Assembly Bill No. 1083

CHAPTER 852

An act to amend Sections 1385.01 and 1393.6 of, to add 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 addArticle 3.15 (commencing with Section 1357.50) of Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Section 10181 of, to add Sections 10127.19, 10198.10, and 10750 to, to add Chapter 8.01 (commencing with 10753) and Chapter 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, the Insurance Code, relating to health care coverage.

[Approved by Governor September 30, 2012. Filed with Secretary of State September 30, 2012.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1083, 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, on or after January 1, 2014, from imposing any preexisting condition provision upon any individual, except as specified. 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 adopt emergency regulations implementing the bill's provisions regarding grandfathered plans by August 31, 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.

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

SECTION 1. Section 1348.95 is added to the Health and Safety Code, to read:

1348.95. Commencing March 1, 2013, and at least annually thereafter, every health care service plan, not including a health care service plan

offering specialized health care service plan contracts, shall provide to the department, in a form and manner determined by the department in consultation with the Department of Insurance, the number of enrollees, by product type, as of December 31 of the prior year, that receive health care coverage under a health care service plan contract that covers individuals, small groups, large groups, or administrative services only business lines. Health care service plans shall include the enrollment data in specific product types as determined by the department, including, but not limited to, HMO, point-of-service, PPO, grandfathered, and Medi-Cal managed care. The department shall publicly report the data provided by each health care service plan pursuant to this section, including, but not limited to, posting the data on the department's Internet Web site. The department shall consult with the Department of Insurance to ensure that the data reported is comparable and consistent, does not duplicate existing reporting requirements, and utilizes existing reporting formats.

SEC. 2. Section 1357.19 is added to the Health and Safety Code, to read:

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

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

Article 3.16. Nongrandfathered Small Employer Plans

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

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

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

(c) "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this

paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

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

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

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

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

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

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

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

(f) "Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan consistent with the periods provided pursuant to Section 1357.503 and who subsequently requests enrollment in a health benefit plan of that small employer, except where the employee or dependent qualifies for a special enrollment period provided pursuant to Section 1357.503. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract consistent with the periods provided pursuant to Section 1357.503 and who subsequently requests enrollment in the plan, except where that member or person qualifies for a special enrollment period provided pursuant to Section 1357.503.

(g) "New business" means a health care service plan contract issued to a small employer that is not the plan's in force business.

(h) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. No health care service plan shall limit or exclude coverage for any individual based on a preexisting condition whether or not any medical

advice, diagnosis, care, or treatment was recommended or received before that date.

(i) "Creditable coverage" means:

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

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

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

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

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

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

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

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

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

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

(j) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than 12 months from the date of issuance or renewal of the plan contract.

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

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority

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

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

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

(*l*) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (k), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance

as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

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

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

(m) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

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

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

(p) "Nongrandfathered small employer health care service plan contract" means a small employer health care service plan contract that is not a grandfathered health plan.

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

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

(s) "Small employer health care service plan contract" means a health care service plan contract issued to a small employer.

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

(u) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

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

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

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

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

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

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

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

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

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

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

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

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

enrollment periods required in the individual nongrandfathered market in the state under Section 1399.849, except for the triggering events identified in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of Federal Regulations with respect to plan contracts offered through the Exchange.

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

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

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

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

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

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

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

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

(1) Encourage or direct small employers to refrain from filing an application for coverage with a plan because of the health status, claims

experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

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

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

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

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

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

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

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

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

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

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

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

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

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

contract shall become effective no later than the first day of the second month following notification.

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

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

(c) In determining whether a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

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

1357.507. Nothing in this article shall be construed as prohibiting a health care service plan from restricting enrollment of late enrollees to open enrollment periods provided under Section 1357.503 as authorized under Section 2702 of the federal Public Health Service Act.

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

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

(a) To a small employer, if the small employer is not physically located in a plan's approved service areas, or if an eligible employee and dependents

who are to be covered by the plan contract do not work or reside within a plan's approved service areas.

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

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

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

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

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

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

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

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

Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or subsidiary.

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

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

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

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

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

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

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

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

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

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined based on the individual's birthday and shall not vary by more than three to one for adults.

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

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

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

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

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

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

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

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

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

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

(x) Region 10 shall consist of the Counties of San Joaquin, Stanislaus, Merced, Mariposa, and Tulare.

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

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

(xiii) Region 13 shall consist of the Counties of Mono, Inyo, and Imperial.

(xiv) Region 14 shall consist of the County of Kern.

(xv) Region 15 shall consist of the ZIP Codes in Los Angeles County starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(xvi) Region 16 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (xv).

(xvii) Region 17 shall consist of the Counties of San Bernardino and Riverside.

(xviii) Region 18 shall consist of the County of Orange.

(xix) Region 19 shall consist of the County of San Diego.

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Insurance, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and submit a report to the appropriate policy committees of the Legislature.

(3) Whether the contract covers an individual or family, as described in PPACA.

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

(c) The rating period for rates subject to this section shall be no less than 12 months from the date of issuance or renewal of the plan contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

compliance with Section 1357.512. Plans that will be offering to a small employer plan contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

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

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

1357.516. (a) Health care service plans may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Health care service plans that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The health care service plan shall permit all qualified associations to assume one or more of these functions when the health care service plan determines the qualified association demonstrates the administrative capacity to assume these functions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article 3.15. Preexisting Condition Provisions

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

(1) “Health benefit plan” means a health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or coverage under a specialized health care service plan contract.

(2) “Preexisting condition provision” means a contract provision that excludes coverage for charges or expenses incurred during a specified period

following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(3) "Creditable coverage" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) "Grandfathered health benefit plan" means a health benefit plan that is a grandfathered health plan, as defined in Section 1251 of PPACA.

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

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

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

(b) A grandfathered health benefit plan for individual coverage shall not exclude coverage on the basis of a waivered condition provision or preexisting condition provision for a period greater than 12 months following the enrollee's effective date of coverage, nor limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause or waivered condition provision pursuant to this article. Waivered condition provisions or preexisting condition provisions contained in individual grandfathered health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

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

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

(d) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to an enrollee, a plan shall credit the time the enrollee was covered under creditable coverage, provided that the enrollee becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under

the succeeding plan within the applicable enrollment period. A plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting or affiliation period.

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

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

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

(a) Health status.

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

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

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

(h) Disability.

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

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

SEC. 5. Section 1357.55 is added to the Health and Safety Code, to read:

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

SEC. 6. Article 3.17 (commencing with Section 1357.600) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.17. Grandfathered Small Employer Plans

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

(a) "Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health care service plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include

dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (n).

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

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

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

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

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

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

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

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

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

association pursuant to subdivision (n), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer

health benefit plan, including a plan offered through the California Health Benefit Exchange, at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(e) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. No health care service plan shall limit or exclude coverage for any individual based on a preexisting condition whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(f) "Creditable coverage" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Under 30
30–39
40–49
50–54
55–59
60–64
65 and over

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

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

(A) Single.

(B) Married couple or registered domestic partners.

(C) One adult and child or children.

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

(3) (A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP

Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

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

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

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

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

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish

eligibility. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this subparagraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association. This subparagraph shall be implemented to the extent consistent with PPACA, except that the minimum requirement of one employee shall be implemented only to the extent required by PPACA.

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

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

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

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

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

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

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

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

(p) "Grandfathered small employer health care service plan contract" means a small employer health care service plan contract that constitutes a grandfathered health plan.

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

(r) "Nongrandfathered small employer health care service plan contract" means a small employer health care service plan contract that is not a grandfathered health plan.

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

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

(u) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(v) "Small employer health care service plan contract" means a health care service plan contract issued to a small employer.

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

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

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

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

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

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

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

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

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

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

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

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

(b) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in renewing its grandfathered health care service plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (a) of Section 1357.600 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage

under subdivision (n) of Section 1357.600, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

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

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

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

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

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

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

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

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

1357.606. (a) For plan contracts expiring after July 1, 1994, 60 days prior to July 1, 1994, an association that meets the definition of a guaranteed association, as set forth in Section 1357.600, except for the requirement that

1,000 persons be covered, shall be entitled to renew grandfathered small employer health care service plan contracts as if the association were a guaranteed association, except that the coverage shall be guaranteed only for those members of an association, as defined in Section 1357.600, (1) who were receiving coverage or had successfully applied for coverage through the association as of June 30, 1993, (2) who were receiving coverage through the association as of December 31, 1992, and whose coverage lapsed at any time thereafter because the employment through which coverage was received ended or an employer's contribution to health coverage ended, or (3) who were covered at any time between June 30, 1993, and July 1, 1994, under a contract that was in force on June 30, 1993.

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

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

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

(c) In determining whether a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

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

1357.608. Nothing in this article shall be construed as prohibiting a health care service plan from restricting enrollment of late enrollees to open enrollment periods consistent with federal law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) At the time it renews a grandfathered small employer health care service plan contract, each plan shall provide the small employer with a

statement of all of its nongrandfathered small employer health care service plan contracts, including the rates for each plan contract, in the service area in which the employer's employees and eligible dependents who are to be covered by the plan contract work or reside. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

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

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

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

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

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

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

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

in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

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

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

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

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

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

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

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

Each health care service plan that enters into an agreement with any qualified association for the provision of administrative services shall offer

all qualified associations with which it contracts the same premium discounts for performing those services the health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service plan shall apply these uniform discounts to the health care service plan's risk adjusted employee risk rates after the health plan has determined the qualified association's risk adjusted employee risk rates pursuant to Section 1357.612. The health care service plan shall report to the department its schedule of discounts for each administrative service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

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

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

(a) "Large group health care service plan contract" means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

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

(c) "PPACA" means Section 2794 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal Patient Protection and Affordable Care Act (Public Law (111-148)), and any subsequent rules, regulations, or guidance issued under that section.

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

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

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

(a) Any person, solicitor, or solicitor firm, other than a health care service plan, who willfully violates any provision of this chapter, or who willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two hundred fifty dollars ($250)

for each first violation, and of not less than one thousand dollars ($1,000) and not more than two thousand five hundred dollars ($2,500) for each subsequent violation.

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

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

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

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

10127.19. Commencing March 1, 2013, and at least annually thereafter, every health insurer, not including a health insurer offering specialized health insurance policies, shall provide to the department, in a form and manner determined by the department in consultation with the Department of Managed Health Care, the number of covered lives, by product type, as of December 31 of the prior year, that receive health care coverage under a health insurance policy that covers individuals, small groups, large groups, or administrative services only business lines. Health insurers shall include the unduplicated enrollment data in specific product types as determined by the department, including, but not limited to, HMO, point-of-service, PPO, grandfathered, and Medi-Cal managed care. The department shall publicly report the data provided by each health insurer pursuant to this section, including, but not limited to, posting the data on the department's Internet Web site. The department shall consult with the Department of Managed Health Care to ensure that the data reported is comparable and consistent, does not duplicate existing reporting requirements, and utilizes existing reporting formats.

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

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

(a) "Large group health insurance policy" means a group health insurance policy other than a policy issued to a small employer, as defined in Section 10700, 10753, or 10755.

(b) "Small group health insurance policy" means a group health insurance policy issued to a small employer, as defined in Section 10700, 10753, or 10755.

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

and Affordable Care Act (Public Law 111-148), and any subsequent rules, regulations, or guidance issued pursuant to that law.

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

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

Article 7. Preexisting Condition Provisions

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

(a) "Health benefit plan" means any group or individual policy of health insurance, as defined in Section 106. The term does not include coverage of Medicare services pursuant to contracts with the United States government or coverage that provides excepted benefits as described in Sections 2722 and 2791 of the federal Public Health Service Act, subject to Section 10198.61.

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

(c) "Creditable coverage" means:

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

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

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

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

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

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

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

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

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

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

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

(e) "Grandfathered health benefit plan" means a health benefit plan that is a grandfathered health plan, as defined in Section 1251 of PPACA.

(f) "Nongrandfathered health benefit plan" means a health benefit plan that is not a grandfathered health plan as defined in Section 1251 of PPACA.

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

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

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

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

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for coverage that provides essential health benefits as defined by the state pursuant to Section 1302 of PPACA, and (ii) the disclosure form as described in Section 10603 contains the following statement prominently on the first page: "This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

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

(3) In the case of a policy or certificate described in this section and that is offered for the first time in this state for plan years on or after January 1, 2014, the carrier files with the commissioner the information and statement

required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

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

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

(b) A grandfathered health benefit plan for individual coverage shall not exclude coverage on the basis of a waivered condition provision or preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor limit or exclude coverage for a specific insured by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause or waivered condition provision pursuant to this article. Waivered condition provisions or preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) A health benefit plan for group coverage may apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents and if consistent with PPACA. A waitingperiod shall not be based on a preexisting condition of an employee or dependent, the health status of an employee or dependent, or any other factor listed in Section 10198.9. During the waiting period, the health benefit plan is not required to provide health care services and no premium shall be charged to the policyholder or insureds.

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

(d) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting period applies to a person, a health benefit plan shall credit the time the person was covered under creditable coverage, provided that the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage under the succeeding plan within the applicable enrollment period. A plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered

through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting period, and applies for coverage under the succeeding plan within the applicable enrollment period.

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

10198.8. This article applies to all health benefit plans that provide benefits to residents of this state regardless of the situs of the contract or group master policyholder.

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

(a) Health status.

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

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

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

(h) Disability.

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

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

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

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

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

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

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

Chapter 8.01. Nongrandfathered Small Employer Health Insurance

Article 1. Definitions

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

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

(c) "Carrier" means a health insurer or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder.

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

(e) "Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (s).

(f) "Eligible employee" means either of the following:

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

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

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

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

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

(2) Any member of a guaranteed association as defined in subdivision (s).

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

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

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

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

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

(j) "Health benefit plan" means a policy of health insurance, as defined in Section 106, for the covered eligible employees of a small employer and their dependents. The term does not include coverage of Medicare services pursuant to contracts with the United States government, or coverage that provides excepted benefits, as described in Sections 2722 and 2791 of the federal Public Health Service Act, subject to Section 10701.

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

(*l*) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan consistent with the periods provided pursuant to Section 10753.05 and who subsequently requests enrollment in a health benefit plan of that small employer, except where the employee or dependent qualifies for a special enrollment period provided pursuant to Section 10753.05. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's health benefit plan consistent with the periods provided pursuant to Section 10753.05 and who subsequently requests enrollment in the plan, except where the employee or dependent qualifies for a special enrollment period provided pursuant to Section 10753.05.

(m) "New business" means a health benefit plan issued to a small employer that is not the carrier's in force business.

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

(o) "Creditable coverage" means:

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

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

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

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

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

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

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

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

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

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

(p) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than 12 months from the date of issuance or renewal of the health benefit plan.

(q) (1) "Small employer" means either of the following:

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health benefit plans, and in which a bona fide employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health benefit plans, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a carrier shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this chapter, provisions of this chapter that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this subparagraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association. This subparagraph shall be implemented to the extent consistent with PPACA, except that the minimum requirement of one employee shall be implemented only to the extent required by PPACA.

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

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

(r) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (q), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and

membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has been offering health insurance to its members for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any benefit plan design that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the carrier with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

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

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

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

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

(u) "Nongrandfathered health benefit plan" means a health benefit plan that is not a grandfathered health plan.

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

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

(x) "Waiting period" means a period that is required to pass with respect to the employee before the employee is eligible to be covered for benefits under the terms of the contract.

(y) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

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

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

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

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for coverage that provides essential health benefits as defined by the state pursuant to Section 1302 of PPACA, and (ii) the disclosure forms as described in Section 10603 contains the following statement prominently on the first page: "This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

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

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

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

Article 2. Small Employer Carrier Requirements

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

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

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

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

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

10753.03. The commissioner shall have the authority to determine whether a health benefit plan is covered by this chapter, and to determine whether an employer is a small employer within the meaning of Section 10753.

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

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

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

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

(3) A carrier shall provide enrollment periods consistent with PPACA and set forth in Section 155.725 of Title 45 of the Code of Federal Regulations. A carrier shall provide special enrollment periods consistent with the special enrollment periods required in the individual nongrandfathered market in the state, as set forth in Section 10965.3, except for the triggering events identified in paragraphs (d)(3) and (d)(6) of Section

155.420 of Title 45 of the Code of Federal Regulations with respect to health benefit plans offered through the Exchange.

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

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

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

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

(8) For purposes of paragraphs (4) and (6), an association is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to that date, which has a constitution and bylaws, or other analogous governing

documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

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

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

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

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

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

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

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

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

(A) Advise the small employer of the carrier’s obligation to sell to any small employer any of the health benefit plans it offers to small employers,

consistent with PPACA, and provide them, upon request, with the actual rates that would be charged to that employer for a given health benefit plan.

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

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

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

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

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

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

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

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

(f) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10753, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section 10753, is provided in connection with a guaranteed association.

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

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

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

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

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

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

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

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

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

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

(*l*) (1) With respect to the obligation to provide coverage newly issued under subdivision (c), to the extent permitted by PPACA, the carrier may cease enrolling new small employer groups and new eligible employees as defined by paragraph (2) of subdivision (f) of Section 10753 if it certifies to the commissioner that the number of eligible employees and dependents, of the employers newly enrolled or insured during the current calendar year by the carrier equals or exceeds: (A) in the case of a carrier that administers any self-funded health benefits arrangement in California, 10 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured in California by that carrier as of December 31 of the preceding year, or (B) in the case of a carrier that does not administer any self-funded health benefit arrangements in California, 8 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured by the carrier in California as of December 31 of the preceding year.

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

(m) (1) Except as provided in paragraph (2), this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, in which case carriers subject to this section shall instead be governed by Section 10705 to the extent permitted by federal law, and all references in this chapter to this section shall instead refer to Section 10705, except for purposes of paragraph (2).

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

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

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

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

10753.06. Every carrier shall file with the commissioner the reasonable participation requirements and employer contribution requirements that are to be included in its health benefit plans. Participation requirements shall be applied uniformly among all small employer groups, except that a carrier may vary application of minimum employer participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A carrier shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (e) of Section 10753 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a carrier to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage eligible under subdivision (s) of Section 10753 but not electing any health coverage through the association shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a carrier's reasonable participation standards.

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

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

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

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

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

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

(b) A health benefit plan may apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents and if consistent with PPACA. A waiting period shall not be based on a preexisting condition of an employee or dependent, the health status of an employee or dependent, or any other factor listed in subdivision (j) of Section 10753. During the waiting period, the health benefit plan is not required to provide coverage and no premium shall be charged to the policyholder or insureds.

(c) In determining whether a waiting period applies to any person, a carrier shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A carrier shall also credit any time an eligible employee must wait before enrolling in the plan, including any employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

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

10753.09. Nothing in this chapter shall be construed as prohibiting a carrier from restricting enrollment of late enrollees to open enrollment periods provided under Section 10753.05 as authorized under Section 2702 of the federal Public Health Service Act.

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

(a) To offer coverage to, or accept applications from, a small employer as defined in subparagraph (A) of paragraph (1) of subdivision (q) of Section 10753, where the small employer is not physically located in a carrier's approved service areas.

(b) To offer coverage to or accept applications from a small employer as defined in subparagraph (B) of paragraph (1) of subdivision (q) of Section 10753 where the small employer is seeking coverage for eligible employees who do not work or reside in a carrier's approved service areas.

(c) To include in a health benefit plan an otherwise eligible employee or dependent, when the eligible employee or dependent does not work or reside within a carrier's approved service area, except as provided in Section 10753.02.1.

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

A carrier that cannot offer coverage to small employers in a specific service area because it is lacking sufficient capacity may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the carrier notifies the commissioner that it has regained capacity to deliver services to small employers, and certifies to the commissioner that from the date of the notice it will enroll all small groups requesting coverage from the carrier until the carrier has met the requirements of subdivision (h) of Section 10753.05.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined based on the individual's birthday and shall not vary by more than three to one for adults.

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

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

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

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

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

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

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

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

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

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

(x) Region 10 shall consist of the Counties of San Joaquin, Stanislaus, Merced, Mariposa, and Tulare.

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

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

(xiii) Region 13 shall consist of the Counties of Mono, Inyo, and Imperial.

(xiv) Region 14 shall consist of the County of Kern.

(xv) Region 15 shall consist of the ZIP Codes in Los Angeles County starting with 906 to 912, inclusive, 915, 917, 918, and 935.

(xvi) Region 16 shall consist of the ZIP Codes in Los Angeles County other than those identified in clause (xv).

(xvii) Region 17 shall consist of the Counties of San Bernardino and Riverside.

(xviii) Region 18 shall consist of the County of Orange.

(xix) Region 19 shall consist of the County of San Diego.

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Health Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and make a report to the appropriate policy committees of the Legislature.

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

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

(c) The rating period for rates subject to this section shall be no less than 12 months from the date of issuance or renewal of the health benefit plan.

(d) This section shall become inoperative if Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added by Section 1201 of PPACA, is repealed, in which case rates for health benefit plans subject to this section shall instead be subject to Section 10714, to the extent permitted by federal law, and all references to this section shall be deemed to be references to Section 10714.

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

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

(a) The provisions concerning the carrier's ability to change premium rates and the factors that affect changes in premium rates. The carrier shall disclose that claims experience cannot be used.

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

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

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

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

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

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

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

(2) Either:

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

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

(c) If the commissioner notifies the carrier, in writing, that the carrier's rating factors do not comply with the requirements of this chapter, specifying

the reasons for his or her opinion, it is unlawful for the carrier, at any time after the receipt of such notice, to utilize the noncomplying health benefit plan or rating factors in conjunction with the health benefit plans or benefit plan designs for which the filing was made.

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

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

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

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

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

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

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

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

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

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

10753.18.5. (a) (1) In addition to any other remedy permitted by law, whenever the commissioner shall have reason to believe that any carrier, production agent, or other person or entity engaged in the business of insurance has violated this chapter, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the

commissioner may issue and serve upon that entity an order to show cause containing a statement of the charges, a statement of the entity's potential liability under this chapter, and a notice of a public hearing thereon before the Administrative Law Bureau of the department to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the commissioner should issue an order to that entity to pay the penalty imposed by this chapter and such order or orders as shall be reasonably necessary to correct, eliminate, or remedy the alleged violations of this chapter, including, but not limited to, an order to cease and desist from the specified violations of this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 8.02. Grandfathered Small Employer Health Insurance

Article 1. Definitions

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

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

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

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

(d) "Dependent" means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (t).

(e) "Eligible employee" means either of the following:

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

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

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

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

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The insurer may request any necessary information to document

the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

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

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

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

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

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

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

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

(j) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's health benefit plan and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, another person eligible for coverage through a guaranteed association pursuant to subdivision (t), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program,

the AIM Program, the Medi-Cal program, or the California Health Benefit Exchange was the reason for declining enrollment provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

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

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

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

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

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

(B) In the case of an eligible employee who is a guaranteed association member, the plan cannot produce a written statement from the guaranteed association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets

the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

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

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

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

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

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

effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

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

(*l*) "Creditable coverage" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

(p) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.

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

Under 30
30–39
40–49
50–54
55–59
60–64
65 and over

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

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

(A) Single.

(B) Married couple or registered domestic partners.

(C) One adult and child or children.

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

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

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

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

(q) (1) "Small employer" means either of the following:

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health benefit plans, and in which a bona fide employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health benefit plans, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a carrier shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this chapter, provisions of this chapter that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this subparagraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association. This subparagraph shall be implemented to the extent consistent with PPACA, except that the minimum requirement of one employee shall be implemented only to the extent required by PPACA.

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

(2) For plan years commencing on or after January 1, 2014, the definition of an employer, for purposes of determining whether an employer with one

employee shall include sole proprietors, certain owners of "S" corporations, or other individuals, shall be consistent with Section 1304 of PPACA.

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

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

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

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

(t) "Members of a guaranteed association" means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it may also include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include those persons as members of the guaranteed association, the association must so elect in advance of

purchasing coverage from a plan. Health plans may require an association to adhere to the membership composition it selects for up to 12 months.

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

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

(w) "Nongrandfathered health benefit plan" means a health benefit plan that is not a grandfathered health plan.

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

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

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

(aa) "Registered domestic partner" means a person who has established a domestic partnership as described in Section 297 of the Family Code.

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

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

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

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for coverage that provides essential health benefits as defined by the state pursuant to Section 1302 of PPACA, and (ii) contain the disclosure forms as described in Section 10603 with the following statement prominently on the first page: "This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as required under federal law."

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

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

(b) As used in this section, "policies or certificates of specified disease" and "policies or certificates of hospital confinement indemnity" mean policies or certificates of insurance sold to an insured to supplement other

health insurance coverage as specified in this section. An insurer issuing a "policy or certificate of specified disease" or a "policy or certificate of hospital confinement indemnity" shall require that the person to be insured is covered by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

Article 2. Small Employer Carrier Requirements

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

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

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

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

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

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

10755.04. (a) The department may adopt emergency regulations implementing this chapter no later than August 31, 2013. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(b) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(c) This section shall become operative on January 1, 2013.

10755.05. (a) (1) Each carrier, except a self-funded employer, shall fairly and affirmatively renew all of the carrier's health benefit plans that are sold to small employers or associations that include small employers.

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

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

(4) Each carrier that sells health benefit plans to members of one association pursuant to paragraph (3) shall submit an annual statement to the commissioner which states that the carrier is selling health benefit plans pursuant to paragraph (3) and which, for the one association, lists all the information required by paragraph (5).

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

(6) For purposes of paragraphs (2) and (3), an association is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to

that date, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

(b) Each carrier shall make available to each small employer all nongrandfathered health benefit plans that the carrier offers or sells to small employers or to associations that include small employers. Notwithstanding subdivision (d) of Section 10755, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(c) Each carrier shall do all of the following:

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

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

(3) Provide to small employers and agents and brokers, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted employee risk rates. When requesting this information, small employers and agents and brokers shall provide the plan with the information the plan needs to determine the small employer’s risk adjusted employee risk rate.

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

(5) Notwithstanding subdivision (c) of Section 10755, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(e) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (e) of Section 10755, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (e) of Section 10755, is provided in connection with a guaranteed association.

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

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

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

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

(h) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in subdivision (q) of Section 10755 shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

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

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

10755.05.1. (a) For contracts expiring after July 1, 1994, 60 days prior to July 1, 1994, an association that meets the definition of guaranteed association, as set forth in Section 10755, except for the requirement that 1,000 persons be covered, shall be entitled to purchase small employer health coverage as if the association were a guaranteed association, except that the coverage shall be guaranteed only for those members of an association, as defined in Section 10755, (1) who were receiving coverage or had successfully applied for coverage through the association as of June 30, 1993, (2) who were receiving coverage through the association as of December 31, 1992, and whose coverage lapsed at any time thereafter because the employment through which coverage was received ended or an employer's contribution to health coverage ended, or (3) who were covered at any time between June 30, 1993, and July 1, 1994, under a contract that was in force on June 30, 1993.

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

10755.06. Every carrier shall file with the commissioner the reasonable participation requirements that will be required in renewing its health benefit plans. Participation requirements of a health benefit plan shall be applied uniformly among all small employer groups, except that a carrier may vary application of minimum employer participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements of a health benefit plan shall not vary by employer size. A carrier shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (d) of Section 10755 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a carrier to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage eligible under subdivision (t) of Section 10755 but not electing any health coverage through the association shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a carrier's reasonable participation standards.

10755.08. (a) A health benefit plan shall not impose a preexisting condition provision upon any individual.

(b) A health benefit plan may apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents and if consistent with PPACA. A waiting period shall not be

based on a preexisting condition of an employee or dependent, the health status of an employee or dependent, or any other factor listed in subdivision (j) of Section 10705. During the waiting period, the health benefit plan is not required to provide health care services and no premium shall be charged to the policyholder or insureds.

(c) In determining whether a waiting period applies to any person, a carrier shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A carrier shall also credit any time an eligible employee must wait before enrolling in the plan, including any employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

(d) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning waiting periods. The requirements of this subdivision shall only be exercised to the extent they are not preempted by ERISA.

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

10755.09. Nothing in this chapter shall be construed as prohibiting a carrier from restricting enrollment of late enrollees to open enrollment periods consistent with federal law.

10755.11. No carrier shall be required by the provisions of this chapter:

(a) To include in a health benefit plan an otherwise eligible employee or dependent, when the eligible employee or dependent does not work or reside within a carrier's approved service area, except as provided in Section 10755.02.1.

(b) To offer coverage to an eligible employee, as defined in paragraph (2) of subdivision (e) of Section 10755, who within 12 months of application for coverage terminated from a health benefit plan offered by the carrier.

10755.13. All grandfathered health benefit plans shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder, or small employer except as follows:

(a) (1) For nonpayment of the required premiums by the policyholder, contractholder, or small employer, if the policyholder, contractholder, or small employer has been duly notified and billed for the charge and at least a 30-day grace period has elapsed since the date of notification or, if longer,

the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and any subsequent rules or regulations has elapsed.

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

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

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

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

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

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

(3) A carrier that ceases to write, issue, or administer new health benefit plans to small employers in this state after the passage of this chapter shall be prohibited from writing, issuing, or administering new health benefit plans to small employers in this state for a period of five years from the date of notice to the commissioner.

(e) When a carrier withdraws a health benefit plan from the small employer market, provided that the carrier notifies all affected policyholders, contractholders, or small employers and the commissioner at least 90 days prior to the discontinuation of those contracts, and that the carrier makes available to the small employer all nongrandfathered small employer health benefit plans which it markets and satisfies the requirements of Section 10714.

(f) If coverage is made available through a bona fide association pursuant to subdivision (q) of Section 10755 or a guaranteed association pursuant to subdivision (s) of Section 10755, the membership of the employer or the individual, respectively, ceases, but only if that coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

10755.14. Premiums for grandfathered health benefit plans written or administered by carriers on or after the January 1, 2014, shall be subject to the following requirements:

(a) (1) The premium for new business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the carrier's standard employee risk rates. The risk adjusted employee risk rate may not be more than 110 percent or less than 90 percent.

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

(3) The standard employee risk rates applied to a small employer for new business shall be in effect for no less than 12 months.

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

(2) The premium charged a small employer for in force business shall be equal to the sum of the risk adjusted employee risk rates. The standard employee risk rates shall be in effect for 12 months.

(c) (1) For any small employer, a carrier may, with the consent of the small employer, establish composite employee and dependent rates for renewal of in force business. The composite rates shall be determined as the average of the risk adjusted employee risk rates for the small employer, as determined in accordance with the requirements of subdivisions (a) and (b). The sum of the composite rates so determined shall be equal to the sum of the risk adjusted employee risk rates for the small employer.

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

10755.15. Carriers shall apply standard employee risk rates consistently with respect to all small employers.

10755.16. In connection with the renewal of any grandfathered health benefit plan to small employers:

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

(a) The extent to which the premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs of the employees and dependents of the small employer.

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

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

(d) Provisions relating to the prohibition of any preexisting condition provision.

(e) Provisions relating to the small employer's right to apply for any nongrandfathered health benefit plan written, issued, or administered by the carrier, at the time of application for a new health benefit plan, or at the time of renewal of a health benefit plan, consistent with the requirements of PPACA.

(f) The availability, upon request, of a listing of all the carrier's nongrandfathered health benefit plans, offered inside or outside the California Health Benefit Exchange, including the rates for each benefit plan design.

10755.17. (a) No carrier shall renew coverage subject to this chapter until it has done all of the following:

(1) A statement has been filed with the commissioner listing all of the carrier's grandfathered health benefit plans currently in force in this state, identified by form number, and, if previously approved by the commissioner, the date approved by the commissioner as well as the standard employee risk rate for each risk category for each benefit plan design and the highest and lowest risk adjustment factors that the carrier intends to use in determining rates for each benefit plan design. When filing a new benefit plan design pursuant to Section 10755.05, carriers may submit both the policy form and the standard employee risk rates for each risk category at the same time.

(2) Either:

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

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

(b) No carrier shall renew or revise a grandfathered health benefit plan lawfully provided pursuant to subdivision (a), and no carrier shall change the risk categories, risk adjustment factors, or standard employee risk rates for a grandfathered health benefit plan until all of the following requirements are met:

(1) The carrier files with the commissioner a statement of the specific changes which the carrier proposes in the risk categories, risk adjustment factors, or standard employee risk rates.

(2) Either:

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

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

(c) Notwithstanding any provision to the contrary, when a carrier is changing the standard employee risk rates of a health benefit plan lawfully provided under subdivision (a) or (b) but is not changing the risk categories or risk adjustment factors which have been previously authorized, the carrier need not comply with the requirements of paragraph (2) of subdivision (b), but instead shall submit the revised standard employee risk rates for the health benefit plan prior to renewing the health benefit plan.

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

(e) If the commissioner notifies the carrier, in writing, that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter, specifying the reasons for his or her opinion, it is unlawful for the carrier, at any time after the receipt of such notice, to utilize the noncomplying health benefit plan, benefit plan design, risk categories, or risk adjustment factors in conjunction with the health benefit plans or benefit plan designs for which the filing was made.

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

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

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

10755.18. (a) In addition to any other remedy permitted by law, the commissioner shall have the administrative authority to assess penalties against carriers, insurance producers, and other entities engaged in the

business of insurance or other persons or entities for violations of this chapter.

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

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

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

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

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

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

10755.18.5. (a) (1) In addition to any other remedy permitted by law, whenever the commissioner shall have reason to believe that any carrier, production agent, or other person or entity engaged in the business of insurance has violated this chapter, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the commissioner may issue and serve upon that entity an order to show cause containing a statement of the charges, a statement of the entity's potential liability under this chapter, and a notice of a public hearing thereon before the Administrative Law Bureau of the department to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the commissioner should issue an order to that entity to pay the penalty imposed by this chapter and such order or orders as shall be reasonably necessary to correct, eliminate, or remedy the alleged violations of this chapter, including, but not limited to, an order to cease and desist from the specified violations of this chapter.

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

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

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

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

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

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

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

10755.18.6. (a) Carriers may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Carriers that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions

for the administrative services that may be provided by a qualified association or its third-party administrator. The carrier shall permit all qualified associations to assume one or more of these functions when the carrier determines the qualified association demonstrates that it has the administrative capacity to assume these functions.

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

Each carrier that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the carrier has permitted the qualified association or its third-party administrator to assume. The carrier shall apply these uniform discounts to the carrier's risk adjusted employee risk rates after the carrier has determined the qualified association's risk adjusted employee risk rates pursuant to Section 10755.14. The carrier shall report to the department its schedule of discounts for each administrative service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10755.18.7. Notwithstanding any other provision of law, no provision of this chapter shall be construed to limit the applicability of any other provision of the Insurance Code unless such provision is in conflict with the requirements of this chapter.

SEC. 16. Except as otherwise specified in this act, this act shall be implemented to the extent that it meets or exceeds the requirements set forth in the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

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

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