
9 its third-party administrator to assume. The health care service  
10 plan shall apply these uniform discounts to the health care service  
11 plan's risk adjusted employee risk rates after the health plan has  
12 determined the qualified association's risk adjusted employee risk  
13 rates pursuant to Section 1357.612. The health care service plan  
14 shall report to the department its schedule of discounts for each  
15 administrative service.

16 In no instance may a health care service plan provide discounts  
17 to qualified associations that are in any way intended to, or  
18 materially result in, a reduction in premium charges to the qualified  
19 association due to the health status of the membership of the  
20 qualified association. In addition to any other remedies available  
21 to the director to enforce this chapter, the director may declare a  
22 contract between a health care service plan and a qualified  
23 association for administrative services pursuant to this section null  
24 and void if the director determines any discounts provided to the  
25 qualified association are intended to, or materially result in, a  
26 reduction in premium charges to the qualified association due to  
27 the health status of the membership of the qualified association.

28 (b) For the purposes of this section, a qualified association is a  
29 nonprofit corporation comprised of a group of individuals or  
30 employers who associate based solely on participation in a  
31 specified profession or industry, that conforms to all of the  
32 following requirements:

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

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

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

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

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

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

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

10 (8) It agrees to offer only to association members any plan  
11 contract.

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

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

16 (11) It had at least 10,000 enrollees covered by association  
17 sponsored plans immediately prior to enactment of Chapter 1128  
18 of the Statutes of 1992.

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

21 (c) A qualified association shall comply with Section 1357.52.  
22 ~~1357.617. (a) On or before October 1, 2013, and annually~~  
23 ~~thereafter, a health care service plan shall issue the following notice~~  
24 ~~to all individual subscribers enrolled in a grandfathered small~~  
25 ~~employer health care service plan contract:~~

26  
27 ~~“Beginning on and after January 1, 2014, new improved health~~  
28 ~~insurance options are available in California. You currently have~~  
29 ~~health insurance that is exempt from many of the new requirements.~~  
30 ~~You have the option to remain in your current plan or switch to a~~  
31 ~~new plan. Under the new rules, a health insurance company cannot~~  
32 ~~deny your application based on any health conditions you may~~  
33 ~~have. For more information about your options, please contact the~~  
34 ~~California Health Benefit Exchange, the Office of Patient~~  
35 ~~Advocate, your plan or policy representative, an insurance broker,~~  
36 ~~or a health care navigator.”~~

37  
38 ~~(b) A health care service plan shall include the notice described~~  
39 ~~in subdivision (a) in any marketing material of the grandfathered~~  
40 ~~small employer health care service plan contract.~~

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

7 (b)

8 1357.618. (a) The department shall may adopt emergency  
9 regulations implementing this article no later than August 31, 2013.  
10 The department may readopt any emergency regulation authorized  
11 by this section that is the same as or substantially equivalent to an  
12 emergency regulation previously adopted under this section.

13 (c)

14 (b) The initial adoption of emergency regulations implementing  
15 this section and the one readoption of emergency regulations  
16 authorized by this section shall be deemed an emergency and  
17 necessary for the immediate preservation of the public peace,  
18 health, safety, or general welfare. Initial emergency regulations  
19 and the one readoption of emergency regulations authorized by  
20 this section shall be exempt from review by the Office of  
21 Administrative Law. The initial emergency regulations and the  
22 one readoption of emergency regulations authorized by this section  
23 shall be submitted to the Office of Administrative Law for filing  
24 with the Secretary of State and each shall remain in effect for no  
25 more than 180 days, by which time final regulations may be  
26 adopted.

27 ~~SEC. 8.~~

28 SEC. 7. Section 1385.01 of the Health and Safety Code is  
29 amended to read:

30 1385.01. For purposes of this article, the following definitions  
31 shall apply:

32 (a) “Large group health care service plan contract” means a  
33 group health care service plan contract other than a contract issued  
34 to a small employer, as defined in Section 1357, 1357.500, or  
35 1357.600.

36 (b) “Small group health care service plan contract” means a  
37 group health care service plan contract issued to a small employer,  
38 as defined in Section 1357, 1357.500, or 1357.600.

39 (c) “PPACA” means Section 2794 of the federal Public Health  
40 Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal

1 Patient Protection and Affordable Care Act (Public Law ~~111-48~~)  
2 (~~111-148~~)), and any subsequent rules, regulations, or guidance  
3 issued under that section.

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

6 ~~SEC. 9. Section 1389.1 of the Health and Safety Code is~~  
7 ~~amended to read:~~

8 ~~1389.1. (a) The director shall not approve any plan contract~~  
9 ~~unless the director finds that the application conforms to the~~  
10 ~~following requirements, as applicable:~~

11 ~~(1) All applications for coverage, except that which is guaranteed~~  
12 ~~issue, which include health-related questions shall contain clear~~  
13 ~~and unambiguous questions designed to ascertain the health~~  
14 ~~condition or history of the applicant.~~

15 ~~(2) The application questions related to an applicant’s health in~~  
16 ~~applications described in paragraph (1) shall be based on medical~~  
17 ~~information that is reasonable and necessary for medical~~  
18 ~~underwriting purposes. The application shall include a prominently~~  
19 ~~displayed notice that shall read:~~

20  
21 ~~“California law prohibits an HIV test from being required or~~  
22 ~~used by health care service plans as a condition of obtaining~~  
23 ~~coverage.”~~  
24

25 ~~(3) All applications for coverage subject to Article 3.1~~  
26 ~~(commencing with Section 1357) shall comply with paragraph (2)~~  
27 ~~of subdivision (h) of Section 1357.03.~~

28 ~~(b) Nothing in this section shall authorize the director to~~  
29 ~~establish or require a single or standard application form for~~  
30 ~~application questions.~~

31 ~~SEC. 10.~~

32 ~~SEC. 8. Section 1393.6 of the Health and Safety Code is~~  
33 ~~amended to read:~~

34 ~~1393.6. For violations of Article 3.1 (commencing with Section~~  
35 ~~1357), Article 3.15 (commencing with Section 1357.50), Article~~  
36 ~~3.16 (commencing with Section 1357.500), and Article 3.17~~  
37 ~~(commencing with Section 1357.600), the director may, after~~  
38 ~~appropriate notice and opportunity for hearing, by order levy~~  
39 ~~administrative penalties as follows:~~

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

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

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

21 (d) The administrative penalties available to the director pursuant  
 22 to this section are not exclusive, and may be sought and employed  
 23 in any combination with civil, criminal, and other administrative  
 24 remedies deemed advisable by the director to enforce the provisions  
 25 of this chapter.

26 ~~SEC. 11.~~

27 *SEC. 9.* Section 10127.19 is added to the Insurance Code, to  
 28 read:

29 10127.19. Commencing March 1, 2013, and at least annually  
 30 thereafter, every health insurer, not including a health insurer  
 31 offering specialized health insurance policies, shall provide to the  
 32 department, in a form and manner determined by the department  
 33 in consultation with the Department of Managed Health Care, the  
 34 number of covered lives, *by product type*, as of December 31 of  
 35 the prior year, that receive health care coverage under a health  
 36 insurance policy that covers individuals, small groups, ~~groups of~~  
 37 ~~51-100, groups of 101 or more~~ *large groups*, or administrative  
 38 services only business lines. Health insurers shall include the  
 39 unduplicated enrollment data in specific product ~~lines~~ *types* as  
 40 determined by the department, including, but not limited to, HMO,

1 point-of-service, PPO, ~~Medicare excluding Medicare supplement,~~  
 2 ~~grandfathered, and Medi-Cal managed care, and traditional~~  
 3 ~~indemnity non-PPO health insurance.~~ The department shall publicly  
 4 report the data provided by each health insurer pursuant to this  
 5 section, including, but not limited to, posting the data on the  
 6 department’s Internet Web site. The department shall consult with  
 7 the Department of Managed Health Care to ensure that the data  
 8 reported is comparable and consistent, *does not duplicate existing*  
 9 *reporting requirements, and utilizes existing reporting formats.*

10 ~~SEC. 12.~~

11 *SEC. 10.* Section 10181 of the Insurance Code is amended to  
 12 read:

13 10181. For purposes of this article, the following definitions  
 14 shall apply:

15 (a) “Large group health insurance policy” means a group health  
 16 insurance policy other than a policy issued to a small employer,  
 17 as defined in Section 10700, *10753*, or *10755*.

18 (b) “Small group health insurance policy” means a group health  
 19 insurance policy issued to a small employer, as defined in Section  
 20 10700, *10753*, or *10755*.

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

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

28 ~~SEC. 13.~~

29 *SEC. 11.* Article 7 (commencing with Section 10198.6) is added  
 30 to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

31  
 32 Article 7. Preexisting Condition Provisions

33  
 34 10198.6. For purposes of this article, the following definitions  
 35 shall apply:

36 (a) “Health benefit plan” means any group or individual policy  
 37 of health insurance, as defined in Section 106. The term does not  
 38 include coverage of Medicare services pursuant to contracts with  
 39 the United States government, ~~Medicare supplement coverage,~~ or  
 40 coverage ~~consisting solely of~~ *that provides* excepted benefits as

1 described in Sections 2722 and 2791 of the federal Public Health  
 2 Service Act, subject to Section 10198.61.

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

9 (c) “Creditable coverage” means:

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

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

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

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

32 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
 33 (Civilian Health and Medical Program of the Uniformed Services  
 34 (CHAMPUS)).

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

37 (7) A health plan offered under 5 U.S.C. Chapter 89  
 38 (commencing with Section 8901) (Federal Employees Health  
 39 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 of~~  
11 ~~the health benefit plan, must expire before health care services~~  
12 ~~under the plan become effective.~~

13 ~~(e)~~

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

18 ~~(f)~~

19 (e) “Grandfathered health benefit plan” means a health benefit  
20 plan that is a grandfathered health plan, as defined in Section 1251  
21 of PPACA.

22 ~~(g)~~

23 (f) “Nongrandfathered health benefit plan” means a health  
24 benefit plan that is not a grandfathered health plan as defined in  
25 Section 1251 of PPACA.

26 ~~(h)~~

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

32 10198.61. (a) For purposes of this article, “health benefit plan”  
33 does not include policies or certificates of specified disease or  
34 hospital confinement indemnity provided that the carrier offering  
35 those policies or certificates complies with the following:

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

39 (2) The certification required in paragraph (1) shall contain the  
40 following:

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

18 (B) A summary description of each policy or certificate  
 19 described in this section, including the average annual premium  
 20 rates, or range of premium rates in cases where premiums vary by  
 21 age, gender, or other factors, charged for the policies and  
 22 certificates *issued or delivered* in this state.

23 (3) In the case of a policy or certificate described in this section  
 24 and that is offered for the first time in this state for plan years on  
 25 or after January 1, 2014, the carrier files with the commissioner  
 26 the information and statement required in paragraph (2) at least  
 27 30 days prior to the date such a policy or certificate is issued or  
 28 delivered in this state.

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

39 10198.7. (a) A nongrandfathered health benefit plan for group  
 40 or individual coverage or a grandfathered health benefit plan for

1 group coverage shall not impose any preexisting condition  
2 *provision* or waived condition *provision* upon any individual.

3 (b) A grandfathered health benefit plan for individual coverage  
4 shall not exclude coverage on the basis of a waived condition  
5 *provision* or preexisting condition *provision* for a period greater  
6 than 12 months following the individual's effective date of  
7 coverage, nor limit or exclude coverage for a specific ~~enrollee~~  
8 *insured* by type of illness, treatment, medical condition, or accident,  
9 except for satisfaction of a preexisting condition clause *or waived*  
10 *condition provision* pursuant to this article. ~~Waived conditions~~  
11 *condition provisions* or preexisting condition provisions contained  
12 in health benefit plans may relate only to conditions for which  
13 medical advice, diagnosis, care, or treatment, including use of  
14 prescription drugs, was recommended or received from a licensed  
15 health practitioner during the 12 months immediately preceding  
16 the effective date of coverage.

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

31 (2) A health benefit plan for individual coverage shall not  
32 impose a waiting ~~or affiliation~~ period.

33 (d) In determining whether a preexisting condition provision,  
34 a waived condition *provision*, or a waiting ~~or affiliation~~ period  
35 applies to a person, a health benefit plan shall credit the time the  
36 person was covered under creditable coverage, provided that the  
37 person becomes eligible for coverage under the succeeding health  
38 benefit plan within 62 days of termination of prior coverage,  
39 exclusive of any waiting ~~or affiliation~~ period, and applies for  
40 coverage under the succeeding plan within the applicable

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

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

16 10198.8. This article applies to all health benefit plans that  
17 provide ~~hospital, medical, or surgical~~ benefits to residents of this  
18 state regardless of the situs of the contract or group master  
19 policyholder.

20 10198.9. A health benefit plan for group coverage shall not  
21 establish rules for eligibility, including continued eligibility, of an  
22 individual, or dependent of an individual, to enroll under the terms  
23 of the plan based on any of the following health status-related  
24 factors:

- 25 (a) Health status.
- 26 (b) Medical condition, including physical and mental illnesses.
- 27 (c) Claims experience.
- 28 (d) Receipt of health care.
- 29 (e) Medical history.
- 30 (f) Genetic information.
- 31 (g) Evidence of insurability, including conditions arising out of  
32 acts of domestic violence.
- 33 (h) Disability.
- 34 (i) Any other health status-related factor as determined by any  
35 federal regulations, rules, or guidance issued pursuant to Section  
36 2705 of the federal Public Health Service Act.

37 10198.10. This article shall become operative on January 1,  
38 2014.

1 ~~SEC. 14.~~

2 *SEC. 12.* Section 10198.10 is added to the Insurance Code, to  
3 read:

4 10198.10. This article shall remain in effect only until January  
5 1, 2014, and as of that date is repealed, unless a later enacted  
6 statute, that is enacted before January 1, 2014, deletes or extends  
7 that date.

8 ~~SEC. 15.~~ Section 10291.5 of the Insurance Code is amended  
9 to read:

10 ~~10291.5.~~ (a) The purpose of this section is to achieve both of  
11 the following:

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

14 (2) ~~Assure that the language of all insurance policies can be~~  
15 ~~readily understood and interpreted.~~

16 (b) ~~The commissioner shall not approve any disability policy~~  
17 ~~for insurance or delivery in this state in any of the following~~  
18 ~~circumstances:~~

19 (1) ~~If the commissioner finds that it contains any provision, or~~  
20 ~~has any label, description of its contents, title, heading, backing,~~  
21 ~~or other indication of its provisions which is unintelligible,~~  
22 ~~uncertain, ambiguous, or abstruse, or likely to mislead a person to~~  
23 ~~whom the policy is offered, delivered or issued.~~

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

39 (3) ~~If it contains any provision for payment for disability caused~~  
40 ~~by particular event or events (as distinguished from character of~~

1 physical injury or illness of the insured) payable for a term more  
 2 than twice the least term of payment provided by the policy for  
 3 the same degree of disability caused by any other event or events;  
 4 or if it contains any benefit for total nonconfining disability payable  
 5 for lifetime or for more than 12 months and any benefit for partial  
 6 disability, unless the benefit for partial disability is payable for at  
 7 least three months; or if it contains any benefit for total confining  
 8 disability payable for lifetime or for more than 12 months, unless  
 9 it also contains benefit for total nonconfining disability caused by  
 10 the same event or events payable for at least three months, and, if  
 11 it also contains any benefit for partial disability, unless the benefit  
 12 for partial disability is payable for at least three months. The  
 13 provisions of this paragraph shall apply separately to accident  
 14 benefits and to sickness benefits.

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

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

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

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

36 (iii) ~~Losses which result from accident occurring or sickness~~  
 37 ~~contracted while the policy is in force and arise out of the care or~~  
 38 ~~treatment of illness or injury and which occur within 90 days from~~  
 39 ~~the termination of the policy or during a period of continuous~~

1 compensable loss or losses which period commences prior to the  
2 end of such 90 days.

3 (iv) ~~Losses other than those specified in clause (i), (ii), or (iii)~~  
4 ~~of this paragraph which result from accident occurring or sickness~~  
5 ~~contracted while the policy is in force and which losses occur~~  
6 ~~within 90 days following the accident or the contraction of the~~  
7 ~~sickness.~~

8 (5) ~~If by any caption, label, title, or description of contents the~~  
9 ~~policy states, implies, or infers without reasonable qualification~~  
10 ~~that it provides loss of time indemnity for lifetime, or for any period~~  
11 ~~of more than two years, if the loss of time indemnity is made~~  
12 ~~payable only when house confined or only under special~~  
13 ~~contingencies not applicable to other total loss of time indemnity.~~

14 (6) ~~If it contains any benefit for total confining disability payable~~  
15 ~~only upon condition that the confinement be of an abnormally~~  
16 ~~restricted nature unless the caption of the part containing any such~~  
17 ~~benefit is accurately descriptive of the nature of the confinement~~  
18 ~~required and unless, if the policy has a description of contents,~~  
19 ~~label, or title, at least one of them contain reference to the nature~~  
20 ~~of the confinement required.~~

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

24 (B) ~~In determining whether benefits are of real economic value~~  
25 ~~to the insured, the commissioner shall not differentiate between~~  
26 ~~insureds of the same or similar economic or occupational classes~~  
27 ~~and shall give due consideration to all of the following:~~

28 (i) ~~The right of insurers to exercise sound underwriting judgment~~  
29 ~~in the selection and amounts of risks.~~

30 (ii) ~~Amount of benefit, length of time of benefit, nature or extent~~  
31 ~~of benefit, or any combination of those factors.~~

32 (iii) ~~The relative value in purchasing power of the benefit or~~  
33 ~~benefits.~~

34 (iv) ~~Differences in insurance issued on an industrial or other~~  
35 ~~special basis.~~

36 (C) ~~To be of real economic value, it shall not be necessary that~~  
37 ~~any benefit or benefits cover the full amount of any loss which~~  
38 ~~might be suffered by reason of the occurrence of any hazard or~~  
39 ~~event insured against.~~

1     ~~(8) If it substitutes a specified indemnity upon the occurrence~~  
2 ~~of accidental death for any benefit of the policy, other than a~~  
3 ~~specified indemnity for dismemberment, which would accrue prior~~  
4 ~~to the time of that death or if it contains any provision which has~~  
5 ~~the effect, other than at the election of the insured exercisable~~  
6 ~~within not less than 20 days in the case of benefits specifically~~  
7 ~~limited to the loss by removal of one or more fingers or one or~~  
8 ~~more toes or within not less than 90 days in all other cases, of~~  
9 ~~doing any of the following:~~

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

22     ~~(B) Of substituting, upon the occurrence of any other~~  
23 ~~dismemberment some specified indemnity for any or all benefits~~  
24 ~~under the policy unless the indemnity so specified is equal to or~~  
25 ~~greater than one-fourth of the total of the benefit or benefits for~~  
26 ~~which the specified indemnity is substituted and which, assuming~~  
27 ~~in all cases that the insured would continue to live, could possibly~~  
28 ~~accrue within four years from the date of the dismemberment under~~  
29 ~~all other provisions of the policy applicable to the particular event~~  
30 ~~or events (as distinguished from character of physical injury or~~  
31 ~~illness) causing the dismemberment.~~

32     ~~(C) Of substituting a specified indemnity upon the occurrence~~  
33 ~~of any dismemberment for any benefit of the policy which would~~  
34 ~~accrue prior to the time of dismemberment.~~

35     ~~As used in this section, loss of a hand shall be severance at or~~  
36 ~~above the wrist joint, loss of a foot shall be severance at or above~~  
37 ~~the ankle joint, loss of an eye shall be the irrecoverable loss of the~~  
38 ~~entire sight thereof, loss of a finger shall mean at least one entire~~  
39 ~~phalanx thereof and loss of a toe the entire toe.~~

1 ~~(9) If it contains provision, other than as provided in Section~~  
2 ~~10369.3, reducing any original benefit more than 50 percent on~~  
3 ~~account of age of the insured.~~

4 ~~(10) If the insuring clause or clauses contain no reference to the~~  
5 ~~exceptions, limitations, and reductions (if any) or no specific~~  
6 ~~reference to, or brief statement of, each abnormally restrictive~~  
7 ~~exception, limitation, or reduction.~~

8 ~~(11) If it contains benefit or benefits for loss or losses from~~  
9 ~~specified diseases only unless:~~

10 ~~(A) All of the diseases so specified in each provision granting~~  
11 ~~the benefits fall within some general classification based upon the~~  
12 ~~following:~~

13 ~~(i) The part or system of the human body principally subject to~~  
14 ~~all such diseases.~~

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

16 ~~(iii) In case of diseases of an unusually serious nature and~~  
17 ~~protracted course of treatment, the common characteristics of all~~  
18 ~~such diseases with respect to severity of affliction and cost of~~  
19 ~~treatment.~~

20 ~~(B) The policy is entitled and each provision granting the~~  
21 ~~benefits is separately captioned in clearly understandable words~~  
22 ~~so as to accurately describe the classification of diseases covered~~  
23 ~~and expressly point out, when that is the case, that not all diseases~~  
24 ~~of the classification are covered.~~

25 ~~(12) If it does not contain provision for a grace period of at least~~  
26 ~~the number of days specified below for the payment of each~~  
27 ~~premium falling due after the first premium, during which grace~~  
28 ~~period the policy shall continue in force provided, that the grace~~  
29 ~~period to be included in the policy shall be not less than seven days~~  
30 ~~for policies providing for weekly payment of premium, not less~~  
31 ~~than 10 days for policies providing for monthly payment of~~  
32 ~~premium and not less than 31 days for all other policies.~~

33 ~~(13) If it fails to conform in any respect with any law of this~~  
34 ~~state.~~

35 ~~(e) The commissioner shall not approve any disability policy~~  
36 ~~covering hospital, medical, or surgical expenses unless the~~  
37 ~~commissioner finds that the application conforms to the following~~  
38 ~~requirements, as applicable:~~

39 ~~(1) All applications for disability insurance covering hospital,~~  
40 ~~medical, or surgical expenses, except that which is guaranteed~~

1 issue, which include questions relating to medical conditions, shall  
2 contain clear and unambiguous questions designed to ascertain the  
3 health condition or history of the applicant.

4 (2) ~~The application questions designed to ascertain the health  
5 condition or history of the applicant in applications subject to  
6 paragraph (1) shall be based on medical information that is  
7 reasonable and necessary for medical underwriting purposes. The  
8 application shall include a prominently displayed notice that states:~~

9  
10 “California law prohibits an HIV test from being required or  
11 used by health insurance companies as a condition of obtaining  
12 health insurance coverage.”

13  
14 (3) ~~All applications for coverage subject to Chapter 8  
15 (commencing with Section 10700) shall comply with paragraph  
16 (2) of subdivision (j) of Section 10705.~~

17 (d) ~~Nothing in this section authorizes the commissioner to  
18 establish or require a single or standard application form for  
19 application questions.~~

20 (e) ~~The commissioner may, from time to time as conditions  
21 warrant, after notice and hearing, promulgate such reasonable rules  
22 and regulations, and amendments and additions thereto, as are  
23 necessary or convenient, to establish, in advance of the submission  
24 of policies, the standard or standards conforming to subdivision  
25 (b), by which he or she shall disapprove or withdraw approval of  
26 any disability policy.~~

27 ~~In promulgating any such rule or regulation the commissioner  
28 shall give consideration to the criteria herein established and to  
29 the desirability of approving for use in policies in this state uniform  
30 provisions, nationwide or otherwise, and is hereby granted the  
31 authority to consult with insurance authorities of any other state  
32 and their representatives individually or by way of convention or  
33 committee, to seek agreement upon those provisions.~~

34 ~~Any such rule or regulation shall be promulgated in accordance  
35 with the procedure provided in Chapter 3.5 (commencing with  
36 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
37 Code.~~

38 (f) ~~The commissioner may withdraw approval of filing of any  
39 policy or other document or matter required to be approved by the  
40 commissioner, or filed with him or her, by this chapter when the~~

1 commissioner would be authorized to disapprove or refuse filing  
2 of the same if originally submitted at the time of the action of  
3 withdrawal.

4 Any such withdrawal shall be in writing and shall specify  
5 reasons. An insurer adversely affected by any such withdrawal  
6 may, within a period of 30 days following mailing or delivery of  
7 the writing containing the withdrawal, by written request secure  
8 a hearing to determine whether the withdrawal should be annulled,  
9 modified, or confirmed. Unless, at any time, it is mutually agreed  
10 to the contrary, a hearing shall be granted and commenced within  
11 30 days following filing of the request and shall proceed with  
12 reasonable dispatch to determination. Unless the commissioner in  
13 writing in the withdrawal, or subsequent thereto, grants an  
14 extension, any such withdrawal shall, in the absence of any such  
15 request, be effective, prospectively and not retroactively, on the  
16 91st day following the mailing or delivery of the withdrawal, and,  
17 if request for the hearing is filed, on the 91st day following mailing  
18 or delivery of written notice of the commissioner's determination.

19 (g) No proceeding under this section is subject to Chapter 5  
20 (commencing with Section 11500) of Part 1 of Division 3 of Title  
21 2 of the Government Code.

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

26 Notwithstanding any other provision of law to the contrary,  
27 petition for any such review may be filed at any time before the  
28 effective date of the action taken by the commissioner. No action  
29 of the commissioner shall become effective before the expiration  
30 of 20 days after written notice and a copy thereof are mailed or  
31 delivered to the person adversely affected, and any action so  
32 submitted for review shall not become effective for a further period  
33 of 15 days after the filing of the petition in court. The court may  
34 stay the effectiveness thereof for a longer period.

35 (i) This section shall be liberally construed to effectuate the  
36 purpose and intentions herein stated; but shall not be construed to  
37 grant the commissioner power to fix or regulate rates for disability  
38 insurance or prescribe a standard form of disability policy, except  
39 that the commissioner shall prescribe a standard supplementary

1 disclosure form for presentation with all disability insurance  
2 policies, pursuant to Section 10603.

3 (j) This section shall be effective on and after July 1, 1950, as  
4 to all policies thereafter submitted and on and after January 1,  
5 1951, the commissioner may withdraw approval pursuant to  
6 subdivision (d) of any policy thereafter issued or delivered in this  
7 state irrespective of when its form may have been submitted or  
8 approved, and prior to those dates the provisions of law in effect  
9 on January 1, 1949, shall apply to those policies.

10 (k) Any such policy issued by an insurer to an insured on a form  
11 approved by the commissioner, and in accordance with the  
12 conditions, if any, contained in the approval, at a time when that  
13 approval is outstanding shall, as between the insurer and the  
14 insured, or any person claiming under the policy, be conclusively  
15 presumed to comply with, and conform to, this section.

16 SEC. 13. Section 10750 is added to the Insurance Code, to  
17 read:

18 10750. This chapter shall not apply to a health benefit plan  
19 that is subject to Chapter 8.01 (commencing with Section 10753)  
20 or Chapter 8.02 (commencing with Section 10755), except as  
21 otherwise provided in those chapters.

22 ~~SEC. 16.~~

23 SEC. 14. Chapter 8 8.01 (commencing with Section 10700)  
24 10753) is added to Part 2 of Division 2 of the Insurance Code, to  
25 read:

26  
27 CHAPTER 8:8.01. NONGRANDFATHERED SMALL EMPLOYER  
28 HEALTH INSURANCE

29  
30 Article 1. Definitions

31  
32 ~~10700.~~

33 10753. (a) “Agent or broker” means a person or entity licensed  
34 under Chapter 5 (commencing with Section 1621) of Part 2 of  
35 Division 1.

36 (b) “Benefit plan design” means a specific health coverage  
37 product issued by a carrier to small employers, to trustees of  
38 associations that include small employers, or to individuals if the  
39 coverage is offered through employment or sponsored by an  
40 employer. It includes services covered and the levels of copayment

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

7 ~~(e) “Board” means the Major Risk Medical Insurance Board.~~

8 ~~(d)~~

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

13 ~~(e)~~

14 (d) “Child” means a child described in Section 22775 of the  
15 Government Code and subdivisions (n) to (p), inclusive, of Section  
16 599.500 of Title 2 of the California Code of Regulations.

17 ~~(f)~~

18 (e) “Dependent” means the spouse; *or registered* domestic  
19 partner, or child, of an eligible employee, subject to applicable  
20 terms of the health benefit plan covering the employee, and  
21 includes dependents of guaranteed association members if the  
22 association elects to include dependents under its health coverage  
23 at the same time it determines its membership composition pursuant  
24 to subdivision-~~(t)~~ (s).

25 ~~(g)~~

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

27 (1) Any permanent employee who is actively engaged on a  
28 full-time basis in the conduct of the business of the small employer  
29 with a normal workweek of an average of 30 hours per week over  
30 the course of a month, in the small employer’s regular place of  
31 business, who has met any statutorily authorized applicable waiting  
32 period requirements. The term includes sole proprietors or partners  
33 of a partnership, if they are actively engaged on a full-time basis  
34 in the small employer’s business, and they are included as  
35 employees under a health benefit plan of a small employer, but  
36 does not include employees who work on a part-time, temporary,  
37 or substitute basis. It includes any eligible employee, as defined  
38 in this paragraph, who obtains coverage through a guaranteed  
39 association. Employees of employers purchasing through a  
40 guaranteed association shall be deemed to be eligible employees

1 if they would otherwise meet the definition except for the number  
2 of persons employed by the employer. A permanent employee  
3 who works at least 20 hours but not more than 29 hours is deemed  
4 to be an eligible employee if all four of the following apply:

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

7 (B) The employer offers the employee health coverage under a  
8 health benefit plan.

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

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

17 (2) Any member of a guaranteed association as defined in  
18 subdivision ~~(t)~~ (s).

19 ~~(h)~~

20 (g) “Enrollee” means an eligible employee or dependent who  
21 receives health coverage through the program from a participating  
22 carrier.

23 ~~(i)~~

24 (h) “Exchange” means the California Health Benefit Exchange  
25 created by Section 100500 of the Government Code.

26 ~~(j)~~

27 (i) “Financially impaired” means, for the purposes of this  
28 chapter, a carrier that, on or after the effective date of this chapter,  
29 is not insolvent and is either:

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

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

34 ~~(k)~~

35 (j) “Health benefit plan” means a policy of health insurance, as  
36 defined in Section 106, ~~that arranges or provides health care~~  
37 ~~benefits~~ for the covered eligible employees of a small employer  
38 and their dependents. The term does not include coverage of  
39 Medicare services pursuant to contracts with the United States  
40 government, ~~Medicare supplement, long-term care insurance, or~~

1 coverage ~~consisting solely of~~ *that provides* excepted benefits, as  
2 described in Sections 2722 and 2791 of the federal Public Health  
3 Service Act, subject to Section 10701.

4 ~~(t)~~

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

7 ~~(m)~~

8 (l) “Late enrollee” means an eligible employee or dependent  
9 who has declined health coverage under a health benefit plan  
10 offered by a small employer at the time of the initial enrollment  
11 period provided under the terms of the health benefit plan  
12 consistent with the periods provided pursuant to Section ~~10705~~  
13 *10753.05* and who subsequently requests enrollment in a health  
14 benefit plan of that small employer, except where the employee  
15 or dependent qualifies for a special enrollment period provided  
16 pursuant to Section ~~10705~~ *10753.05*. It also means any member  
17 of an association that is a guaranteed association as well as any  
18 other person eligible to purchase through the guaranteed association  
19 when that person has failed to purchase coverage during the initial  
20 enrollment period provided under the terms of the guaranteed  
21 association’s health benefit plan consistent with the periods  
22 provided pursuant to Section ~~10705~~ *10753.05* and who  
23 subsequently requests enrollment in the plan, except where the  
24 employee or dependent qualifies for a special enrollment period  
25 provided pursuant to Section ~~10705~~ *10753.05*.

26 ~~(n)~~

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

29 ~~(o)~~

30 (n) “Preexisting condition provision” means a policy provision  
31 that excludes coverage for charges or expenses incurred during a  
32 specified period following the insured’s effective date of coverage,  
33 as to a condition for which medical advice, diagnosis, care, or  
34 treatment was recommended or received during a specified period  
35 immediately preceding the effective date of coverage.

36 ~~(p)~~

37 (o) “Creditable coverage” means:

38 (1) Any individual or group policy, contract, or program, that  
39 is written or administered by a ~~disability~~ *health* insurer, health care  
40 service plan, fraternal benefits society, self-insured employer plan,

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

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

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

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

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

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

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

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

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

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

36 ~~(q)~~

37 (p) "Rating period" means the period for which premium rates  
 38 established by a carrier are in effect and shall be ~~from January 1~~  
 39 ~~to December 31, inclusive~~ *no less than 12 months from the date*  
 40 *of issuance or renewal of the health benefit plan.*

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

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

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

8 ~~(s)~~

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

37 This subdivision applies regardless of whether a master policy  
38 by an admitted insurer is delivered directly to the association or a  
39 trust formed for or sponsored by an association to administer  
40 benefits for association members.

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

8 ~~(t)~~

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

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

24 ~~(v)~~

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

27 ~~(w)~~

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

30 ~~(x)~~

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

33 ~~(y)~~

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

39 ~~(z)~~

1 (x) “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 (y) “Registered domestic partner” means a person who has  
 5 established a domestic partnership as described in Section 297 of  
 6 the Family Code.

7 ~~10701.~~

8 10753.01. (a) For purposes of this chapter, “health benefit  
 9 plan” does not include policies or certificates of specified disease  
 10 or hospital confinement indemnity provided that the carrier offering  
 11 those policies or certificates complies with the following:

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

15 (2) The certification required in paragraph (1) shall contain the  
 16 following:

17 (A) A statement from the carrier certifying that policies or  
 18 certificates described in this section (i) are being offered and  
 19 marketed as supplemental health insurance and not as a substitute  
 20 for coverage that provides essential health benefits as defined by  
 21 the state pursuant to Section 1302 of PPACA, and (ii) the  
 22 disclosure forms as described in Section 10603 contains the  
 23 following statement prominently on the first page: “This is a  
 24 supplement to health insurance. It is not a substitute for essential  
 25 health benefits or minimum essential coverage as defined in federal  
 26 law. Commencing January 1, 2014, you may be subject to a federal  
 27 tax if you do not obtain minimum essential coverage,” and (iii)  
 28 are not being offered, marketed, or sold in a manner that would  
 29 make the purchase of the policies contingent upon the sale of any  
 30 product sold under Sections 10700 and 10718, or under Section  
 31 1357 of the Health and Safety Code or the renewal of a product  
 32 under Section 10755 or Section 1357.600 of the Health and Safety  
 33 Code. law.”

34 (B) A summary description of each policy or certificate  
 35 described in this section, including the average annual premium  
 36 rates, or range of premium rates in cases where premiums vary by  
 37 age, gender, or other factors, charged for the policies and  
 38 certificates issued or delivered in this state.

39 (3) In the case of a policy or certificate that is described in this  
 40 section and that is offered for the first time in this state with respect

1 to plan years on or after January 1, 2014, the carrier files with the  
2 commissioner the information and statement required in paragraph  
3 (2) at least 30 days prior to the date such a policy or certificate is  
4 issued or delivered in this state.

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

15  
16 Article 2. Small Employer Carrier Requirements

17  
18 ~~10702.~~

19 *10753.02.* (a) This chapter shall apply only to  
20 nongrandfathered health benefit plans and only with respect to  
21 plan years commencing on or after January 1, 2014.

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

25 (1) Any portion of the premium for any health benefit plan or  
26 benefits is paid by a small employer, or any covered individual is  
27 reimbursed, whether through wage adjustments or otherwise, by  
28 a small employer for any portion of the premium.

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

32 ~~10702.1.~~

33 *10753.02.1.* Any person or entity subject to the requirements  
34 of this chapter shall comply with the standards set forth in Chapter  
35 7 (commencing with Section 3750) of Part 1 of Division 9 of the  
36 Family Code and Section 14124.94 of the Welfare and Institutions  
37 Code.

38 ~~10703.~~

39 *10753.03.* The commissioner shall have the authority to  
40 determine whether a health benefit plan is covered by this chapter,

1 and to determine whether an employer is a small employer within  
2 the meaning of Section ~~10700~~ 10753.

3 ~~10704.~~

4 10753.04. The commissioner may issue regulations that are  
5 necessary to carry out the purposes of this chapter.

6 ~~10705.~~

7 10753.05. (a) No group or individual policy or contract or  
8 certificate of group insurance or statement of group coverage  
9 providing benefits to employees of small employers as defined in  
10 this chapter shall be issued or delivered by a carrier subject to the  
11 jurisdiction of the commissioner regardless of the situs of the  
12 contract or master policyholder or of the domicile of the carrier  
13 nor, except as otherwise provided in Sections 10270.91 and  
14 10270.92, shall a carrier provide coverage subject to this chapter  
15 until a copy of the form of the policy, contract, certificate, or  
16 statement of coverage is filed with and approved by the  
17 commissioner in accordance with Sections 10290 and 10291, and  
18 the carrier has complied with the requirements of Section ~~10717~~  
19 10753.17.

20 (b) (1) On and after October 1, 2013, each carrier shall fairly  
21 and affirmatively offer, market, and sell all of the carrier’s health  
22 benefit plans that are sold to, offered through, or sponsored by,  
23 small employers or associations that include small employers *for*  
24 *plan years on or after January 1, 2014*, to all small employers in  
25 each geographic region in which the carrier makes coverage  
26 available or provides benefits.

27 (2) A carrier that offers qualified health plans through the  
28 Exchange shall be deemed to be in compliance with paragraph (1)  
29 with respect to health benefit plans offered through the Exchange  
30 in those geographic regions in which the carrier offers plans  
31 through the Exchange.

32 (3) A carrier shall provide enrollment periods consistent with  
33 PPACA and set forth in Section 155.725 of Title 45 of the Code  
34 of Federal Regulations. A carrier shall provide special enrollment  
35 periods consistent with the special enrollment periods required in  
36 the individual nongrandfathered market in the state, *as set forth*  
37 *in Section 10965.3*, except for the triggering events identified in  
38 paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the  
39 Code of Federal Regulations with respect to health benefit plans  
40 offered through the Exchange.

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

15 (5) A carrier which (A) effective January 1, 1992, and at least  
16 20 years prior to that date, markets, offers, or sells benefit plan  
17 designs only to all members of one association and (B) does not  
18 market, offer or sell any other individual, selected group, or group  
19 policy or contract providing medical, hospital and surgical benefits  
20 shall not be required to market, offer, or sell to those who are not  
21 members of the association. However, if the carrier markets, offers  
22 or sells any benefit plan design or any other individual, selected  
23 group, or group policy or contract providing medical, hospital and  
24 surgical benefits to those who are not members of the association  
25 it is subject to the requirements of this section.

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

31 (7) Each carrier that sells health benefit plans to members of  
32 any association shall submit an annual statement to the  
33 commissioner which lists each association to which the carrier  
34 sells health benefit plans, the industry or profession which is served  
35 by the association, the association's membership criteria, a list of  
36 officers, the state in which the association is organized, and the  
37 site of its principal office.

38 (8) For purposes of paragraphs (4) and (6), an association is a  
39 nonprofit organization comprised of a group of individuals or  
40 employers who associate based solely on participation in a

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

17 (c) On and after October 1, 2013, each carrier shall make  
18 available to each small employer all health benefit plans that the  
19 carrier offers or sells to small employers or to associations that  
20 include small employers *for plan years on or after January 1,*  
21 *2014.* Notwithstanding subdivision (d) of Section ~~10700~~ 10753,  
22 for purposes of this subdivision, companies that are affiliated  
23 companies or that are eligible to file a consolidated income tax  
24 return shall be treated as one carrier.

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

26 (1) Prepare a brochure that summarizes all of its health benefit  
27 plans and make this summary available to small employers, agents,  
28 and brokers upon request. The summary shall include for each  
29 plan information on benefits provided, a generic description of the  
30 manner in which services are provided, such as how access to  
31 providers is limited, benefit limitations, required copayments and  
32 deductibles, an explanation of how creditable coverage is calculated  
33 if a waiting ~~or affiliation~~ period is imposed, and a telephone number  
34 that can be called for more detailed benefit information. Carriers  
35 are required to keep the information contained in the brochure  
36 accurate and up to date, and, upon updating the brochure, send  
37 copies to agents and brokers representing the carrier. Any entity  
38 that provides administrative services only with regard to a health  
39 benefit plan written or issued by another carrier shall not be

1 required to prepare a summary brochure which includes that benefit  
2 plan.

3 (2) For each health benefit plan, prepare a more detailed  
4 evidence of coverage and make it available to small employers,  
5 agents and brokers upon request. The evidence of coverage shall  
6 contain all information that a prudent buyer would need to be aware  
7 of in making selections of benefit plan designs. An entity that  
8 provides administrative services only with regard to a health benefit  
9 plan written or issued by another carrier shall not be required to  
10 prepare an evidence of coverage for that health benefit plan.

11 (3) Provide copies of the current summary brochure to all agents  
12 or brokers who represent the carrier and, upon updating the  
13 brochure, send copies of the updated brochure to agents and brokers  
14 representing the carrier for the purpose of selling health benefit  
15 plans.

16 (4) Notwithstanding subdivision ~~(d)~~ (c) of Section ~~10700~~ 10753,  
17 for purposes of this subdivision, companies that are affiliated  
18 companies or that are eligible to file a consolidated income tax  
19 return shall be treated as one carrier.

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

23 (1) When providing information on a health benefit plan to a  
24 small employer but making no specific recommendations on  
25 particular benefit plan designs:

26 (A) Advise the small employer of the carrier's obligation to sell  
27 to any small employer any of the health benefit plans it offers to  
28 small employers, consistent with PPACA, and provide them, upon  
29 request, with the actual rates that would be charged to that  
30 employer for a given health benefit plan.

31 (B) Notify the small employer that the agent or broker will  
32 procure rate and benefit information for the small employer on  
33 any health benefit plan offered by a carrier for whom the agent or  
34 broker sells health benefit plans.

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

39 (D) Notify the small employer of the availability of coverage  
40 and the availability of tax credits for certain employers consistent

1 with PPACA and state law, including any rules, regulations, or  
2 guidance issued in connection therewith.

3 (2) When recommending a particular benefit plan design or  
4 designs, advise the small employer that, upon request, the agent  
5 will provide the small employer with the brochure required by  
6 paragraph (1) of subdivision (d) containing the benefit plan design  
7 or designs being recommended by the agent or broker.

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

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

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

17 (C) Obtain a signed statement from the small employer  
18 acknowledging that the small employer has received the disclosures  
19 required by this paragraph and Section ~~10716~~ 10753.16.

20 (f) No carrier, agent, or broker shall induce or otherwise  
21 encourage a small employer to separate or otherwise exclude an  
22 eligible employee from a health benefit plan which, in the case of  
23 an eligible employee meeting the definition in paragraph (1) of  
24 subdivision ~~(g)~~ (f) of Section ~~10700~~ 10753, is provided in  
25 connection with the employee’s employment or which, in the case  
26 of an eligible employee as defined in paragraph (2) of subdivision  
27 ~~(g)~~ (f) of Section ~~10700~~ 10753, is provided in connection with a  
28 guaranteed association.

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

31 (1) The small employer as defined by subparagraph (A) of  
32 paragraph (1) of subdivision ~~(r)~~ (q) of Section ~~10700~~ 10753 offers  
33 health benefits to 100 percent of its eligible employees as defined  
34 in paragraph (1) of subdivision ~~(g)~~ (f) of Section ~~10700~~ 10753.  
35 Employees who waive coverage on the grounds that they have  
36 other group coverage shall not be counted as eligible employees.

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

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

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

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

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

22 (j) (1) A health benefit plan offered to a small employer, as  
23 defined in Section 1304(b) of PPACA and in Section ~~10700~~ 10753,  
24 shall not establish rules for eligibility, including continued  
25 eligibility, of an individual, or dependent of an individual, to enroll  
26 under the terms of the plan based on any of the following health  
27 status-related factors:

28 (A) Health status.

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

30 (C) Claims experience.

31 (D) Receipt of health care.

32 (E) Medical history.

33 (F) Genetic information.

34 (G) Evidence of insurability, including conditions arising out  
35 of acts of domestic violence.

36 (H) Disability.

37 (I) Any other health status-related factor as determined by any  
38 federal regulations, rules, or guidance issued pursuant to Section  
39 2705 of the federal Public Health Service Act.

1 (2) ~~A~~ *Notwithstanding Section 10291.5, a carrier shall not*  
2 *require an eligible employee or dependent to fill out a health*  
3 *assessment or medical questionnaire prior to enrollment under a*  
4 *health benefit plan. A carrier shall not acquire or request*  
5 *information that relates to a health status-related factor from the*  
6 *applicant or his or her dependent or any other source prior to*  
7 *enrollment of the individual.*

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

13 (l) (1) With respect to the obligation to provide coverage newly  
14 issued under subdivision (c), to the extent permitted by PPACA,  
15 the carrier may cease enrolling new small employer groups and  
16 new eligible employees as defined by paragraph (2) of subdivision  
17 ~~(g)~~ (f) of Section ~~10700~~ 10753 if it certifies to the commissioner  
18 that the number of eligible employees and dependents, of the  
19 employers newly enrolled or insured during the current calendar  
20 year by the carrier equals or exceeds: (A) in the case of a carrier  
21 that administers any self-funded health benefits arrangement in  
22 California, 10 percent of the total number of eligible employees,  
23 or eligible employees and dependents, respectively, enrolled or  
24 insured in California by that carrier as of December 31 of the  
25 preceding year, or (B) in the case of a carrier that does not  
26 administer any self-funded health benefit arrangements in  
27 California, 8 percent of the total number of eligible employees, or  
28 eligible employees and dependents, respectively, enrolled or  
29 insured by the carrier in California as of December 31 of the  
30 preceding year.

31 (2) Certification shall be deemed approved if not disapproved  
32 within 45 days after submission to the commissioner. If that  
33 certification is approved, the small employer carrier shall not offer  
34 coverage to any small employers under any health benefit plans  
35 during the remainder of the current year. If the certification is not  
36 approved, the carrier shall continue to issue coverage as required  
37 by subdivision (c) and be subject to administrative penalties as  
38 established in Section ~~10718~~ 10753.18.

39 (m) (1) *Except as provided in paragraph (2), this section shall*  
40 *become inoperative if Section 2702 of the federal Public Health*

1 *Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201*  
2 *of PPACA, is repealed, in which case carriers subject to this*  
3 *section shall instead be governed by Section 10705 to the extent*  
4 *permitted by federal law, and all references in this chapter to this*  
5 *section shall instead refer to Section 10705, except for purposes*  
6 *of paragraph (2).*

7 *(2) Paragraph (3) of subdivision (b) of this section shall remain*  
8 *operative as it relates to health benefit plans offered through the*  
9 *Exchange.*

10 ~~10705.1.~~

11 *10753.05.2.* (a) For contracts expiring after July 1, 1994, 60  
12 days prior to July 1, 1994, an association that meets the definition  
13 of guaranteed association, as set forth in Section ~~10700~~ *10753*,  
14 except for the requirement that 1,000 persons be covered, shall be  
15 entitled to purchase small employer health coverage as if the  
16 association were a guaranteed association, except that the coverage  
17 shall be guaranteed only for those members of an association, as  
18 defined in Section ~~10700~~ *10753*, (1) who were receiving coverage  
19 or had successfully applied for coverage through the association  
20 as of June 30, 1993, (2) who were receiving coverage through the  
21 association as of December 31, 1992, and whose coverage lapsed  
22 at any time thereafter because the employment through which  
23 coverage was received ended or an employer's contribution to  
24 health coverage ended, or (3) who were covered at any time  
25 between June 30, 1993, and July 1, 1994, under a contract that was  
26 in force on June 30, 1993.

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

31 ~~10706.~~

32 *10753.06.* Every carrier shall file with the commissioner the  
33 reasonable participation requirements and employer contribution  
34 requirements that are to be included in its health benefit plans.  
35 Participation requirements shall be applied uniformly among all  
36 small employer groups, except that a carrier may vary application  
37 of minimum employer participation requirements by the size of  
38 the small employer group and whether the employer contributes  
39 100 percent of the eligible employee's premium. Employer  
40 contribution requirements shall not vary by employer size. A carrier

1 shall not establish a participation requirement that (1) requires a  
 2 person who meets the definition of a dependent in subdivision ~~(f)~~  
 3 ~~(e)~~ of Section ~~10700~~ 10753 to enroll as a dependent if he or she is  
 4 otherwise eligible for coverage and wishes to enroll as an eligible  
 5 employee and (2) allows a carrier to reject an otherwise eligible  
 6 small employer because of the number of persons that waive  
 7 coverage due to coverage through another employer. Members of  
 8 an association eligible for health coverage eligible under  
 9 subdivision ~~(t)~~ (s) of Section ~~10700~~ 10753 but not electing any  
 10 health coverage through the association shall not be counted as  
 11 eligible employees for purposes of determining whether the  
 12 guaranteed association meets a carrier’s reasonable participation  
 13 standards.

14 ~~10706.5.~~

15 10753.06.5. (a) With respect to health benefit plans offered  
 16 outside the Exchange, after a small employer submits a completed  
 17 application, the carrier shall, within 30 days, notify the employer  
 18 of the employer’s actual rates in accordance with Section ~~10714~~  
 19 10753.14. The employer shall have 30 days in which to exercise  
 20 the right to buy coverage at the quoted rates.

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

30 (2) A carrier shall apply coverage effective dates for health  
 31 benefit plans subject to this chapter consistent with the coverage  
 32 effective dates applicable to nongrandfathered individual health  
 33 benefit plans *set forth in Section 10965.3.*

34 (c) During the first 30 days of coverage, the small employer  
 35 shall have the option of changing coverage to a different health  
 36 benefit plan offered by the same carrier. If a small employer  
 37 notifies the carrier of the change within the first 15 days of a month,  
 38 coverage under the new health benefit plan shall become effective  
 39 no later than the first day of the following month. If a small  
 40 employer notifies the carrier of the change after the 15th day of a

1 month, coverage under the new health benefit plan shall become  
2 effective no later than the first day of the second month following  
3 notification.

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

7 ~~10708.~~

8 *10753.08.* (a) A health benefit plan shall not impose a  
9 preexisting condition provision upon any individual.

10 (b) A health benefit plan may apply a waiting period of up to  
11 60 days as a condition of employment if applied equally to all  
12 eligible employees and dependents and if consistent with PPACA.  
13 ~~A health benefit plan offered through a health maintenance~~  
14 ~~organization, as defined in Section 2791 of the federal Public~~  
15 ~~Health Service Act, may impose an affiliation period not to exceed~~  
16 ~~60 days. A waiting or affiliation period shall not be based on a~~  
17 ~~preexisting condition of an employee or dependent, the health~~  
18 ~~status of an employee or dependent, or any other factor listed in~~  
19 ~~subdivision (j) of Section 10705 10753. An affiliation period shall~~  
20 ~~run concurrently with a waiting period. During the waiting or~~  
21 ~~affiliation period, the health benefit plan is not required to provide~~  
22 ~~health care services coverage and no premium shall be charged to~~  
23 ~~the policyholder or insureds.~~

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

1 applies for coverage under the succeeding health benefit plan  
2 within the applicable enrollment period.

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

7 ~~10709.~~

8 *10753.09.* Nothing in this chapter shall be construed as  
9 prohibiting a carrier from restricting enrollment of late enrollees  
10 to open enrollment periods provided under Section ~~10705~~ *10753.05*  
11 as authorized under Section 2702 of the federal Public Health  
12 Service Act. ~~No premium shall be charged to the late enrollee until~~  
13 ~~the exclusion period has ended.~~

14 ~~10711.~~

15 *10753.11.* To the extent permitted by PPACA, no carrier shall  
16 be required by the provisions of this chapter:

17 (a) To offer coverage to, or accept applications from, a small  
18 employer as defined in subparagraph (A) of paragraph (1) of  
19 subdivision ~~(†)~~ (q) of Section ~~10700~~ *10753*, where the small  
20 employer is not physically located in a carrier’s approved service  
21 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 ~~(†)~~ (q) of Section ~~10700~~ *10753* where the small  
25 employer is seeking coverage for eligible employees who do not  
26 work or reside 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~~ *10753.02.1*.

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~~ 10753.05.

8 (e) To offer coverage to a small employer, or an eligible  
9 employee as defined in paragraph (2) of subdivision ~~(g)~~ (f) of  
10 Section ~~10700~~ 10753, who within 12 months of application for  
11 coverage terminated from a health benefit plan offered by the  
12 carrier.

13 ~~10712.~~

14 10753.12. (a) A carrier shall not be required to offer coverage  
15 or accept applications for benefit plan designs pursuant to this  
16 chapter where the commissioner determines that the acceptance  
17 of an application or applications would place the carrier in a  
18 financially impaired condition.

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

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

28 ~~10713.~~

29 10753.13. All health benefit plans subject to this chapter shall  
30 be renewable with respect to all eligible employees or dependents  
31 at the option of the policyholder, contractholder, or small employer  
32 except as follows:

33 (a) (1) For nonpayment of the required premiums by the  
34 policyholder, contractholder, or small employer, if the policyholder,  
35 contractholder, or small employer has been duly notified and billed  
36 for the charge and at least a 30-day grace period has elapsed since  
37 the date of notification or, if longer, the period of time required  
38 for notice and any other requirements pursuant to Section 2703,  
39 2712, or 2742 of the federal Public Health Service Act (42 U.S.C.

1 Secs. 300gg-2, 300gg-12, and 300gg-42) and any subsequent rules  
2 or regulations has elapsed.

3 (2) An insurer shall continue to provide coverage as required  
4 by the policyholder's, contractholder's, or small employer's policy  
5 during the period described in paragraph (1). Nothing in this section  
6 shall be construed to affect or impair the policyholder's,  
7 contractholder's, small employer's, or insurer's other rights and  
8 responsibilities pursuant to the subscriber contract.

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

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

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

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

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

32 (3) Except in the case where a certification has been approved  
33 pursuant to subdivision (l) of Section ~~10705~~ 10753.05 or the  
34 commissioner has made a determination pursuant to subdivision  
35 (a) of Section ~~10712~~ 10753.12, a carrier that ceases to write, issue,  
36 or administer new health benefit plans to small employers in this  
37 state after the passage of this chapter shall be prohibited from  
38 writing, issuing, or administering new health benefit plans to small  
39 employers in this state for a period of five years from the date of  
40 notice to the commissioner.

1 (e) When a carrier withdraws a benefit plan design from the  
2 small employer market, provided that the carrier notifies all  
3 affected policyholders, contractholders, or small employers and  
4 the commissioner at least 90 days prior to the discontinuation of  
5 those contracts, and that the carrier makes available to the small  
6 employer all small employer benefit plan designs which it markets.

7 (f) If coverage is made available through a bona fide association  
8 pursuant to subdivision ~~(r)~~ (q) of Section ~~10700~~ 10753 or a  
9 guaranteed association pursuant to subdivision ~~(s)~~ (r) of Section  
10 ~~10700~~ 10753, the membership of the employer or the individual,  
11 respectively, ceases, but only if that coverage is terminated under  
12 this subdivision uniformly without regard to any health  
13 status-related factor of covered individuals.

14 ~~10714.~~

15 10753.14. (a) The premium rate for a health benefit plan  
16 issued, amended, or renewed on *or* after January 1, 2014, shall  
17 vary with respect to the particular coverage involved only by the  
18 following:

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

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

33 (A)

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

38 (B)

39 (ii) Region 2 shall consist of the Counties of Napa, Sonoma,  
40 Solano, and Marin.

- 1     ~~(C)~~
- 2     (iii) Region 3 shall consist of the Counties of Sacramento,
- 3     Placer, El Dorado, and Yolo.
- 4     ~~(D) Region 4 shall consist of the Counties of San Francisco,~~
- 5     ~~Contra Costa, Alameda, Santa Clara, and San Mateo.~~
- 6     (iv) *Region 4 shall consist of the County of San Francisco.*
- 7     (v) *Region 5 shall consist of the County of Contra Costa.*
- 8     (vi) *Region 6 shall consist of the County of Alameda.*
- 9     (vii) *Region 7 shall consist of the County of Santa Clara.*
- 10    (viii) *Region 8 shall consist of the County of San Mateo.*
- 11    ~~(E)~~
- 12    ~~(ix) Region 5 9 shall consist of the Counties of Santa Cruz,~~
- 13    ~~Monterey, and San Benito.~~
- 14    ~~(F)~~
- 15    (x) ~~Region 6 10 shall consist of the Counties of San Joaquin,~~
- 16    ~~Stanislaus, Merced, Mariposa, Madera, Fresno, Kings, and Tulare.~~
- 17    (xi) *Region 11 shall consist of the Counties of Madera, Fresno,*
- 18    ~~and Kings.~~
- 19    ~~(G)~~
- 20    ~~(xii) Region 7 12 shall consist of the Counties of San Luis~~
- 21    ~~Obispo, Santa Barbara, and Ventura.~~
- 22    ~~(H)~~
- 23    ~~(xiii) Region 8 13 shall consist of the Counties of Mono, Inyo,~~
- 24    ~~Kern, and Imperial.~~
- 25    (xiv) *Region 14 shall consist of the County of Kern.*
- 26    ~~(I)~~
- 27    ~~(xv) Region 9 15 shall consist of the ZIP Codes in Los Angeles~~
- 28    ~~County starting with 906 to 912, inclusive, 915, 917, 918, and 935.~~
- 29    ~~(J)~~
- 30    ~~(xvi) Region 10 16 shall consist of the ZIP Codes in Los Angeles~~
- 31    ~~County other than those identified in subparagraph (I) clause (xv).~~
- 32    ~~(K)~~
- 33    ~~(xvii) Region 11 17 shall consist of the Counties of San~~
- 34    ~~Bernardino and Riverside.~~
- 35    ~~(L)~~
- 36    ~~(xviii) Region 12 18 shall consist of the County of Orange.~~
- 37    ~~(M)~~
- 38    ~~(xix) Region 13 19 shall consist of the County of San Diego.~~
- 39    (B) *No later than June 1, 2017, the department, in collaboration*
- 40    ~~with the Exchange and the Department of Managed Health Care,~~

1 shall review the geographic rating regions specified in this  
2 paragraph and the impacts of those regions on the health care  
3 coverage market in California, and make a report to the  
4 appropriate policy committees of the Legislature.

5 (3) Whether the health benefit plan covers an individual or  
6 family, as described in PPACA.

7 (b) The rate for a health benefit plan subject to this section shall  
8 not vary by any factor not described in this section.

9 (c) The rating period for rates subject to this section shall be  
10 from January 1 to December 31, inclusive no less than 12 months  
11 from the date of issuance or renewal of the health benefit plan.

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

18 ~~(2) The department shall adopt emergency regulations~~  
19 ~~implementing this section 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 ~~(3) 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 ~~(d) This section shall become inoperative if Section 2701 of the~~  
37 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added~~  
38 ~~by Section 1201 of PPACA, is repealed, in which case rates for~~  
39 ~~health benefit plans subject to this section shall instead be subject~~  
40 ~~to Section 10714, to the extent permitted by federal law, and all~~

1 *references to this section shall be deemed to be references to*  
 2 *Section 10714.*

3 ~~10716.~~

4 *10753.16.* In connection with the offering for sale of a health  
 5 benefit plan subject to this chapter to small employers:

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

8 (a) The provisions concerning the carrier’s ability to change  
 9 premium rates and the factors ~~other than claim experience which~~  
 10 *that* affect changes in premium rates. *The carrier shall disclose*  
 11 *that claims experience cannot be used.*

12 (b) Provisions relating to the guaranteed issue of policies and  
 13 contracts.

14 (c) A statement that no preexisting condition provisions shall  
 15 be allowed.

16 (d) Provisions relating to the small employer’s right to apply  
 17 for any health benefit plan written, issued, or administered by the  
 18 carrier at the time of application for a new health benefit plan, or  
 19 at the time of renewal of a health benefit plan.

20 (e) The availability, upon request, of a listing of all the carrier’s  
 21 benefit plan designs offered, both inside and outside the Exchange,  
 22 including the rates for each benefit plan design.

23 ~~10717.~~

24 *10753.17.* (a) No carrier shall provide or renew coverage  
 25 subject to this chapter until a statement has been filed with the  
 26 commissioner listing all of the carrier’s health benefit plans  
 27 currently in force that are offered or proposed to be offered for  
 28 sale in this state, identified by form number, and, if previously  
 29 approved by the commissioner, the date approved by the  
 30 commissioner.

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

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

36 (2) Either:

37 (A) Thirty days expires after the statement is filed without  
 38 written notice from the commissioner specifying the reasons for  
 39 his or her opinion that the carrier’s rating factors do not comply  
 40 with the requirements of this chapter.

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

4 (c) If the commissioner notifies the carrier, in writing, that the  
5 carrier's rating factors do not comply with the requirements of this  
6 chapter, specifying the reasons for his or her opinion, it is unlawful  
7 for the carrier, at any time after the receipt of such notice, to utilize  
8 the noncomplying health benefit plan or rating factors in  
9 conjunction with the health benefit plans or benefit plan designs  
10 for which the filing was made.

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

14 (e) Each carrier shall make the information and documentation  
15 described in this section available to the commissioner upon  
16 request.

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

20 ~~10718.~~

21 *10753.18.* (a) In addition to any other remedy permitted by  
22 law, the commissioner shall have the administrative authority to  
23 assess penalties against carriers, insurance producers, and other  
24 entities engaged in the business of insurance or other persons or  
25 entities for violations of this chapter.

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

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

33 (d) Any production agent or other person or entity engaged in  
34 the business of insurance, other than a carrier, that engages in  
35 practices prohibited by this chapter a second or subsequent time,  
36 or who commits a knowing violation of this chapter, is liable for  
37 administrative penalties of not less than one thousand dollars  
38 (\$1,000) and not more than two thousand five hundred dollars  
39 (\$2,500) for each violation.

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

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

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

14 ~~10718.5.~~

15 *10753.18.5.* (a) (1) In addition to any other remedy permitted  
16 by law, whenever the commissioner shall have reason to believe  
17 that any carrier, production agent, or other person or entity engaged  
18 in the business of insurance has violated this chapter, and that a  
19 proceeding by the commissioner in respect thereto would be in the  
20 interest of the public, the commissioner may issue and serve upon  
21 that entity an order to show cause containing a statement of the  
22 charges, a statement of the entity’s potential liability under this  
23 chapter, and a notice of a public hearing thereon before the  
24 Administrative Law Bureau of the department to be held at a time  
25 and place fixed therein, which shall not be less than 30 days after  
26 the service thereof, for the purpose of determining whether the  
27 commissioner should issue an order to that entity to pay the penalty  
28 imposed by this chapter and such order or orders as shall be  
29 reasonably necessary to correct, eliminate, or remedy the alleged  
30 violations of this chapter, including, but not limited to, an order  
31 to cease and desist from the specified violations of this chapter.

32 (2) The hearings provided by this subdivision shall be conducted  
33 in accordance with the Administrative Procedure Act (Chapter 5  
34 commencing with Section 11500) of Part 1 of Division 3 of Title  
35 2 of the Government Code), and the commissioner shall have all  
36 the powers granted therein.

37 (b) (1) Whenever it appears to the commissioner that irreparable  
38 loss and injury has occurred or may occur to an insured, employer,  
39 employee, or other member of the public because a carrier,  
40 production agent, or other person or entity engaged in the business

1 of insurance has violated this chapter, the commissioner may,  
2 before hearing, but after notice and opportunity to submit relevant  
3 information, issue and cause to be served upon the entity such  
4 order or orders as shall be reasonably necessary to correct,  
5 eliminate, or remedy the alleged violations of this chapter,  
6 including, but not limited to, an order requiring the entity to  
7 forthwith cease and desist from engaging further in the violations  
8 which are causing or may cause such irreparable injury.

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

15 (3) The hearings provided by this subdivision shall be conducted  
16 in accordance with the Administrative Procedure Act (Chapter 5  
17 (commencing with Section 11500) of Part 1 of Division 3 of Title  
18 2 of the Government Code), and the commissioner shall have all  
19 the powers granted therein.

20 (4) At any time prior to the commencement of a hearing as  
21 provided in this subdivision, the entity against which the  
22 commissioner has served an order may waive the hearing and have  
23 judicial review of the order by means of any remedy afforded by  
24 law without first exhausting administrative remedies or procedures.

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

33 (d) In addition to any other penalty provided by law or the  
34 availability of any administrative procedure, if a carrier, after notice  
35 and hearing, is found to have violated this chapter knowingly or  
36 as a general business practice the commissioner may suspend the  
37 carrier's certificate of authority to transact disability insurance.  
38 The order of suspension shall prescribe the period of such  
39 suspension. The proceedings shall be conducted in accordance  
40 with the Administrative Procedure Act, Chapter 5 (commencing

1 with Section 11500) of Part 1 of Division 3 of Title 2 of the  
2 Government Code and the commissioner shall have all the powers  
3 granted therein.

4 ~~10718.55.~~

5 *10753.18.55.* (a) Carriers may enter into contractual  
6 agreements with qualified associations, as defined in subdivision  
7 (b), under which these qualified associations may assume  
8 responsibility for performing specific administrative services, as  
9 defined in this section, for qualified association members. Carriers  
10 that enter into agreements with qualified associations for  
11 assumption of administrative services shall establish uniform  
12 definitions for the administrative services that may be provided  
13 by a qualified association or its third-party administrator. The  
14 carrier shall permit all qualified associations to assume one or  
15 more of these functions when the carrier determines the qualified  
16 association demonstrates that it has the administrative capacity to  
17 assume these functions.

18 For the purposes of this section, administrative services provided  
19 by qualified associations or their third-party administrators shall  
20 be services pertaining to eligibility determination, enrollment,  
21 premium collection, sales, or claims administration on a per-claim  
22 basis that would otherwise be provided directly by the carrier or  
23 through a third-party administrator on a commission basis or an  
24 agent or solicitor workforce on a commission basis.

25 Each carrier that enters into an agreement with any qualified  
26 association for the provision of administrative services shall offer  
27 all qualified associations with which it contracts the same premium  
28 discounts for performing those services the carrier has permitted  
29 the qualified association or its third-party administrator to assume.  
30 The carrier shall apply these uniform discounts to the carrier's  
31 rates pursuant to Section ~~10714~~ *10753.14*. The carrier shall report  
32 to the department its schedule of discounts for each administrative  
33 service.

34 In no instance may a carrier provide discounts to qualified  
35 associations that are in any way intended to, or materially result  
36 in, a reduction in premium charges to the qualified association due  
37 to the health status of the membership of the qualified association.  
38 In addition to any other remedies available to the commissioner  
39 to enforce this chapter, the commissioner may declare a contract  
40 between a carrier and a qualified association for administrative

1 services pursuant to this section null and void if the commissioner  
2 determines any discounts provided to the qualified association are  
3 intended to, or materially result in, a reduction in premium charges  
4 to the qualified association due to the health status of the  
5 membership of the qualified association.

6 (b) For the purposes of this section, a qualified association is a  
7 nonprofit corporation comprised of a group of individuals or  
8 employers who associate based solely on participation in a  
9 specified profession or industry, that conforms to all of the  
10 following requirements:

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

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

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

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

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

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

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

28 (8) It agrees to offer any plan contract only to association  
29 members.

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

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

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

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

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

1 10718.7.

2 10753.18.7. Notwithstanding any other provision of law, no  
3 provision of this chapter shall be construed to limit the applicability  
4 of any other provision of the Insurance Code unless such provision  
5 is in conflict with the requirements of this chapter.

6 ~~SEC. 17. Section 10702 of the Insurance Code is amended to~~  
7 ~~read:~~

8 10702. (a) ~~All carriers writing, issuing, or administering health~~  
9 ~~benefit plans with respect to plan years commencing prior to~~  
10 ~~January 1, 2014, that cover employees of small employers shall~~  
11 ~~be subject to this chapter if any one of the following conditions~~  
12 ~~are met:~~

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

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

20 (b) ~~For purposes of this section, “plan year” has the meaning~~  
21 ~~provided in Section 144.103 of Title 45 of the Code of Federal~~  
22 ~~Regulations.~~

23 ~~SEC. 18. Section 10750 is added to the Insurance Code, to~~  
24 ~~read:~~

25 10750. ~~This chapter shall remain in effect only until January~~  
26 ~~1, 2014, and as of that date is repealed, unless a later enacted~~  
27 ~~statute, that is enacted before January 1, 2014, deletes or extends~~  
28 ~~that date.~~

29 ~~SEC. 19.~~

30 ~~SEC. 15. Chapter 8.01 8.02 (commencing with Section 10755)~~  
31 ~~is added to Part 2 of Division 2 of the Insurance Code, to read:~~

32  
33 CHAPTER ~~8.01~~8.02. GRANDFATHERED SMALL EMPLOYER  
34 HEALTH INSURANCE

35  
36 Article 1. Definitions

37  
38 10755. As used in this chapter, the following definitions shall  
39 apply:

1 (a) “Agent or broker” means a person or entity licensed under  
2 Chapter 5 (commencing with Section 1621) of Part 2 of Division  
3 1.

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

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

19 (d) “Dependent” means the spouse *or registered domestic*  
20 *partner*, or child, of an eligible employee, subject to applicable  
21 terms of the health benefit plan covering the employee, and  
22 includes dependents of guaranteed association members if the  
23 association elects to include dependents under its health coverage  
24 at the same time it determines its membership composition pursuant  
25 to subdivision-~~(z)~~ (t).

26 (e) “Eligible employee” means either of the following:

27 (1) Any permanent employee who is actively engaged on a  
28 full-time basis in the conduct of the business of the small employer  
29 with a normal workweek of an average of 30 hours per week over  
30 the course of a month, in the small employer’s regular place of  
31 business, who has met any statutorily authorized applicable waiting  
32 period requirements. The term includes sole proprietors or partners  
33 of a partnership, if they are actively engaged on a full-time basis  
34 in the small employer’s business, and they are included as  
35 employees under a health benefit plan of a small employer, but  
36 does not include employees who work on a part-time, temporary,  
37 or substitute basis. It includes any eligible employee, as defined  
38 in this paragraph, who obtains coverage through a guaranteed  
39 association. Employees of employers purchasing through a  
40 guaranteed association shall be deemed to be eligible employees

1 if they would otherwise meet the definition except for the number  
2 of persons employed by the employer. A permanent employee  
3 who works at least 20 hours but not more than 29 hours is deemed  
4 to be an eligible employee if all four of the following apply:

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

7 (B) The employer offers the employee health coverage under a  
8 health benefit plan.

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

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

17 (2) Any member of a guaranteed association as defined in  
18 subdivision ~~(z)~~ (t).

19 (f) “Enrollee” means an eligible employee or dependent who  
20 receives health coverage through the program from a participating  
21 carrier.

22 (g) “Financially impaired” means, for the purposes of this  
23 chapter, a carrier that, on or after the effective date of this chapter,  
24 is not insolvent and is either:

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

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

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

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

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

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

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

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

36 (C) He or she has lost or will lose coverage under another  
37 employer health benefit plan as a result of termination of  
38 employment of the individual or of a person through whom the  
39 individual was covered as a dependent, change in employment  
40 status of the individual, or of a person through whom the individual

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

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

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

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

20 (4) (A) In the case of an eligible employee as defined in  
21 paragraph (1) of subdivision-(f) (e), the carrier cannot produce a  
22 written statement from the employer stating that the individual or  
23 the person through whom an individual was eligible to be covered  
24 as a dependent, prior to declining coverage, was provided with,  
25 and signed acknowledgment of, an explicit written notice in  
26 boldface type specifying that failure to elect coverage during the  
27 initial enrollment period permits the carrier to impose, at the time  
28 of the individual's later decision to elect coverage, an exclusion  
29 from coverage for a period of 12 months as well as a six-month  
30 preexisting condition exclusion unless the individual meets the  
31 criteria specified in paragraph (1), (2), or (3).

32 (B) In the case of an eligible employee who is a guaranteed  
33 association member, the plan cannot produce a written statement  
34 from the guaranteed association stating that the association sent a  
35 written notice in boldface type to all potentially eligible association  
36 members at their last known address prior to the initial enrollment  
37 period informing members that failure to elect coverage during  
38 the initial enrollment period permits the plan to impose, at the time  
39 of the member's later decision to elect coverage, an exclusion from  
40 coverage for a period of 12 months as well as a six-month

1 preexisting condition exclusion unless the member can demonstrate  
2 that he or she meets the requirements of subparagraphs (A), (C),  
3 and (D) of paragraph (1) or meets the requirements of paragraph  
4 (2) or (3).

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

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

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

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

1 before the time the employee is offered an opportunity to enroll  
 2 in plan coverage.

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

21 (k) “Preexisting condition provision” means a policy provision  
 22 that excludes coverage for charges or expenses incurred during a  
 23 specified period following the insured’s effective date of coverage,  
 24 as to a condition for which medical advice, diagnosis, care, or  
 25 treatment was recommended or received during a specified period  
 26 immediately preceding the effective date of coverage.

27 (l) “Creditable coverage” means:

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

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

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

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

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

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

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

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

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

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

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

26 (m) “Rating period” means the period for which premium rates  
27 established by a carrier are in effect and shall be no less than 12  
28 months from the date of issuance or renewal of the health benefit  
29 plan.

30 (n) “Risk adjusted employee risk rate” means the rate determined  
31 for an eligible employee of a small employer in a particular risk  
32 category after applying the risk adjustment factor.

33 (o) “Risk adjustment factor” means the percent adjustment to  
34 be applied equally to each standard employee risk rate for a  
35 particular small employer, based upon any expected deviations  
36 from standard claims. This factor may not be more than 110 percent  
37 or less than 90 percent.

38 (p) “Risk category” means the following characteristics of an  
39 eligible employee: age, geographic region, and family size of the

1 employee, plus the benefit plan design selected by the small  
 2 employer.

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

5 Under 30

6 30–39

7 40–49

8 50–54

9 55–59

10 60–64

11 65 and over

12 However, for the 65 and over age category, separate premium  
 13 rates may be specified depending upon whether coverage under  
 14 the health benefit plan will be primary or secondary to benefits  
 15 provided by the federal Medicare Program pursuant to Title XVIII  
 16 of the federal Social Security Act.

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

19 (A) Single.

20 (B) Married couple *or registered domestic partners*.

21 (C) One adult and child or children.

22 (D) Married couple *or registered domestic partners* and child  
 23 or children.

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

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

1 determined in the last federal census, multiplied by nine. The  
2 resulting number shall be rounded to the nearest whole integer.  
3 No region may be smaller than an area in which the first three  
4 digits of all its ZIP Codes are in common within a county and no  
5 county may be divided into more than two regions. The area  
6 encompassed in a geographic region shall be separate and distinct  
7 from areas encompassed in other geographic regions. Geographic  
8 regions may be noncontiguous. No carrier shall have less than one  
9 geographic area.

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

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

1 anniversary following the date the employer no longer meets the  
2 requirements of this definition. It includes any small employer as  
3 defined in this subparagraph who purchases coverage through a  
4 guaranteed association, and any employer purchasing coverage  
5 for employees through a guaranteed association. This subparagraph  
6 shall be implemented to the extent consistent with PPACA, except  
7 that the minimum requirement of one employee shall be  
8 implemented only to the extent required by PPACA.

9 (B) Any guaranteed association, as defined in subdivision ~~(y)~~  
10 ~~(s)~~, that purchases health coverage for members of the association.

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

16 (r) “Standard employee risk rate” means the rate applicable to  
17 an eligible employee in a particular risk category in a small  
18 employer group.

19 (s) “Guaranteed association” means a nonprofit organization  
20 comprised of a group of individuals or employers who associate  
21 based solely on participation in a specified profession or industry,  
22 accepting for membership any individual or employer meeting its  
23 membership criteria which (1) includes one or more small  
24 employers as defined in *subparagraph (A) of paragraph (1) of*  
25 ~~subdivision (w)~~ *(q)*, (2) does not condition membership directly  
26 or indirectly on the health or claims history of any person, (3) uses  
27 membership dues solely for and in consideration of the membership  
28 and membership benefits, except that the amount of the dues shall  
29 not depend on whether the member applies for or purchases  
30 insurance offered by the association, (4) is organized and  
31 maintained in good faith for purposes unrelated to insurance, (5)  
32 has been in active existence on January 1, 1992, and for at least  
33 five years prior to that date, (6) has been offering health insurance  
34 to its members for at least five years prior to January 1, 1992, (7)  
35 has a constitution and bylaws, or other analogous governing  
36 documents that provide for election of the governing board of the  
37 association by its members, (8) offers any benefit plan design that  
38 is purchased to all individual members and employer members in  
39 this state, (9) includes any member choosing to enroll in the benefit  
40 plan design offered to the association provided that the member

1 has agreed to make the required premium payments, and (10)  
2 covers at least 1,000 persons with the carrier with which it  
3 contracts. The requirement of 1,000 persons may be met if  
4 component chapters of a statewide association contracting  
5 separately with the same carrier cover at least 1,000 persons in the  
6 aggregate.

7 This subdivision applies regardless of whether a master policy  
8 by an admitted insurer is delivered directly to the association or a  
9 trust formed for or sponsored by an association to administer  
10 benefits for association members.

11 For purposes of this subdivision, an association formed by a  
12 merger of two or more associations after January 1, 1992, and  
13 otherwise meeting the criteria of this subdivision shall be deemed  
14 to have been in active existence on January 1, 1992, if its  
15 predecessor organizations had been in active existence on January  
16 1, 1992, and for at least five years prior to that date and otherwise  
17 met the criteria of this subdivision.

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

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

33 ~~(v)~~

34 (u) "Grandfathered health benefit plan" means a health benefit  
35 plan that constitutes a grandfathered health plan.

36 ~~(w)~~

37 (v) "Grandfathered health plan" has the meaning set forth in  
38 Section 1251 of PPACA.

39 ~~(x)~~

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

3 ~~(y)~~

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

6 ~~(z)~~

7 (y) “PPACA” means the federal Patient Protection and  
8 Affordable Care Act (Public Law 111-148), as amended by the  
9 federal Health Care and Education Reconciliation Act (Public Law  
10 111-152), and any rules, regulations, or guidance issued thereunder.

11 ~~(aa)~~

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

15 (aa) “Registered domestic partner” means a person who has  
16 established a domestic partnership as described in Section 297 of  
17 the Family Code.

18 10755.01. (a) For purposes of this chapter, “health benefit  
19 plan” does not include policies or certificates of specified disease  
20 or hospital confinement indemnity provided that the carrier offering  
21 those policies or certificates complies with the following:

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

25 (2) The certification required in paragraph (1) shall contain the  
26 following:

27 (A) A statement from the carrier certifying that policies or  
28 certificates described in this section (i) are being offered and  
29 marketed as supplemental health insurance and not as a substitute  
30 for coverage that provides essential health benefits as defined by  
31 the state pursuant to Section 1302 of PPACA, and (ii) contain the  
32 disclosure forms as described in Section 10603 with the following  
33 statement prominently on the first page: “This is a supplement to  
34 health insurance. It is not a substitute for essential health benefits  
35 or minimum essential coverage as required under federal law.  
36 Commencing January 1, 2014, you may be subject to a tax if you  
37 do not obtain minimum essential coverage,” and (iii) are not being  
38 offered, marketed, or sold in a manner that would make the  
39 purchase of the policies contingent upon the sale of any product  
40 sold under Sections 10700 and 10718, or under Section 1357 of

1 ~~the Health and Safety Code or the renewal of a product under~~  
2 ~~Section 10755 or Section 1357.600 of the Health and Safety Code.~~  
3 ~~law.”~~

4 (B) A summary description of each policy or certificate  
5 described in this section, including the average annual premium  
6 rates, or range of premium rates in cases where premiums vary by  
7 age, gender, or other factors, charged for the policies and  
8 certificates *issued or delivered* in this state.

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

15 (b) As used in this section, “policies or certificates of specified  
16 disease” and “policies or certificates of hospital confinement  
17 indemnity” mean policies or certificates of insurance sold to an  
18 insured to supplement other health insurance coverage as specified  
19 in this section. An insurer issuing a “policy or certificate of  
20 specified disease” or a “policy or certificate of hospital confinement  
21 indemnity” shall require that the person to be insured is covered  
22 by an individual or group policy or contract that arranges or  
23 provides medical, hospital, and surgical coverage not designed to  
24 supplement other private or governmental plans.

25

## 26 Article 2. Small Employer Carrier Requirements

27

28 10755.02. (a) This chapter shall apply only to grandfathered  
29 health benefit plans and only with respect to plan years  
30 commencing on or after January 1, 2014.

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

34 (1) Any portion of the premium for any health benefit plan or  
35 benefits is paid by a small employer, or any covered individual is  
36 reimbursed, whether through wage adjustments or otherwise, by  
37 a small employer for any portion of the premium.

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

1 10755.02.1. Any person or entity subject to the requirements  
2 of this chapter shall comply with the standards set forth in Chapter  
3 7 (commencing with Section 3750) of Part 1 of Division 9 of the  
4 Family Code and Section 14124.94 of the Welfare and Institutions  
5 Code.

6 10755.03. The commissioner shall have the authority to  
7 determine whether a health benefit plan is covered by this chapter,  
8 and to determine whether an employer is a small employer within  
9 the meaning of Section 10755.

10 ~~10755.04. (a) The department may issue regulations that are  
11 necessary to carry out the purposes of this chapter.~~

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

17 ~~(c)~~

18 10755.04. (a) The department ~~shall~~ *may* adopt emergency  
19 regulations implementing this chapter no later than August 31,  
20 2013. The department may readopt any emergency regulation  
21 authorized by this section that is the same as or substantially  
22 equivalent to an emergency regulation previously adopted under  
23 this section.

24 ~~(d)~~

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

38 ~~(e)~~

39 (c) This section shall become operative on January 1, 2013.

1 10755.05. (a) (1) Each carrier, except a self-funded employer,  
2 shall fairly and affirmatively renew all of the carrier's health benefit  
3 plans that are sold to small employers or associations that include  
4 small employers.

5 (2) Nothing in this section shall be construed to require an  
6 association, or a trust established and maintained by an association  
7 to receive a master insurance policy issued by an admitted insurer  
8 and to administer the benefits thereof solely for association  
9 members, to offer, market or sell a benefit plan design to those  
10 who are not members of the association. However, if the  
11 association markets, offers or sells a benefit plan design to those  
12 who are not members of the association it is subject to the  
13 requirements of this section. This shall apply to an association that  
14 otherwise meets the requirements of paragraph (6) formed by  
15 merger of two or more associations after January 1, 1992, if the  
16 predecessor organizations had been in active existence on January  
17 1, 1992, and for at least five years prior to that date and met the  
18 requirements of paragraph (3).

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

30 (4) Each carrier that sells health benefit plans to members of  
31 one association pursuant to paragraph (3) shall submit an annual  
32 statement to the commissioner which states that the carrier is selling  
33 health benefit plans pursuant to paragraph (3) and which, for the  
34 one association, lists all the information required by paragraph (5).

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

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

3 (6) For purposes of paragraphs (2) and (3), an association is a  
4 nonprofit organization comprised of a group of individuals or  
5 employers who associate based solely on participation in a  
6 specified profession or industry, accepting for membership any  
7 individual or small employer meeting its membership criteria,  
8 which do not condition membership directly or indirectly on the  
9 health or claims history of any person, which uses membership  
10 dues solely for and in consideration of the membership and  
11 membership benefits, except that the amount of the dues shall not  
12 depend on whether the member applies for or purchases insurance  
13 offered by the association, which is organized and maintained in  
14 good faith for purposes unrelated to insurance, which has been in  
15 active existence on January 1, 1992, and at least five years prior  
16 to that date, which has a constitution and bylaws, or other  
17 analogous governing documents which provide for election of the  
18 governing board of the association by its members, which has  
19 contracted with one or more carriers to offer one or more health  
20 benefit plans to all individual members and small employer  
21 members in this state.

22 (b) Each carrier shall make available to each small employer  
23 all nongrandfathered health benefit plans that the carrier offers or  
24 sells to small employers or to associations that include small  
25 employers. Notwithstanding subdivision (d) of Section ~~10700~~  
26 ~~10755~~, for purposes of this subdivision, companies that are  
27 affiliated companies or that are eligible to file a consolidated  
28 income tax return shall be treated as one carrier.

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

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

1 and up to date, and, upon updating the brochure, send copies to  
2 agents and brokers representing the carrier. Any entity that provides  
3 administrative services only with regard to a benefit plan design  
4 written or issued by another carrier shall not be required to prepare  
5 a summary brochure which includes that benefit plan design.

6 (2) For each health benefit plan, prepare a more detailed  
7 evidence of coverage and make it available to small employers,  
8 agents and brokers upon request. The evidence of coverage shall  
9 contain all information that a prudent buyer would need to be aware  
10 of in making selections of benefit plan designs. An entity that  
11 provides administrative services only with regard to a benefit plan  
12 design written or issued by another carrier shall not be required to  
13 prepare an evidence of coverage for that benefit plan design.

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

21 (4) Provide copies of the current summary brochure to all agents  
22 or brokers who represent the carrier and, upon updating the  
23 brochure, send copies of the updated brochure to agents and brokers  
24 representing the carrier for the purpose of selling health benefit  
25 plans.

26 (5) Notwithstanding subdivision (c) of Section 10755, for  
27 purposes of this subdivision, companies that are affiliated  
28 companies or that are eligible to file a consolidated income tax  
29 return shall be treated as one carrier.

30 (e) No carrier, agent, or broker shall induce or otherwise  
31 encourage a small employer to separate or otherwise exclude an  
32 eligible employee from a health benefit plan which, in the case of  
33 an eligible employee meeting the definition in paragraph (1) of  
34 subdivision (e) of Section 10755, is provided in connection with  
35 the employee's employment or which, in the case of an eligible  
36 employee as defined in paragraph (2) of subdivision (e) of Section  
37 10755, is provided in connection with a guaranteed association.

38 (f) No carrier or agent or broker shall, directly or indirectly,  
39 engage in the following activities:

- 1 (1) Encourage or direct small employers to refrain from filing  
2 an application for coverage with a carrier because of the health  
3 status, claims experience, industry, occupation, or geographic  
4 location within the carrier’s approved service area of the small  
5 employer or the small employer’s employees.
- 6 (2) Encourage or direct small employers to seek coverage from  
7 another carrier or the California Health Benefit Exchange because  
8 of the health status, claims experience, industry, occupation, or  
9 geographic location within the carrier’s approved service area of  
10 the small employer or the small employer’s employees.
- 11 (g) No carrier shall, directly or indirectly, enter into any contract,  
12 agreement, or arrangement with an agent or broker that provides  
13 for or results in the compensation paid to an agent or broker for a  
14 health benefit plan to be varied because of the health status, claims  
15 experience, industry, occupation, or geographic location of the  
16 small employer or the small employer’s employees. This  
17 subdivision shall not apply with respect to a compensation  
18 arrangement that provides compensation to an agent or broker on  
19 the basis of percentage of premium, provided that the percentage  
20 shall not vary because of the health status, claims experience,  
21 industry, occupation, or geographic area of the small employer.
- 22 (h) A policy or contract that covers a small employer, as defined  
23 in Section 1304(b) of PPACA and in subdivision (q) of Section  
24 10755 shall not establish rules for eligibility, including continued  
25 eligibility, of an individual, or dependent of an individual, to enroll  
26 under the terms of the plan based on any of the following health  
27 status-related factors:
- 28 (1) Health status.
  - 29 (2) Medical condition, including physical and mental illnesses.
  - 30 (3) Claims experience.
  - 31 (4) Receipt of health care.
  - 32 (5) Medical history.
  - 33 (6) Genetic information.
  - 34 (7) Evidence of insurability, including conditions arising out of  
35 acts of domestic violence.
  - 36 (8) Disability.
  - 37 (9) Any other health status-related factor as determined by any  
38 federal regulations, rules, or guidance issued pursuant to Section  
39 2705 of the federal Public Health Service Act.

1 (i) If a carrier enters into a contract, agreement, or other  
2 arrangement with a third-party administrator or other entity to  
3 provide administrative, marketing, or other services related to the  
4 offering of health benefit plans to small employers in this state,  
5 the third-party administrator shall be subject to this chapter.

6 10755.05.1. (a) For contracts expiring after July 1, 1994, 60  
7 days prior to July 1, 1994, an association that meets the definition  
8 of guaranteed association, as set forth in Section 10755, except  
9 for the requirement that 1,000 persons be covered, shall be entitled  
10 to purchase small employer health coverage as if the association  
11 were a guaranteed association, except that the coverage shall be  
12 guaranteed only for those members of an association, as defined  
13 in Section 10755, (1) who were receiving coverage or had  
14 successfully applied for coverage through the association as of  
15 June 30, 1993, (2) who were receiving coverage through the  
16 association as of December 31, 1992, and whose coverage lapsed  
17 at any time thereafter because the employment through which  
18 coverage was received ended or an employer's contribution to  
19 health coverage ended, or (3) who were covered at any time  
20 between June 30, 1993, and July 1, 1994, under a contract that was  
21 in force on June 30 1993.

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

26 10755.06. Every carrier shall file with the commissioner the  
27 reasonable participation requirements that will be required in  
28 renewing its health benefit plans. Participation requirements of a  
29 health benefit plan shall be applied uniformly among all small  
30 employer groups, except that a carrier may vary application of  
31 minimum employer participation requirements by the size of the  
32 small employer group and whether the employer contributes 100  
33 percent of the eligible employee's premium. Employer contribution  
34 requirements of a health benefit plan shall not vary by employer  
35 size. A carrier shall not establish a participation requirement that  
36 (1) requires a person who meets the definition of a dependent in  
37 subdivision (d) of Section 10755 to enroll as a dependent if he or  
38 she is otherwise eligible for coverage and wishes to enroll as an  
39 eligible employee and (2) allows a carrier to reject an otherwise  
40 eligible small employer because of the number of persons that

1 waive coverage due to coverage through another employer.  
2 Members of an association eligible for health coverage eligible  
3 under subdivision (t) of Section 10755 but not electing any health  
4 coverage through the association shall not be counted as eligible  
5 employees for purposes of determining whether the guaranteed  
6 association meets a carrier's reasonable participation standards.

7 10755.08. (a) A health benefit plan shall not impose a  
8 preexisting condition provision upon any individual.

9 (b) A health benefit plan may apply a waiting period of up to  
10 60 days as a condition of employment if applied equally to all  
11 eligible employees and dependents and if consistent with PPACA.  
12 ~~A health benefit plan offered through a health maintenance~~  
13 ~~organization, as defined in Section 2791 of the federal Public~~  
14 ~~Health Service Act, may impose an affiliation period not to exceed~~  
15 ~~60 days. A waiting or affiliation period shall not be based on a~~  
16 ~~preexisting condition of an employee or dependent, the health~~  
17 ~~status of an employee or dependent, or any other factor listed in~~  
18 ~~subdivision (j) of Section 10705. An affiliation period shall run~~  
19 ~~concurrently with a waiting period. During the waiting or affiliation~~  
20 ~~period, the health benefit plan is not required to provide health~~  
21 ~~care services and no premium shall be charged to the policyholder~~  
22 ~~or insureds.~~

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

1 applies for coverage under the succeeding health benefit plan  
2 within the applicable enrollment period.

3 (d) A carrier providing aggregate or specific stop loss coverage  
4 or any other assumption of risk with reference to a health benefit  
5 plan shall provide that the plan meets all requirements of this  
6 section concerning waiting or affiliation periods. The requirements  
7 of this subdivision shall only be exercised to the extent they are  
8 not preempted by ERISA.

9 (e) An individual's period of creditable coverage shall be  
10 certified pursuant to subsection (e) of Section 2704 of Title XXVII  
11 of the federal Public Health Service Act (42 U.S.C. Sec.  
12 300gg-3(e)).

13 10755.09. Nothing in this chapter shall be construed as  
14 prohibiting a carrier from restricting enrollment of late enrollees  
15 to open enrollment periods consistent with federal law. ~~No~~  
16 ~~premium shall be charged to the late enrollee until the exclusion~~  
17 ~~period has ended.~~

18 10755.11. No carrier shall be required by the provisions of this  
19 chapter:

20 (a) To include in a health benefit plan an otherwise eligible  
21 employee or dependent, when the eligible employee or dependent  
22 does not work or reside within a carrier's approved service area,  
23 except as provided in Section 10755.02.1.

24 (b) To offer coverage to an eligible employee, as defined in  
25 paragraph (2) of subdivision (e) of Section 10755, who within 12  
26 months of application for coverage terminated from a health benefit  
27 plan offered by the carrier.

28 10755.13. All grandfathered health benefit plans shall be  
29 renewable with respect to all eligible employees or dependents at  
30 the option of the policyholder, contractholder, or small employer  
31 except as follows:

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

1 (2) An insurer shall continue to provide coverage as required  
 2 by the policyholder’s, contractholder’s, or small employer’s policy  
 3 during the period described in paragraph (1). Nothing in this section  
 4 shall be construed to affect or impair the policyholder’s,  
 5 contractholder’s, small employer’s, or insurer’s other rights and  
 6 responsibilities pursuant to the subscriber contract.

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

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

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

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

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

30 (3) A carrier that ceases to write, issue, or administer new health  
 31 benefit plans to small employers in this state after the passage of  
 32 this chapter shall be prohibited from writing, issuing, or  
 33 administering new health benefit plans to small employers in this  
 34 state for a period of five years from the date of notice to the  
 35 commissioner.

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

1 employer all nongrandfathered small employer health benefit plans  
2 which it markets and satisfies the requirements of Section 10714.

3 (f) If coverage is made available through a bona fide association  
4 pursuant to subdivision (q) of Section 10755 or a guaranteed  
5 association pursuant to subdivision (s) of Section 10755, 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 10755.14. Premiums for grandfathered health benefit plans  
11 written or administered by carriers on or after the January 1, 2014,  
12 shall be subject to the following requirements:

13 (a) (1) The premium for new business shall be determined for  
14 an eligible employee in a particular risk category after applying a  
15 risk adjustment factor to the carrier's standard employee risk rates.  
16 The risk adjusted employee risk rate may not be more than 110  
17 percent or less than 90 percent.

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

20 (3) The standard employee risk rates applied to a small employer  
21 for new business shall be in effect for no less than 12 months.

22 (b) (1) The premium for in force business shall be determined  
23 for an eligible employee in a particular risk category after applying  
24 a risk adjustment factor to the carrier's standard employee risk  
25 rates. The risk adjusted employee risk rate may not be more than  
26 110 percent or less than 90 percent. The risk adjustment factor  
27 applied to a small employer may not increase by more than 10  
28 percentage points from the risk adjustment factor applied in the  
29 prior rating period. The risk adjustment factor for a small employer  
30 may not be modified more frequently than every 12 months.

31 (2) The premium charged a small employer for in force business  
32 shall be equal to the sum of the risk adjusted employee risk rates.  
33 The standard employee risk rates shall be in effect for 12 months.

34 (c) (1) For any small employer, a carrier may, with the consent  
35 of the small employer, establish composite employee and  
36 dependent rates for renewal of in force business. The composite  
37 rates shall be determined as the average of the risk adjusted  
38 employee risk rates for the small employer, as determined in  
39 accordance with the requirements of subdivisions (a) and (b). The

1 sum of the composite rates so determined shall be equal to the sum  
2 of the risk adjusted employee risk rates for the small employer.

3 (2) The composite rates shall be used for all employees and  
4 dependents covered throughout a rating period of 12 months, except  
5 that a carrier may reserve the right to redetermine the composite  
6 rates if the enrollment under the health benefit plan changes by  
7 more than a specified percentage during the rating period. Any  
8 redetermination of the composite rates shall be based on the same  
9 risk adjusted employee risk rates used to determine the initial  
10 composite rates for the rating period. If a carrier reserves the right  
11 to redetermine the rates and the enrollment changes more than the  
12 specified percentage, the carrier shall redetermine the composite  
13 rates if the redetermined rates would result in a lower premium  
14 for the small employer. A carrier reserving the right to redetermine  
15 the composite rates based upon a change in enrollment shall use  
16 the same specified percentage to measure that change with respect  
17 to all small employers electing composite rates.

18 10755.15. ~~Carrier~~ Carriers shall apply standard employee risk  
19 rates consistently with respect to all small employers.

20 10755.16. In connection with the renewal of any grandfathered  
21 health benefit plan to small employers:

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

24 (a) The extent to which the premium rates for a specified small  
25 employer are established or adjusted in part based upon the actual  
26 or expected variation in claims costs ~~or actual or expected variation~~  
27 ~~in health conditions~~ of the employees and dependents of the small  
28 employer.

29 (b) The provisions concerning the carrier's ability to change  
30 premium rates and the factors other than claim experience which  
31 affect changes in premium rates.

32 (c) Provisions relating to the guaranteed issue of policies and  
33 contracts.

34 (d) Provisions relating to the ~~effect~~ *prohibition* of any  
35 preexisting condition provision.

36 (e) Provisions relating to the small employer's right to apply  
37 for any nongrandfathered health benefit plan written, issued, or  
38 administered by the carrier, at the time of application for a new  
39 health benefit plan, or at the time of renewal of a health benefit  
40 plan, consistent with the requirements of PPACA.

1 (f) The availability, upon request, of a listing of all the carrier's  
2 nongrandfathered health benefit plans, offered inside or outside  
3 the California Health Benefit Exchange, including the rates for  
4 each benefit plan design.

5 10755.17. (a) No carrier shall renew coverage subject to this  
6 chapter until it has done all of the following:

7 (1) A statement has been filed with the commissioner listing all  
8 of the carrier's grandfathered health benefit plans currently in force  
9 in this state, identified by form number, and, if previously approved  
10 by the commissioner, the date approved by the commissioner as  
11 well as the standard employee risk rate for each risk category for  
12 each benefit plan design and the highest and lowest risk adjustment  
13 factors that the carrier intends to use in determining rates for each  
14 benefit plan design. When filing a new benefit plan design pursuant  
15 to Section 10755.05, carriers may submit both the policy form and  
16 the standard employee risk rates for each risk category at the same  
17 time.

18 (2) Either:

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

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

27 (b) No carrier shall renew or revise a grandfathered health  
28 benefit plan lawfully provided pursuant to subdivision (a), and no  
29 carrier shall change the risk categories, risk adjustment factors, or  
30 standard employee risk rates for a grandfathered health benefit  
31 plan until all of the following requirements are met:

32 (1) The carrier files with the commissioner a statement of the  
33 specific changes which the carrier proposes in the risk categories,  
34 risk adjustment factors, or standard employee risk rates.

35 (2) Either:

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

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

4 (c) Notwithstanding any provision to the contrary, when a carrier  
5 is changing the standard employee risk rates of a health benefit  
6 plan lawfully provided under subdivision (a) or (b) but is not  
7 changing the risk categories or risk adjustment factors which have  
8 been previously authorized, the carrier need not comply with the  
9 requirements of paragraph (2) of subdivision (b), but instead shall  
10 submit the revised standard employee risk rates for the health  
11 benefit plan prior to renewing the health benefit plan.

12 (d) When submitting filings under subdivision (a), (b), or (c),  
13 a carrier may also file with the commissioner at the time of the  
14 filings a statement of the standard employee risk rate for each risk  
15 category the carrier intends to use for each month in the 12 months  
16 subsequent to the date of the filing. Once the requirements of the  
17 applicable subdivision (a), (b), or (c), have been met, these rates  
18 shall be used by the carrier for the 12-month period unless the  
19 carrier is otherwise informed by the commissioner in his or her  
20 response to the filings submitted under subdivision (a), (b), or (c),  
21 provided that any subsequent change in the standard employee  
22 risk rates charged by the carrier which differ from those previously  
23 filed with the commissioner must be newly filed in accordance  
24 with this subdivision and provided that the carrier does not change  
25 the risk categories or risk adjustment factors for the health benefit  
26 plan.

27 (e) If the commissioner notifies the carrier, in writing, that the  
28 carrier’s risk categories or risk adjustment factors do not comply  
29 with the requirements of this chapter, specifying the reasons for  
30 his or her opinion, it is unlawful for the carrier, at any time after  
31 the receipt of such notice, to utilize the noncomplying health  
32 benefit plan, benefit plan design, risk categories, or risk adjustment  
33 factors in conjunction with the health benefit plans or benefit plan  
34 designs for which the filing was made.

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

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

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

4 10755.18. (a) In addition to any other remedy permitted by  
5 law, the commissioner shall have the administrative authority to  
6 assess penalties against carriers, insurance producers, and other  
7 entities engaged in the business of insurance or other persons or  
8 entities for violations of this chapter.

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

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

16 (d) Any production agent or other person or entity engaged in  
17 the business of insurance, other than a carrier, that engages in  
18 practices prohibited by this chapter a second or subsequent time,  
19 or who commits a knowing violation of this chapter, is liable for  
20 administrative penalties of not less than one thousand dollars  
21 (\$1,000) and not more than two thousand five hundred dollars  
22 (\$2,500) for each violation.

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

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

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

36 10755.18.5. (a) (1) In addition to any other remedy permitted  
37 by law, whenever the commissioner shall have reason to believe  
38 that any carrier, production agent, or other person or entity engaged  
39 in the business of insurance has violated this chapter, and that a  
40 proceeding by the commissioner in respect thereto would be in the

1 interest of the public, the commissioner may issue and serve upon  
2 that entity an order to show cause containing a statement of the  
3 charges, a statement of the entity's potential liability under this  
4 chapter, and a notice of a public hearing thereon before the  
5 Administrative Law Bureau of the department to be held at a time  
6 and place fixed therein, which shall not be less than 30 days after  
7 the service thereof, for the purpose of determining whether the  
8 commissioner should issue an order to that entity to pay the penalty  
9 imposed by this chapter and such order or orders as shall be  
10 reasonably necessary to correct, eliminate, or remedy the alleged  
11 violations of this chapter, including, but not limited to, an order  
12 to cease and desist from the specified violations of this chapter.

13 (2) The hearings provided by this subdivision shall be conducted  
14 in accordance with the Administrative Procedure Act, Chapter 5  
15 (commencing with Section 11500) of Part 1 of Division 3 of Title  
16 2 of the Government Code, and the commissioner shall have all  
17 the powers granted therein.

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

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

36 (3) The hearings provided by this subdivision shall be conducted  
37 in accordance with the Administrative Procedure Act, Chapter 5  
38 (commencing with Section 11500) of Part 1 of Division 3 of Title  
39 2 of the Government Code, and the commissioner shall have all  
40 the powers granted therein.

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

6 (c) If, after hearing as provided by subdivision (a) or (b), the  
7 charges, or any of them, that an entity has violated this chapter are  
8 found to be justified, the commissioner shall issue and cause to be  
9 served upon that entity an order requiring that entity to pay the  
10 penalty imposed by this chapter and such order or orders as shall  
11 be reasonably necessary to correct, eliminate, or remedy the alleged  
12 violations of this chapter, including, but not limited to, an order  
13 to cease and desist from the specified violations of this chapter.

14 (d) In addition to any other penalty provided by law or the  
15 availability of any administrative procedure, if a carrier, after notice  
16 and hearing, is found to have violated this chapter knowingly or  
17 as a general business practice the commissioner may suspend the  
18 carrier's certificate of authority to transact disability insurance.  
19 The order of suspension shall prescribe the period of such  
20 suspension. The proceedings shall be conducted in accordance  
21 with the Administrative Procedure Act, Chapter 5 (commencing  
22 with Section 11500) of Part 1 of Division 3 of Title 2 of the  
23 Government Code and the commissioner shall have all the powers  
24 granted therein.

25 10755.18.6. (a) Carriers may enter into contractual agreements  
26 with qualified associations, as defined in subdivision (b), under  
27 which these qualified associations may assume responsibility for  
28 performing specific administrative services, as defined in this  
29 section, for qualified association members. Carriers that enter into  
30 agreements with qualified associations for assumption of  
31 administrative services shall establish uniform definitions for the  
32 administrative services that may be provided by a qualified  
33 association or its third-party administrator. The carrier shall permit  
34 all qualified associations to assume one or more of these functions  
35 when the carrier determines the qualified association demonstrates  
36 that it has the administrative capacity to assume these functions.

37 For the purposes of this section, administrative services provided  
38 by qualified associations or their third-party administrators shall  
39 be services pertaining to eligibility determination, enrollment,  
40 premium collection, sales, or claims administration on a per-claim

1 basis that would otherwise be provided directly by the carrier or  
2 through a third-party administrator on a commission basis or an  
3 agent or solicitor workforce on a commission basis.

4 Each carrier that enters into an agreement with any qualified  
5 association for the provision of administrative services shall offer  
6 all qualified associations with which it contracts the same premium  
7 discounts for performing those services the carrier has permitted  
8 the qualified association or its third-party administrator to assume.  
9 The carrier shall apply these uniform discounts to the carrier's risk  
10 adjusted employee risk rates after the carrier has determined the  
11 qualified association's risk adjusted employee risk rates pursuant  
12 to Section 10755.14. The carrier shall report to the department its  
13 schedule of discounts for each administrative service.

14 In no instance may a carrier provide discounts to qualified  
15 associations that are in any way intended to, or materially result  
16 in, a reduction in premium charges to the qualified association due  
17 to the health status of the membership of the qualified association.  
18 In addition to any other remedies available to the commissioner  
19 to enforce this chapter, the commissioner may declare a contract  
20 between a carrier and a qualified association for administrative  
21 services pursuant to this section null and void if the commissioner  
22 determines any discounts provided to the qualified association are  
23 intended to, or materially result in, a reduction in premium charges  
24 to the qualified association due to the health status of the  
25 membership of the qualified association.

26 (b) For the purposes of this section, a qualified association is a  
27 nonprofit corporation comprised of a group of individuals or  
28 employers who associate based solely on participation in a  
29 specified profession or industry, that conforms to all of the  
30 following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

21 10755.18.7. Notwithstanding any other provision of law, no  
22 provision of this chapter shall be construed to limit the applicability  
23 of any other provision of the Insurance Code unless such provision  
24 is in conflict with the requirements of this chapter.

25 ~~10755.19. (a) On or before October 1, 2013, and annually~~  
26 ~~thereafter, a carrier shall issue the following notice to all insureds~~  
27 ~~enrolled in a grandfathered health benefit plan:~~

28  
29 ~~“Beginning on and after January 1, 2014, new improved health~~  
30 ~~insurance options are available in California. You currently have~~  
31 ~~health insurance that is exempt from many of the new requirements.~~  
32 ~~You have the option to remain in your current plan or switch to a~~  
33 ~~new plan. Under the new rules, a health insurance company cannot~~  
34 ~~deny your application based on any health conditions you may~~  
35 ~~have. For more information about your options, please contact the~~  
36 ~~California Health Benefit Exchange, the Office of Patient~~  
37 ~~Advocate, your plan or policy representative, an insurance broker,~~  
38 ~~or a health care navigator.”~~

39

1 ~~(b) A carrier shall include the notice described in subdivision~~  
2 ~~(a) in any marketing material of the individual grandfathered health~~  
3 ~~plan.~~

4 ~~SEC. 20. Nothing in this act shall preclude the Legislature from~~  
5 ~~considering and adopting future legislation to allow premium~~  
6 ~~ratings based on tobacco use and wellness incentives, to the extent~~  
7 ~~permitted under the federal Patient Protection and Affordable Care~~  
8 ~~Act (Public Law 111-148) and any rules, regulations, or guidance~~  
9 ~~issued consistent with that law.~~

10 ~~SEC. 21.~~

11 ~~SEC. 16. This act~~ *Except as otherwise specified in this act, this*  
12 *act shall be implemented to the extent consistent with that it meets*  
13 *or exceeds the requirements set forth in the federal Patient*  
14 *Protection and Affordable Care Act (Public Law 111-148), as*  
15 *amended by the federal Health Care and Education Reconciliation*  
16 *Act of 2010 (Public Law 111-152), and any rules, regulations, or*  
17 *guidance issued pursuant to that law, except to the extent that this*  
18 *act provides greater consumer protections.*

19 ~~SEC. 22.~~

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