

**Introduced by Senator Monning**February 14, 2014

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An act to amend Sections 1357.51, 1357.514, 1357.600, and 1357.614 of, and to repeal and add Sections 1357.506 and 1357.607 of, the Health and Safety Code, and to amend Sections 10198.7, 10753.05, 10755, and 10755.05 of, and to repeal and add Sections 10753.08 and 10755.08 of, the Insurance Code, relating to health care coverage.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1034, as introduced, Monning. Health care coverage: waiting periods.

Existing 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 prohibits a group health plan and a health insurance issuer offering group health insurance coverage from applying a waiting period that exceeds 90 days.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and 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 also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a group health care service plan contract and a group health insurance policy, as defined, to apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents.

This bill would prohibit those group contracts and policies from imposing any waiting or affiliation period, as defined, and would make related conforming changes. Because a willful violation of the bill's

requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 1357.51 of the Health and Safety Code  
2 is amended to read:

3 1357.51. (a) A health benefit plan for group coverage shall  
4 not impose any preexisting condition provision or waived  
5 condition provision upon any enrollee.

6 (b) (1) A nongrandfathered health benefit plan for individual  
7 coverage shall not impose any preexisting condition provision or  
8 waived condition provision upon any enrollee.

9 (2) A grandfathered health benefit plan for individual coverage  
10 shall not exclude coverage on the basis of a waived condition  
11 provision or preexisting condition provision for a period greater  
12 than 12 months following the enrollee’s effective date of coverage,  
13 nor limit or exclude coverage for a specific enrollee by type of  
14 illness, treatment, medical condition, or accident, except for  
15 satisfaction of a preexisting condition provision or waived  
16 condition provision pursuant to this article. Waivered condition  
17 provisions or preexisting condition provisions contained in  
18 individual grandfathered health benefit plans may relate only to  
19 conditions for which medical advice, diagnosis, care, or treatment,  
20 including use of prescription drugs, was recommended or received  
21 from a licensed health practitioner during the 12 months  
22 immediately preceding the effective date of coverage.

23 (3) If Section 5000A of the Internal Revenue Code, as added  
24 by Section 1501 of PPACA, is repealed or amended to no longer  
25 apply to the individual market, as defined in Section 2791 of the  
26 Public Health Service Act (42 U.S.C. Sec. ~~300gg-4~~, 300gg-91),  
27 paragraph (1) shall become inoperative 12 months after the date  
28 of that repeal or amendment and thereafter paragraph (2) shall

1 apply also to nongrandfathered health benefit plans for individual  
2 coverage.

3 ~~(e) (1) A health benefit plan for group coverage may apply a~~  
4 ~~waiting period of up to 60 days as a condition of employment if~~  
5 ~~applied equally to all eligible employees and dependents and if~~  
6 ~~consistent with PPACA. A health benefit plan for group coverage~~  
7 ~~through a health maintenance organization, as defined in Section~~  
8 ~~2791 of the federal Public Health Service Act (42 U.S.C. Sec.~~  
9 ~~300gg-3(e)), shall not impose any affiliation period that exceeds~~  
10 ~~60 days. A waiting or affiliation period shall not be based on a~~  
11 ~~preexisting condition of an employee or dependent, the health~~  
12 ~~status of an employee or dependent, or any other factor listed in~~  
13 ~~Section 1357.52. An affiliation period shall run concurrently with~~  
14 ~~a waiting period. During the waiting or affiliation period, the plan~~  
15 ~~is not required to provide health care services and no premium~~  
16 ~~shall be charged to the subscriber or enrollees.~~

17 ~~(2)~~

18 ~~(c) A health benefit plan for *group or* individual coverage shall~~  
19 ~~not impose any waiting or affiliation period.~~

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

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

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

4 SEC. 2. Section 1357.506 of the Health and Safety Code is  
5 repealed.

6 ~~1357.506.—(a) A small employer health care service plan~~  
7 ~~contract shall not impose a preexisting condition provision upon~~  
8 ~~any individual.~~

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

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

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

5 SEC. 3. Section 1357.506 is added to the Health and Safety  
6 Code, to read:

7 1357.506. A small employer health care service plan contract  
8 shall not impose a preexisting condition provision or a waiting or  
9 affiliation period upon any individual.

10 SEC. 4. Section 1357.514 of the Health and Safety Code is  
11 amended to read:

12 1357.514. In connection with the offering for sale of a small  
13 employer health care service plan contract subject to this article,  
14 each plan shall make a reasonable disclosure, as part of its  
15 solicitation and sales materials, of the following:

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

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

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

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

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

34 (f) At the time it offers a contract to a small employer, each plan  
35 shall provide the small employer with a statement of all of its small  
36 employer health care service plan contracts, including the rates  
37 for each plan contract, in the service area in which the employer's  
38 employees and eligible dependents who are to be covered by the  
39 plan contract work or reside. For purposes of this subdivision,

1 plans that are affiliated plans or that are eligible to file a  
2 consolidated income tax return shall be treated as one health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 SEC. 5. Section 1357.600 of the Health and Safety Code is  
32 amended to read:

33 1357.600. As used in this article, the following definitions shall  
34 apply:

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

1 health coverage at the same time it determines its membership  
2 composition pursuant to subdivision (n).  
3 (b) “Eligible employee” means either of the following:  
4 (1) Any permanent employee who is actively engaged on a  
5 full-time basis in the conduct of the business of the small employer  
6 with a normal workweek of an average of 30 hours per week over  
7 the course of a month, at the small employer’s regular places of  
8 business, who has met any statutorily authorized applicable waiting  
9 period requirements. The term includes sole proprietors or partners  
10 of a partnership, if they are actively engaged on a full-time basis  
11 in the small employer’s business and included as employees under  
12 a health care service plan contract of a small employer, but does  
13 not include employees who work on a part-time, temporary, or  
14 substitute basis. It includes any eligible employee, as defined in  
15 this paragraph, who obtains coverage through a guaranteed  
16 association. Employees of employers purchasing through a  
17 guaranteed association shall be deemed to be eligible employees  
18 if they would otherwise meet the definition except for the number  
19 of persons employed by the employer. Permanent employees who  
20 work at least 20 hours but not more than 29 hours are deemed to  
21 be eligible employees if all four of the following apply:  
22 (A) They otherwise meet the definition of an eligible employee  
23 except for the number of hours worked.  
24 (B) The employer offers the employees health coverage under  
25 a health benefit plan.  
26 (C) All similarly situated individuals are offered coverage under  
27 the health benefit plan.  
28 (D) The employee must have worked at least 20 hours per  
29 normal workweek for at least 50 percent of the weeks in the  
30 previous calendar quarter. The health care service plan may request  
31 any necessary information to document the hours and time period  
32 in question, including, but not limited to, payroll records and  
33 employee wage and tax filings.  
34 (2) Any member of a guaranteed association as defined in  
35 subdivision (n).  
36 (c) “In force business” means an existing health benefit plan  
37 contract issued by the plan to a small employer.  
38 (d) “Late enrollee” means an eligible employee or dependent  
39 who has declined enrollment in a health benefit plan offered by a  
40 small employer at the time of the initial enrollment period provided

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

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

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

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

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

1 Healthy Families Program, the AIM Program, the Medi-Cal  
2 program, or coverage through the California Health Benefit  
3 Exchange.

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

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

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

15 (4) (A) In the case of an eligible employee, as defined in  
16 paragraph (1) of subdivision (b), the plan cannot produce a written  
17 statement from the employer stating that the individual or the  
18 person through whom the individual was eligible to be covered as  
19 a dependent, prior to declining coverage, was provided with, and  
20 signed, acknowledgment of an explicit written notice in boldface  
21 type specifying that failure to elect coverage during the initial  
22 enrollment period permits the plan to impose, at the time of the  
23 individual's later decision to elect coverage, ~~a waiting period of~~  
24 *an exclusion from coverage* for no longer than 60 days, unless the  
25 individual meets the criteria specified in paragraph (1), (2), or (3).  
26 *This exclusion from coverage shall not be considered a waiting*  
27 *period in violation of Section 1357.51 or 1357.607.*

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

1 *considered a waiting period in violation of Section 1357.51 or*  
2 *1357.607.*

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

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

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

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

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

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

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

31 (f) “Creditable coverage” means:

32 (1) Any individual or group policy, contract, or program that is  
33 written or administered by a disability insurer, health care service  
34 plan, fraternal benefits society, self-insured employer plan, or any  
35 other entity, in this state or elsewhere, and that arranges or provides  
36 medical, hospital, and surgical coverage not designed to supplement  
37 other private or governmental plans. The term includes continuation  
38 or conversion coverage but does not include accident only, credit,  
39 coverage for onsite medical clinics, disability income, Medicare  
40 supplement, long-term care, dental, vision, coverage issued as a

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

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

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

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

13 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)  
14 (Civilian Health and Medical Program of the Uniformed Services  
15 (CHAMPUS)).

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

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

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

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

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

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

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

37 (i) "Risk adjustment factor" means the percentage adjustment  
38 to be applied equally to each standard employee risk rate for a  
39 particular small employer, based upon any expected deviations

1 from standard cost of services. This factor may not be more than  
2 110 percent or less than 90 percent.

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

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

- 9 Under 30
- 10 30–39
- 11 40–49
- 12 50–54
- 13 55–59
- 14 60–64
- 15 65 and over

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

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

- 24 (A) Single.
- 25 (B) Married couple or registered domestic partners.
- 26 (C) One adult and child or children.
- 27 (D) Married couple or registered domestic partners and child  
28 or children.

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

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

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

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

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

25 (A) For plan years commencing on or after January 1, 2014,  
26 and on or before December 31, 2015, any person, firm, proprietary  
27 or nonprofit corporation, partnership, public agency, or association  
28 that is actively engaged in business or service, that, on at least 50  
29 percent of its working days during the preceding calendar quarter  
30 or preceding calendar year, employed at least one, but no more  
31 than 50, eligible employees, the majority of whom were employed  
32 within this state, that was not formed primarily for purposes of  
33 buying health care service plan contracts, and in which a bona fide  
34 employer-employee relationship exists. For plan years commencing  
35 on or after January 1, 2016, any person, firm, proprietary or  
36 nonprofit corporation, partnership, public agency, or association  
37 that is actively engaged in business or service, that, on at least 50  
38 percent of its working days during the preceding calendar quarter  
39 or preceding calendar year, employed at least one, but no more  
40 than 100, eligible employees, the majority of whom were employed

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

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

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

31 (l) “Standard employee risk rate” means the rate applicable to  
32 an eligible employee in a particular risk category in a small  
33 employer group.

34 (m) “Guaranteed association” means a nonprofit organization  
35 comprised of a group of individuals or employers who associate  
36 based solely on participation in a specified profession or industry,  
37 accepting for membership any individual or employer meeting its  
38 membership criteria, and that (1) includes one or more small  
39 employers as defined in subparagraph (A) of paragraph (1) of  
40 subdivision (k), (2) does not condition membership directly or

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

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

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

32 (n) “Members of a guaranteed association” means any individual  
33 or employer meeting the association’s membership criteria if that  
34 person is a member of the association and chooses to purchase  
35 health coverage through the association. At the association’s  
36 discretion, it also may include employees of association members,  
37 association staff, retired members, retired employees of members,  
38 and surviving spouses and dependents of deceased members.  
39 However, if an association chooses to include these persons as  
40 members of the guaranteed association, the association shall make

1 that election in advance of purchasing a plan contract. Health care  
2 service plans may require an association to adhere to the  
3 membership composition it selects for up to 12 months.

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

7 (p) “Grandfathered small employer health care service plan  
8 contract” means a small employer health care service plan contract  
9 that constitutes a grandfathered health plan.

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

12 (r) “Nongrandfathered small employer health care service plan  
13 contract” means a small employer health care service plan contract  
14 that is not a grandfathered health plan.

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

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

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

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

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

30 SEC. 6. Section 1357.607 of the Health and Safety Code is  
31 repealed.

32 ~~1357.607. (a) A small employer health care service plan  
33 contract shall not impose a preexisting condition provision upon  
34 any individual.~~

35 ~~(b) A plan contract may apply a waiting period of up to 60 days  
36 as a condition of employment if applied equally to all eligible  
37 employees and dependents and if consistent with PPACA. A plan  
38 contract through a health maintenance organization, as defined in  
39 Section 2791 of the federal Public Health Service Act, may impose  
40 an affiliation period not to exceed 60 days. A waiting or affiliation~~

1 period shall not be based on a preexisting condition of an employee  
2 or dependent, the health status of an employee or dependent, or  
3 any other factor listed in subdivision (c) of Section 1357.604. An  
4 affiliation period shall run concurrently with a waiting period.  
5 During the waiting or affiliation period, the plan is not required to  
6 provide health care services and no premium shall be charged to  
7 the subscriber or enrollees.

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

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

31 SEC. 7. Section 1357.607 is added to the Health and Safety  
32 Code, to read:

33 1357.607. A small employer health care service plan contract  
34 shall not impose a preexisting condition provision or a waiting or  
35 affiliation period upon any individual.

36 SEC. 8. Section 1357.614 of the Health and Safety Code is  
37 amended to read:

38 1357.614. In connection with the renewal of a grandfathered  
39 small employer health care service plan contract, each plan shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 SEC. 9. Section 10198.7 of the Insurance Code is amended to  
29 read:

30 10198.7. (a) A health benefit plan for group coverage shall  
31 not impose any preexisting condition provision or waived  
32 condition provision upon any individual.

33 (b) (1) A nongrandfathered health benefit plan for individual  
34 coverage shall not impose any preexisting condition provision or  
35 waived condition provision upon any individual.

36 (2) A grandfathered health benefit plan for individual coverage  
37 shall not exclude coverage on the basis of a waived condition  
38 provision or preexisting condition provision for a period greater  
39 than 12 months following the individual's effective date of  
40 coverage, nor limit or exclude coverage for a specific insured by

1 type of illness, treatment, medical condition, or accident, except  
2 for satisfaction of a preexisting condition provision or waived  
3 condition provision pursuant to this article. Waivered condition  
4 provisions or preexisting condition provisions contained in  
5 individual grandfathered health benefit plans may relate only to  
6 conditions for which medical advice, diagnosis, care, or treatment,  
7 including use of prescription drugs, was recommended or received  
8 from a licensed health practitioner during the 12 months  
9 immediately preceding the effective date of coverage.

10 (3) If Section 5000A of the Internal Revenue Code, as added  
11 by Section 1501 of PPACA, is repealed or amended to no longer  
12 apply to the individual market, as defined in Section 2791 of the  
13 Public Health Service Act (42 U.S.C. Sec. ~~300gg-4~~, 300gg-91),  
14 paragraph (1) shall become inoperative 12 months after the date  
15 of that repeal or amendment and thereafter paragraph (2) shall  
16 apply also to nongrandfathered health benefit plans for individual  
17 coverage.

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

27 ~~(2)~~

28 (c) A health benefit plan for *group or* individual coverage shall  
29 not impose a waiting period.

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

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

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

13     SEC. 10. Section 10753.05 of the Insurance Code is amended  
14 to read:

15     10753.05. (a) No group or individual policy or contract or  
16 certificate of group insurance or statement of group coverage  
17 providing benefits to employees of small employers as defined in  
18 this chapter shall be issued or delivered by a carrier subject to the  
19 jurisdiction of the commissioner regardless of the situs of the  
20 contract or master policyholder or of the domicile of the carrier  
21 nor, except as otherwise provided in Sections 10270.91 and  
22 10270.92, shall a carrier provide coverage subject to this chapter  
23 until a copy of the form of the policy, contract, certificate, or  
24 statement of coverage is filed with and approved by the  
25 commissioner in accordance with Sections 10290 and 10291, and  
26 the carrier has complied with the requirements of Section 10753.17.

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

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

39     (3) A carrier shall provide enrollment periods consistent with  
40 PPACA and described in Section 155.725 of Title 45 of the Code

1 of Federal Regulations. Commencing January 1, 2014, a carrier  
2 shall provide special enrollment periods consistent with the special  
3 enrollment periods described in Section 10965.3, to the extent  
4 permitted by PPACA, except for the triggering events identified  
5 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of  
6 the Code of Federal Regulations with respect to health benefit  
7 plans offered through the Exchange.

8 (4) Nothing in this section shall be construed to require an  
9 association, or a trust established and maintained by an association  
10 to receive a master insurance policy issued by an admitted insurer  
11 and to administer the benefits thereof solely for association  
12 members, to offer, market or sell a benefit plan design to those  
13 who are not members of the association. However, if the  
14 association markets, offers or sells a benefit plan design to those  
15 who are not members of the association it is subject to the  
16 requirements of this section. This shall apply to an association that  
17 otherwise meets the requirements of paragraph (8) formed by  
18 merger of two or more associations after January 1, 1992, if the  
19 predecessor organizations had been in active existence on January  
20 1, 1992, and for at least five years prior to that date and met the  
21 requirements of paragraph (5).

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

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

38 (7) Each carrier that sells health benefit plans to members of  
39 any association shall submit an annual statement to the  
40 commissioner which lists each association to which the carrier

1 sells health benefit plans, the industry or profession which is served  
2 by the association, the association's membership criteria, a list of  
3 officers, the state in which the association is organized, and the  
4 site of its principal office.

5 (8) For purposes of paragraphs (4) and (6), an association is a  
6 nonprofit organization comprised of a group of individuals or  
7 employers who associate based solely on participation in a  
8 specified profession or industry, accepting for membership any  
9 individual or small employer meeting its membership criteria,  
10 which do not condition membership directly or indirectly on the  
11 health or claims history of any person, which uses membership  
12 dues solely for and in consideration of the membership and  
13 membership benefits, except that the amount of the dues shall not  
14 depend on whether the member applies for or purchases insurance  
15 offered by the association, which is organized and maintained in  
16 good faith for purposes unrelated to insurance, which has been in  
17 active existence on January 1, 1992, and at least five years prior  
18 to that date, which has a constitution and bylaws, or other  
19 analogous governing documents which provide for election of the  
20 governing board of the association by its members, which has  
21 contracted with one or more carriers to offer one or more health  
22 benefit plans to all individual members and small employer  
23 members in this state. Health coverage through an association that  
24 is not related to employment shall be considered individual  
25 coverage pursuant to Section 144.102(c) of Title 45 of the Code  
26 of Federal Regulations.

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

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

36 (1) Prepare a brochure that summarizes all of its health benefit  
37 plans and make this summary available to small employers, agents,  
38 and brokers upon request. The summary shall include for each  
39 plan information on benefits provided, a generic description of the  
40 manner in which services are provided, such as how access to

1 providers is limited, benefit limitations, required copayments and  
2 deductibles, ~~an explanation of how creditable coverage is calculated~~  
3 ~~if a waiting period is imposed~~, and a telephone number that can  
4 be called for more detailed benefit information. Carriers are  
5 required to keep the information contained in the brochure accurate  
6 and up to date, and, upon updating the brochure, send copies to  
7 agents and brokers representing the carrier. Any entity that provides  
8 administrative services only with regard to a health benefit plan  
9 written or issued by another carrier shall not be required to prepare  
10 a summary brochure which includes that benefit plan.

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

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

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

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

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

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

39 (B) Notify the small employer that the agent or broker will  
40 procure rate and benefit information for the small employer on

1 any health benefit plan offered by a carrier for whom the agent or  
2 broker sells health benefit plans.

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

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

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

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

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

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

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

28 (f) No carrier, agent, or broker shall induce or otherwise  
29 encourage a small employer to separate or otherwise exclude an  
30 eligible employee from a health benefit plan which, in the case of  
31 an eligible employee meeting the definition in paragraph (1) of  
32 subdivision (f) of Section 10753, is provided in connection with  
33 the employee's employment or which, in the case of an eligible  
34 employee as defined in paragraph (2) of subdivision (f) of Section  
35 10753, is provided in connection with a guaranteed association.

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

38 (1) The small employer as defined by subparagraph (A) of  
39 paragraph (1) of subdivision (q) of Section 10753 offers health  
40 benefits to 100 percent of its eligible employees as defined in

1 paragraph (1) of subdivision (f) of Section 10753. Employees who  
2 waive coverage on the grounds that they have other group coverage  
3 shall not be counted as eligible employees.

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

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

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

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

18 (3) Employ marketing practices or benefit designs that will have  
19 the effect of discouraging the enrollment of individuals with  
20 significant health needs or discriminate based on the individual's  
21 race, color, national origin, present or predicted disability, age,  
22 sex, gender identity, sexual orientation, expected length of life,  
23 degree of medical dependency, quality of life, or other health  
24 conditions.

25 This subdivision shall be enforced in the same manner as Section  
26 790.03, including through Sections 790.035 and 790.05.

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

38 (j) (1) A health benefit plan offered to a small employer, as  
39 defined in Section 1304(b) of PPACA and in Section 10753, shall  
40 not establish rules for eligibility, including continued eligibility,

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

- 4 (A) Health status.
- 5 (B) Medical condition, including physical and mental illnesses.
- 6 (C) Claims experience.
- 7 (D) Receipt of health care.
- 8 (E) Medical history.
- 9 (F) Genetic information.
- 10 (G) Evidence of insurability, including conditions arising out  
11 of acts of domestic violence.
- 12 (H) Disability.
- 13 (I) Any other health status-related factor as determined by any  
14 federal regulations, rules, or guidance issued pursuant to Section  
15 2705 of the federal Public Health Service Act.

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

22 (k) (1) A carrier shall consider as a single risk pool for rating  
23 purposes in the small employer market the claims experience of  
24 all insureds in all nongrandfathered small employer health benefit  
25 plans offered by the carrier in this state, whether offered as health  
26 care service plan contracts or health insurance policies, including  
27 those insureds and enrollees who enroll in coverage through the  
28 Exchange and insureds and enrollees covered by the carrier outside  
29 of the Exchange.

30 (2) At least each calendar year, and no more frequently than  
31 each calendar quarter, a carrier shall establish an index rate for the  
32 small employer market in the state based on the total combined  
33 claims costs for providing essential health benefits, as defined  
34 pursuant to Section 1302 of PPACA and Section 10112.27, within  
35 the single risk pool required under paragraph (1). The index rate  
36 shall be adjusted on a marketwide basis based on the total expected  
37 marketwide payments and charges under the risk adjustment and  
38 reinsurance programs established for the state pursuant to Sections  
39 1343 and 1341 of PPACA. The premium rate for all of the carrier's  
40 nongrandfathered health benefit plans shall use the applicable

1 index rate, as adjusted for total expected marketwide payments  
2 and charges under the risk adjustment and reinsurance programs  
3 established for the state pursuant to Sections 1343 and 1341 of  
4 PPACA, subject only to the adjustments permitted under paragraph  
5 (3).

6 (3) A carrier may vary premium rates for a particular  
7 nongrandfathered health benefit plan from its index rate based  
8 only on the following actuarially justified plan-specific factors:

9 (A) The actuarial value and cost-sharing design of the health  
10 benefit plan.

11 (B) The health benefit plan's provider network, delivery system  
12 characteristics, and utilization management practices.

13 (C) The benefits provided under the health benefit plan that are  
14 in addition to the essential health benefits, as defined pursuant to  
15 Section 1302 of PPACA. These additional benefits shall be pooled  
16 with similar benefits within the single risk pool required under  
17 paragraph (1) and the claims experience from those benefits shall  
18 be utilized to determine rate variations for health benefit plans that  
19 offer those benefits in addition to essential health benefits.

20 (D) Administrative costs, excluding any user fees required by  
21 the Exchange.

22 (E) With respect to catastrophic plans, as described in subsection  
23 (e) of Section 1302 of PPACA, the expected impact of the specific  
24 eligibility categories for those plans.

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

30 (m) (1) Except as provided in paragraph (2), this section shall  
31 become inoperative if Section 2702 of the federal Public Health  
32 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201  
33 of PPACA, is repealed, in which case, 12 months after the repeal,  
34 carriers subject to this section shall instead be governed by Section  
35 10705 to the extent permitted by federal law, and all references in  
36 this chapter to this section shall instead refer to Section 10705,  
37 except for purposes of paragraph (2).

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

1 SEC. 11. Section 10753.08 of the Insurance Code is repealed.

2 ~~10753.08.—(a) A health benefit plan shall not impose a~~  
3 ~~preexisting condition provision upon any individual.~~

4 ~~(b) A health benefit plan may apply a waiting period of up to~~  
5 ~~60 days as a condition of employment if applied equally to all~~  
6 ~~eligible employees and dependents and if consistent with PPACA.~~  
7 ~~A waiting period shall not be based on a preexisting condition of~~  
8 ~~an employee or dependent, the health status of an employee or~~  
9 ~~dependent, or any other factor listed in subdivision (j) of Section~~  
10 ~~10753. During the waiting period, the health benefit plan is not~~  
11 ~~required to provide coverage and no premium shall be charged to~~  
12 ~~the policyholder or insureds.~~

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

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

35 SEC. 12. Section 10753.08 is added to the Insurance Code, to  
36 read:

37 10753.08. A health benefit plan shall not impose a preexisting  
38 condition provision or a waiting or affiliation period upon any  
39 individual.

1 SEC. 13. Section 10755 of the Insurance Code is amended to  
2 read:

3 10755. As used in this chapter, the following definitions shall  
4 apply:

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

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

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

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

30 (e) “Eligible employee” means either of the following:  
31 (1) Any permanent employee who is actively engaged on a  
32 full-time basis in the conduct of the business of the small employer  
33 with a normal workweek of an average of 30 hours per week over  
34 the course of a month, in the small employer’s regular place of  
35 business, who has met any statutorily authorized applicable waiting  
36 period requirements. The term includes sole proprietors or partners  
37 of a partnership, if they are actively engaged on a full-time basis  
38 in the small employer’s business, and they are included as  
39 employees under a health benefit plan of a small employer, but  
40 does not include employees who work on a part-time, temporary,

1 or substitute basis. It includes any eligible employee, as defined  
2 in this paragraph, who obtains coverage through a guaranteed  
3 association. Employees of employers purchasing through a  
4 guaranteed association shall be deemed to be eligible employees  
5 if they would otherwise meet the definition except for the number  
6 of persons employed by the employer. A permanent employee  
7 who works at least 20 hours but not more than 29 hours is deemed  
8 to be an eligible employee if all four of the following apply:

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

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

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

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

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

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

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

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

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

33 (h) “Health benefit plan” means a policy or contract written or  
34 administered by a carrier that arranges or provides health care  
35 benefits for the covered eligible employees of a small employer  
36 and their dependents. The term does not include accident only,  
37 credit, disability income, coverage of Medicare services pursuant  
38 to contracts with the United States government, Medicare  
39 supplement, long-term care insurance, dental, vision, coverage  
40 issued as a supplement to liability insurance, automobile medical

1 payment insurance, or insurance under which benefits are payable  
2 with or without regard to fault and that is statutorily required to  
3 be contained in any liability insurance policy or equivalent  
4 self-insurance.

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

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

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

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

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

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

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

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

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

25 (4) (A) In the case of an eligible employee as defined in  
26 paragraph (1) of subdivision (e), the carrier cannot produce a  
27 written statement from the employer stating that the individual or  
28 the person through whom an individual was eligible to be covered  
29 as a dependent, prior to declining coverage, was provided with,  
30 and signed acknowledgment of, an explicit written notice in  
31 boldface type specifying that failure to elect coverage during the  
32 initial enrollment period permits the carrier to impose, at the time  
33 of the individual's later decision to elect coverage, an exclusion  
34 from coverage for a period of 12 months ~~as well as a six-month~~  
35 ~~preexisting condition exclusion~~ unless the individual meets the  
36 criteria specified in paragraph (1), (2), or (3). *This exclusion from*  
37 *coverage shall not be considered a waiting period in violation of*  
38 *Section 10198.7 or 10755.08.*

39 (B) In the case of an eligible employee who is a guaranteed  
40 association member, the plan cannot produce a written statement

1 from the guaranteed association stating that the association sent a  
2 written notice in boldface type to all potentially eligible association  
3 members at their last known address prior to the initial enrollment  
4 period informing members that failure to elect coverage during  
5 the initial enrollment period permits the plan to impose, at the time  
6 of the member's later decision to elect coverage, an exclusion from  
7 coverage for a period of 12 months ~~as well as a six-month~~  
8 ~~preexisting condition exclusion~~ unless the member can demonstrate  
9 that he or she meets the requirements of subparagraphs (A), (C),  
10 and (D) of paragraph (1) or meets the requirements of paragraph  
11 (2) or (3). *This exclusion from coverage shall not be considered*  
12 *a waiting period in violation of Section 10198.7 or 10755.08.*

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

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

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

34 (7) The individual is an eligible employee who previously  
35 declined coverage under an employer health benefit plan, including  
36 a plan offered through the California Health Benefit Exchange,  
37 and who has subsequently acquired a dependent who would be  
38 eligible for coverage as a dependent of the employee through  
39 marriage, birth, adoption, or placement for adoption, and who  
40 enrolls for coverage under that employer health benefit plan on

1 his or her behalf and on behalf of his or her dependent within 30  
2 days following the date of marriage, birth, adoption, or placement  
3 for adoption, in which case the effective date of coverage shall be  
4 the first day of the month following the date the completed request  
5 for enrollment is received in the case of marriage, or the date of  
6 birth, or the date of adoption or placement for adoption, whichever  
7 applies. Notice of the special enrollment rights contained in this  
8 paragraph shall be provided by the employer to an employee at or  
9 before the time the employee is offered an opportunity to enroll  
10 in plan coverage.

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

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

35 (l) “Creditable coverage” means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 companies that are affiliated companies and that are eligible to file  
2 a combined tax return for purposes of state taxation shall be  
3 considered one employer. Subsequent to the issuance of a health  
4 benefit plan to a small employer pursuant to this chapter, and for  
5 the purpose of determining eligibility, the size of a small employer  
6 shall be determined annually. Except as otherwise specifically  
7 provided in this chapter, provisions of this chapter that apply to a  
8 small employer shall continue to apply until the plan contract  
9 anniversary following the date the employer no longer meets the  
10 requirements of this definition. It includes any small employer as  
11 defined in this subparagraph who purchases coverage through a  
12 guaranteed association, and any employer purchasing coverage  
13 for employees through a guaranteed association. This subparagraph  
14 shall be implemented to the extent consistent with PPACA, except  
15 that the minimum requirement of one employee shall be  
16 implemented only to the extent required by PPACA.

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

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

24 (r) “Standard employee risk rate” means the rate applicable to  
25 an eligible employee in a particular risk category in a small  
26 employer group.

27 (s) “Guaranteed association” means a nonprofit organization  
28 comprised of a group of individuals or employers who associate  
29 based solely on participation in a specified profession or industry,  
30 accepting for membership any individual or employer meeting its  
31 membership criteria which (1) includes one or more small  
32 employers as defined in subparagraph (A) of paragraph (1) of  
33 subdivision (q), (2) does not condition membership directly or  
34 indirectly on the health or claims history of any person, (3) uses  
35 membership dues solely for and in consideration of the membership  
36 and membership benefits, except that the amount of the dues shall  
37 not depend on whether the member applies for or purchases  
38 insurance offered by the association, (4) is organized and  
39 maintained in good faith for purposes unrelated to insurance, (5)  
40 has been in active existence on January 1, 1992, and for at least

1 five years prior to that date, (6) has been offering health insurance  
2 to its members for at least five years prior to January 1, 1992, (7)  
3 has a constitution and bylaws, or other analogous governing  
4 documents that provide for election of the governing board of the  
5 association by its members, (8) offers any benefit plan design that  
6 is purchased to all individual members and employer members in  
7 this state, (9) includes any member choosing to enroll in the benefit  
8 plan design offered to the association provided that the member  
9 has agreed to make the required premium payments, and (10)  
10 covers at least 1,000 persons with the carrier with which it  
11 contracts. The requirement of 1,000 persons may be met if  
12 component chapters of a statewide association contracting  
13 separately with the same carrier cover at least 1,000 persons in the  
14 aggregate.

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

19 For purposes of this subdivision, an association formed by a  
20 merger of two or more associations after January 1, 1992, and  
21 otherwise meeting the criteria of this subdivision shall be deemed  
22 to have been in active existence on January 1, 1992, if its  
23 predecessor organizations had been in active existence on January  
24 1, 1992, and for at least five years prior to that date and otherwise  
25 met the criteria of this subdivision.

26 (t) “Members of a guaranteed association” means any individual  
27 or employer meeting the association’s membership criteria if that  
28 person is a member of the association and chooses to purchase  
29 health coverage through the association. At the association’s  
30 discretion, it may also include employees of association members,  
31 association staff, retired members, retired employees of members,  
32 and surviving spouses and dependents of deceased members.  
33 However, if an association chooses to include those persons as  
34 members of the guaranteed association, the association must so  
35 elect in advance of purchasing coverage from a plan. Health plans  
36 may require an association to adhere to the membership  
37 composition it selects for up to 12 months.

38 (u) “Grandfathered health benefit plan” means a health benefit  
39 plan that constitutes a grandfathered health plan.

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

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

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

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

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

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

17 SEC. 14. Section 10755.05 of the Insurance Code is amended  
18 to read:

19 10755.05. (a) (1) Each carrier, except a self-funded employer,  
20 shall fairly and affirmatively renew all of the carrier’s health benefit  
21 plans that are sold to small employers or associations that include  
22 small employers.

23 (2) Nothing in this section shall be construed to require an  
24 association, or a trust established and maintained by an association  
25 to receive a master insurance policy issued by an admitted insurer  
26 and to administer the benefits thereof solely for association  
27 members, to offer, market or sell a benefit plan design to those  
28 who are not members of the association. However, if the  
29 association markets, offers or sells a benefit plan design to those  
30 who are not members of the association it is subject to the  
31 requirements of this section. This shall apply to an association that  
32 otherwise meets the requirements of paragraph (6) formed by  
33 merger of two or more associations after January 1, 1992, if the  
34 predecessor organizations had been in active existence on January  
35 1, 1992, and for at least five years prior to that date and met the  
36 requirements of paragraph (3).

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

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

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

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

20 (6) For purposes of paragraphs (2) and (3), an association is a  
21 nonprofit organization comprised of a group of individuals or  
22 employers who associate based solely on participation in a  
23 specified profession or industry, accepting for membership any  
24 individual or small employer meeting its membership criteria,  
25 which do not condition membership directly or indirectly on the  
26 health or claims history of any person, which uses membership  
27 dues solely for and in consideration of the membership and  
28 membership benefits, except that the amount of the dues shall not  
29 depend on whether the member applies for or purchases insurance  
30 offered by the association, which is organized and maintained in  
31 good faith for purposes unrelated to insurance, which has been in  
32 active existence on January 1, 1992, and at least five years prior  
33 to that date, which has a constitution and bylaws, or other  
34 analogous governing documents which provide for election of the  
35 governing board of the association by its members, which has  
36 contracted with one or more carriers to offer one or more health  
37 benefit plans to all individual members and small employer  
38 members in this state.

39 (b) Each carrier shall make available to each small employer  
40 all nongrandfathered health benefit plans that the carrier offers or

1 sells to small employers or to associations that include small  
2 employers. Notwithstanding subdivision ~~(d)~~ (c) of Section 10755,  
3 for purposes of this subdivision, companies that are affiliated  
4 companies or that are eligible to file a consolidated income tax  
5 return shall be treated as one carrier.

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

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

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

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

38 (4) Provide copies of the current summary brochure to all agents  
39 or brokers who represent the carrier and, upon updating the  
40 brochure, send copies of the updated brochure to agents and brokers

1 representing the carrier for the purpose of selling health benefit  
2 plans.

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

7 ~~(e)~~

8 (d) No carrier, agent, or broker shall induce or otherwise  
9 encourage a small employer to separate or otherwise exclude an  
10 eligible employee from a health benefit plan which, in the case of  
11 an eligible employee meeting the definition in paragraph (1) of  
12 subdivision (e) of Section 10755, is provided in connection with  
13 the employee's employment or which, in the case of an eligible  
14 employee as defined in paragraph (2) of subdivision (e) of Section  
15 10755, is provided in connection with a guaranteed association.

16 ~~(f)~~

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

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

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

29 ~~(g)~~

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

1     ~~(h)~~

2     (g) A policy or contract that covers a small employer, as defined  
3 in Section 1304(b) of PPACA and in subdivision (q) of Section  
4 10755 shall not establish rules for eligibility, including continued  
5 eligibility, of an individual, or dependent of an individual, to enroll  
6 under the terms of the plan based on any of the following health  
7 status-related factors:

8     (1) Health status.

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

10    (3) Claims experience.

11    (4) Receipt of health care.

12    (5) Medical history.

13    (6) Genetic information.

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

16    (8) Disability.

17    (9) Any other health status-related factor as determined by any  
18 federal regulations, rules, or guidance issued pursuant to Section  
19 2705 of the federal Public Health Service Act.

20    ~~(i)~~

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

26    SEC. 15. Section 10755.08 of the Insurance Code is repealed.

27    ~~10755.08. (a) A health benefit plan shall not impose a~~  
28 ~~preexisting condition provision upon any individual.~~

29    ~~(b) A health benefit plan may apply a waiting period of up to~~  
30 ~~60 days as a condition of employment if applied equally to all~~  
31 ~~eligible employees and dependents and if consistent with PPACA.~~  
32 ~~A waiting period shall not be based on a preexisting condition of~~  
33 ~~an employee or dependent, the health status of an employee or~~  
34 ~~dependent, or any other factor listed in subdivision (j) of Section~~  
35 ~~10705. During the waiting period, the health benefit plan is not~~  
36 ~~required to provide health care services and no premium shall be~~  
37 ~~charged to the policyholder or insureds.~~

38    ~~(c) In determining whether a waiting period applies to any~~  
39 ~~person, a carrier shall credit the time the person was covered under~~  
40 ~~creditable coverage, provided the person becomes eligible for~~

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

16 (d) A carrier providing aggregate or specific stop loss coverage  
17 or any other assumption of risk with reference to a health benefit  
18 plan shall provide that the plan meets all requirements of this  
19 section concerning waiting periods. The requirements of this  
20 subdivision shall only be exercised to the extent they are not  
21 preempted by ERISA.

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

26 SEC. 16. Section 10755.08 is added to the Insurance Code, to  
27 read:

28 10755.08. A health benefit plan shall not impose a preexisting  
29 condition provision or a waiting or affiliation period upon any  
30 individual.

31 SEC. 17. No reimbursement is required by this act pursuant to  
32 Section 6 of Article XIII B of the California Constitution because  
33 the only costs that may be incurred by a local agency or school  
34 district will be incurred because this act creates a new crime or  
35 infraction, eliminates a crime or infraction, or changes the penalty  
36 for a crime or infraction, within the meaning of Section 17556 of  
37 the Government Code, or changes the definition of a crime within

1 the meaning of Section 6 of Article XIII B of the California  
2 Constitution.

O