

ASSEMBLY BILL

No. 1425

Introduced by Assembly Member Travis Allen

February 27, 2015

An act to amend Sections 1357.03, 1357.503, and 1357.604 of the Health and Safety Code, and to amend Sections 10700, 10705, 10753, 10753.05, 10755, and 10755.05 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1425, as introduced, Travis Allen. Small employers: health reimbursement arrangements.

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 requires, on and after October 1, 2013, a health care service plan or health insurer to fairly and affirmatively offer, market, and sell all of the plan's or insurer's small employer health benefit plans for plan years on or after January 1, 2014, to all small employers in each service area or geographic region in which the plan or insurer provides or arranges for health care services or benefits. Existing law requires a health care service plan or health insurer to fairly and affirmatively renew a grandfathered plan contract or health benefit plan with small employers. For nongrandfathered small employer health care service plan contracts or health insurance policies, existing law requires employer contributions toward health reimbursement accounts and health savings accounts to

count toward the actuarial value of the product in the manner specified in federal rules and guidance.

This bill would prohibit a health care service plan or health insurer from prohibiting the pairing of a specific health coverage product issued by a plan or insurer to a small employer with a health reimbursement arrangement or other employer-sponsored method for reimbursing employees for all or part of their deductibles, copayments, or other out-of-pocket medical expenses under the plan contract or policy. The bill would prohibit a plan or insurer from entering into a contract with a solicitor, or an agent or broker that results in compensation paid to a solicitor, or an agent or broker for the sale of a health care service plan contract or a health benefit plan to be varied because the small employer is or will implement a health reimbursement arrangement to supplement the benefits of the plan contract or health benefit plan for its employees. Because a willful violation of the bill's provisions by a health care service plan would be a crime, this 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. This act shall be known, and may be cited as, the
- 2 Small Business Access to Coverage Act.
- 3 SEC. 2. (a) The Legislature finds and declares that the federal
- 4 Affordable Care Act provides additional protections for small
- 5 business employers to ensure access to affordable health insurance
- 6 coverage for California employers. Small employers with fewer
- 7 than 50 employees represent more than 95 percent of California
- 8 employers and more than one-half of our states' workforce. Over
- 9 the past decade, employer-sponsored health coverage has declined
- 10 by 1 percent per year as small businesses struggle to provide
- 11 coverage to their employees. While small employers are not
- 12 required to offer employer-sponsored coverage under the federal
- 13 Affordable Care Act, more than 45 percent of employers with 50

1 or fewer employees continue to offer affordable group health
2 coverage.

3 (b) It is the intent of the Legislature, with the enactment of this
4 act, to protect access to alternative coverage options for small
5 businesses and support employers offering employer-sponsored
6 coverage, in both the private commercial marketplace and the
7 public marketplace, the Small Business Health Options Program
8 (SHOP).

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

11 1357.03. (a) (1) Upon the effective date of this article, a plan
12 shall fairly and affirmatively offer, market, and sell all of the plan's
13 health care service plan contracts that are sold to small employers
14 or to associations that include small employers to all small
15 employers in each service area in which the plan provides or
16 arranges for the provision of health care services.

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

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

26 (4) A plan contracting to participate in the voluntary purchasing
27 pool for small employers provided for under Article 4
28 (commencing with Section 10730) of Chapter 8 of Part 2 of
29 Division 2 of the Insurance Code shall be deemed in compliance
30 with the requirements of paragraph (1) for a contract offered
31 through the voluntary purchasing pool established under Article
32 4 (commencing with Section 10730) of Chapter 8 of Part 2 of
33 Division 2 of the Insurance Code in those geographic regions in
34 which plans participate in the pool, if the contract is offered
35 exclusively through the pool.

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

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

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

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

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

19 *(6) A plan shall not prohibit the pairing of a specific health*
20 *coverage product issued by the plan to a small employer with a*
21 *health reimbursement arrangement or other employer-sponsored*
22 *method for reimbursing employees for all or part of their*
23 *deductibles, copayments, or other out-of-pocket expenses under*
24 *the health care service plan contract.*

25 (b) Every plan shall file with the director the reasonable
26 employee participation requirements and employer contribution
27 requirements that will be applied in offering its plan contracts.
28 Participation requirements shall be applied uniformly among all
29 small employer groups, except that a plan may vary application
30 of minimum employee participation requirements by the size of
31 the small employer group and whether the employer contributes
32 100 percent of the eligible employee’s premium. Employer
33 contribution requirements shall not vary by employer size. A health
34 care service plan shall not establish a participation requirement
35 that (1) requires a person who meets the definition of a dependent
36 in subdivision (a) of Section 1357 to enroll as a dependent if he
37 or she is otherwise eligible for coverage and wishes to enroll as
38 an eligible employee and (2) allows a plan to reject an otherwise
39 eligible small employer because of the number of persons that
40 waive coverage due to coverage through another employer.

1 Members of an association eligible for health coverage under
2 subdivision (o) of Section 1357, but not electing any health
3 coverage through the association, shall not be counted as eligible
4 employees for purposes of determining whether the guaranteed
5 association meets a plan's reasonable participation standards.

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

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

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

17 (3) The small employer agrees to inform the small employers'
18 employees of the availability of coverage and the provision that
19 those not electing coverage must wait one year to obtain coverage
20 through the group if they later decide they would like to have
21 coverage.

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

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

28 (1) Encourage or direct small employers to refrain from filing
29 an application for coverage with a plan because of the health status,
30 claims experience, industry, occupation of the small employer, or
31 geographic location provided that it is within the plan's approved
32 service ~~area~~ area, or *because the small employer is or will*
33 *implement a health reimbursement arrangement to supplement*
34 *the benefits of the plan contract for its employees.*

35 (2) Encourage or direct small employers to seek coverage from
36 another plan or the voluntary purchasing pool established under
37 Article 4 (commencing with Section 10730) of Chapter 8 of Part
38 2 of Division 2 of the Insurance Code because of the health status,
39 claims experience, industry, occupation of the small employer, or
40 geographic location provided that it is within the plan's approved

1 ~~service-area.~~ *area, or because the small employer is or will*
2 *implement a health reimbursement arrangement to supplement*
3 *the benefits of the plan contract for its employees.*

4 (e) A plan shall not, directly or indirectly, enter into any contract,
5 agreement, or arrangement with a solicitor that provides for or
6 results in the compensation paid to a solicitor for the sale of a
7 health care service plan contract to be varied because of the health
8 status, claims experience, industry, occupation, or geographic
9 location of the small ~~employer.~~ *employer, or because the small*
10 *employer is or will implement a health reimbursement arrangement*
11 *to supplement the benefits of the plan contract for its employees.*
12 This subdivision does not apply to a compensation arrangement
13 that provides compensation to a solicitor on the basis of percentage
14 of premium, provided that the percentage shall not vary because
15 of the health status, claims experience, industry, occupation, or
16 geographic area of the small ~~employer.~~ *employer, or because the*
17 *small employer is or will implement a health reimbursement*
18 *arrangement to supplement the benefits of the plan contract for*
19 *its employees.*

20 (f) A policy or contract that covers two or more employees shall
21 not establish rules for eligibility, including continued eligibility,
22 of an individual, or dependent of an individual, to enroll under the
23 terms of the plan based on any of the following health status-related
24 factors:

- 25 (1) Health status.
- 26 (2) Medical condition, including physical and mental illnesses.
- 27 (3) Claims experience.
- 28 (4) Receipt of health care.
- 29 (5) Medical history.
- 30 (6) Genetic information.
- 31 (7) Evidence of insurability, including conditions arising out of
32 acts of domestic violence.
- 33 (8) Disability.

34 (g) A plan shall comply with the requirements of Section 1374.3.
35 SEC. 4. Section 1357.503 of the Health and Safety Code is
36 amended to read:

37 1357.503. (a) (1) On and after October 1, 2013, a plan shall
38 fairly and affirmatively offer, market, and sell all of the plan's
39 small employer health care service plan contracts for plan years
40 on or after January 1, 2014, to all small employers in each service

1 area in which the plan provides or arranges for the provision of
2 health care services.

3 (2) On and after October 1, 2013, a plan shall make available
4 to each small employer all small employer health care service plan
5 contracts that the plan offers and sells to small employers or to
6 associations that include small employers in this state for plan
7 years on or after January 1, 2014. Health coverage through an
8 association that is not related to employment shall be considered
9 individual coverage pursuant to Section 144.102(c) of Title 45 of
10 the Code of Federal Regulations.

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

16 (4) *A plan shall not prohibit the pairing of a specific health*
17 *coverage product issued by the plan to a small employer with a*
18 *health reimbursement arrangement or other employer-sponsored*
19 *method for reimbursing employees for all or part of their*
20 *deductibles, copayments, or other out-of-pocket expenses under*
21 *the health care service plan contract.*

22 (b) A plan shall provide enrollment periods consistent with
23 PPACA and described in Section 155.725 of Title 45 of the Code
24 of Federal Regulations. Commencing January 1, 2014, a plan shall
25 provide special enrollment periods consistent with the special
26 enrollment periods described in Section 1399.849, to the extent
27 permitted by PPACA, except for the triggering events identified
28 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
29 the Code of Federal Regulations with respect to plan contracts
30 offered through the Exchange.

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

36 (d) Every plan shall file with the director the reasonable
37 employee participation requirements and employer contribution
38 requirements that will be applied in offering its plan contracts.
39 Participation requirements shall be applied uniformly among all
40 small employer groups, except that a plan may vary application

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

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

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

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

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

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

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

38 (1) Encourage or direct small employers to refrain from filing
39 an application for coverage with a plan because of the health status,
40 claims experience, industry, occupation of the small employer, or

1 geographic location provided that it is within the plan's approved
2 service~~area~~: *area, or because the small employer is or will*
3 *implement a health reimbursement arrangement to supplement*
4 *the benefits of the plan contract for its employees.*

5 (2) Encourage or direct small employers to seek coverage from
6 another plan because of the health status, claims experience,
7 industry, occupation of the small employer, or geographic location
8 provided that it is within the plan's approved service~~area~~: *area,*
9 *or because the small employer is or will implement a health*
10 *reimbursement arrangement to supplement the benefits of the plan*
11 *contract for its employees.*

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

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

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

- 1 (A) Health status.
- 2 (B) Medical condition, including physical and mental illnesses.
- 3 (C) Claims experience.
- 4 (D) Receipt of health care.
- 5 (E) Medical history.
- 6 (F) Genetic information.
- 7 (G) Evidence of insurability, including conditions arising out
- 8 of acts of domestic violence.
- 9 (H) Disability.
- 10 (I) Any other health status-related factor as determined by any
- 11 federal regulations, rules, or guidance issued pursuant to Section
- 12 2705 of the federal Public Health Service Act.
- 13 (2) Notwithstanding Section 1389.1, a health care service plan
- 14 shall not require an eligible employee or dependent to fill out a
- 15 health assessment or medical questionnaire prior to enrollment
- 16 under a small employer health care service plan contract. A health
- 17 care service plan shall not acquire or request information that
- 18 relates to a health status-related factor from the applicant or his or
- 19 her dependent or any other source prior to enrollment of the
- 20 individual.
- 21 (i) (1) A health care service plan shall consider as a single risk
- 22 pool for rating purposes in the small employer market the claims
- 23 experience of all enrollees in all nongrandfathered small employer
- 24 health benefit plans offered by the health care service plan in this
- 25 state, whether offered as health care service plan contracts or health
- 26 insurance policies, including those insureds and enrollees who
- 27 enroll in coverage through the Exchange and insureds and enrollees
- 28 covered by the health care service plan outside of the Exchange.
- 29 (2) At least each calendar year, and no more frequently than
- 30 each calendar quarter, a health care service plan shall establish an
- 31 index rate for the small employer market in the state based on the
- 32 total combined claims costs for providing essential health benefits,
- 33 as defined pursuant to Section 1302 of PPACA and Section
- 34 1367.005, within the single risk pool required under paragraph
- 35 (1). The index rate shall be adjusted on a marketwide basis based
- 36 on the total expected marketwide payments and charges under the
- 37 risk adjustment and reinsurance programs established for the state
- 38 pursuant to Sections 1343 and 1341 of PPACA and Exchange user
- 39 fees, as described in subdivision (d) of Section 156.80 of Title 45
- 40 of the Code of Federal Regulations. The premium rate for all of

1 the nongrandfathered small employer health benefit plans within
2 the single risk pool required under paragraph (1) shall use the
3 applicable marketwide adjusted index rate, subject only to the
4 adjustments permitted under paragraph (3).

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

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

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

13 (C) The benefits provided under the plan contract that are in
14 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 plan contracts that offer
19 those benefits in addition to essential health benefits.

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

23 (E) Administrative costs, excluding any user fees required by
24 the Exchange.

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

26 (k) (1) Except as provided in paragraph (2), if Section 2702 of
27 the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1),
28 as added by Section 1201 of PPACA, is repealed, this section shall
29 become inoperative 12 months after the repeal date, in which case
30 health care service plans subject to this section shall instead be
31 governed by Section 1357.03 to the extent permitted by federal
32 law, and all references in this article to this section shall instead
33 refer to Section 1357.03 except for purposes of paragraph (2).

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

36 SEC. 5. Section 1357.604 of the Health and Safety Code is
37 amended to read:

38 1357.604. (a) (1) A plan shall fairly and affirmatively renew
39 a grandfathered health plan contract with a small employer.

1 (2) Each plan shall make available to each small employer all
2 nongrandfathered small employer health care service plan contracts
3 that the plan offers and sells to small employers or to associations
4 that include small employers in this state consistent with Article
5 3.1 (commencing with Section 1357).

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

11 (4) *A plan shall not prohibit the pairing of a specific health*
12 *coverage product issued by the plan to a small employer with a*
13 *health reimbursement arrangement or other employer-sponsored*
14 *method for reimbursing employees for all or part of their*
15 *deductibles, copayments, or other out-of-pocket expenses under*
16 *the health care service plan contract.*

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

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

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

(2) Encourage or direct small employers to seek coverage from another plan, or coverage offered through the California Health Benefit Exchange, because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service ~~area~~ *area, or because the small employer is or will implement a health reimbursement arrangement to supplement the benefits of the plan contract for its employees.*

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

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

(1) Health status.

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

1 (3) Claims experience.

2 (4) Receipt of health care.

3 (5) Medical history.

4 (6) Genetic information.

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

7 (8) Disability.

8 (9) Any other health status-related factor as determined by any
9 federal regulations, rules, or guidance issued pursuant to Section
10 2705 of the federal Public Health Service Act.

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

12 SEC. 6. Section 10700 of the Insurance Code is amended to
13 read:

14 10700. As used in this chapter:

15 (a) “Agent or broker” means a person or entity licensed under
16 Chapter 5 (commencing with Section 1621) of Part 2 of Division
17 1.

18 (b) “Benefit plan design” means a specific health coverage
19 product issued by a carrier to small employers, to trustees of
20 associations that include small employers, or to individuals if the
21 coverage is offered through employment or sponsored by an
22 employer. It includes services covered and the levels of copayment
23 and deductibles, and it may include the professional providers who
24 are to provide those services and the sites where those services are
25 to be provided. A benefit plan design may also be an integrated
26 system for the financing and delivery of quality health care services
27 which has significant incentives for the covered individuals to use
28 the system. *A benefit plan design shall not prohibit the pairing of*
29 *a health coverage product issued by a carrier to a small employer*
30 *with a health reimbursement arrangement or other*
31 *employer-sponsored method for reimbursing employees for all or*
32 *part of their deductibles, copayments, or other out-of-pocket*
33 *medical expenses under the policy.*

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

35 (d) “Carrier” means any disability insurance company or any
36 other entity that writes, issues, or administers health benefit plans
37 that cover the employees of small employers, regardless of the
38 situs of the contract or master policyholder. For the purposes of
39 Articles 3 (commencing with Section 10719) and 4 (commencing

1 with Section 10730), “carrier” also includes health care service
2 plans.

3 (e) “Dependent” means the spouse or child of an eligible
4 employee, subject to applicable terms of the health benefit plan
5 covering the employee, and includes dependents of guaranteed
6 association members if the association elects to include dependents
7 under its health coverage at the same time it determines its
8 membership composition pursuant to subdivision (z).

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

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

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

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

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

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

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

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

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

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

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

(i) “Fund” means the California Small Group Reinsurance Fund.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 been exhausted. For purposes of this section, the definition of
2 “COBRA” set forth in subdivision (e) of Section 10116.5 shall
3 apply.

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

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

24 (8) The individual is an eligible employee who has declined
25 coverage for himself or herself or his or her dependents during a
26 previous enrollment period because his or her dependents were
27 covered by another employer health benefit plan at the time of the
28 previous enrollment period. That individual may enroll himself or
29 herself or his or her dependents for plan coverage during a special
30 open enrollment opportunity if his or her dependents have lost or
31 will lose coverage under that other employer health benefit plan.
32 The special open enrollment opportunity shall be requested by the
33 employee not more than 30 days after the date that the other health
34 coverage is exhausted or terminated. Upon enrollment, coverage
35 shall be effective not later than the first day of the first calendar
36 month beginning after the date the request for enrollment is
37 received. Notice of the special enrollment rights contained in this
38 paragraph shall be provided by the employer to an employee at or
39 before the time the employee is offered an opportunity to enroll
40 in plan coverage.

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

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

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

9 (p) “Program” means the Health Insurance Plan of California.

10 (q) “Preexisting condition provision” means a policy provision
11 that excludes coverage for charges or expenses incurred during a
12 specified period following the insured’s effective date of coverage,
13 as to a condition for which medical advice, diagnosis, care, or
14 treatment was recommended or received during a specified period
15 immediately preceding the effective date of coverage.

16 (r) “Creditable coverage” means:

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

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

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

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

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

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

3 (7) A state health benefits risk pool.

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

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

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

13 (11) Any other creditable coverage as defined by subdivision
14 (c) of Section 2701 of Title XXVII of the federal Public Health
15 Service Act (42 U.S.C. Sec. 300gg(c)).

16 (s) "Rating period" means the period for which premium rates
17 established by a carrier are in effect and shall be no less than six
18 months.

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

22 (u) "Risk adjustment factor" means the percent adjustment to
23 be applied equally to each standard employee risk rate for a
24 particular small employer, based upon any expected deviations
25 from standard claims. This factor may not be more than 120 percent
26 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
27 this factor may not be more than 110 percent or less than 90
28 percent.

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

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

35 Under 30

36 30-39

37 40-49

38 50-54

39 55-59

40 60-64

1 65 and over

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

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

9 (A) Single.

10 (B) Married couple.

11 (C) One adult and child or children.

12 (D) Married couple and child or children.

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

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

39 (w) "Small employer" means either of the following:

1 (1) Any person, proprietary or nonprofit firm, corporation,
2 partnership, public agency, or association that is actively engaged
3 in business or service that, on at least 50 percent of its working
4 days during the preceding calendar quarter, or preceding calendar
5 year, employed at least 2, but not more than 50, eligible employees,
6 the majority of whom were employed within this state, that was
7 not formed primarily for purposes of buying health insurance and
8 in which a bona fide employer-employee relationship exists. In
9 determining whether to apply the calendar quarter or calendar year
10 test, the insurer shall use the test that ensures eligibility if only one
11 test would establish eligibility. However, for purposes of
12 subdivisions (b) and (h) of Section 10705, the definition shall
13 include employers with at least three eligible employees until July
14 1, 1997, and two eligible employees thereafter. In determining the
15 number of eligible employees, companies that are affiliated
16 companies and that are eligible to file a combined income tax
17 return for purposes of state taxation shall be considered one
18 employer. Subsequent to the issuance of a health benefit plan to a
19 small employer pursuant to this chapter, and for the purpose of
20 determining eligibility, the size of a small employer shall be
21 determined annually. Except as otherwise specifically provided,
22 provisions of this chapter that apply to a small employer shall
23 continue to apply until the health benefit plan anniversary following
24 the date the employer no longer meets the requirements of this
25 definition. It includes any small employer as defined in this
26 paragraph who purchases coverage through a guaranteed
27 association, and any employer purchasing coverage for employees
28 through a guaranteed association.

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

31 (x) "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 (y) "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 which (1) includes one or more small
39 employers as defined in paragraph (1) of subdivision (w), (2) does
40 not condition membership directly or indirectly on the health or

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

21 This subdivision applies regardless of whether a master policy
22 by an admitted insurer is delivered directly to the association or a
23 trust formed for or sponsored by an association to administer
24 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 (z) "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 may also 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 those persons as
40 members of the guaranteed association, the association must so

1 elect in advance of purchasing coverage from a plan. Health plans
2 may require an association to adhere to the membership
3 composition it selects for up to 12 months.

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

7 (ab) "*Health reimbursement arrangement*" means an
8 employer-sponsored method for reimbursing employees for all or
9 part of their deductibles, copayments, or other out-of-pocket
10 medical expenses. A health reimbursement arrangement includes,
11 but is not limited to, arrangements governed under Section 105,
12 125, or 223 of the Internal Revenue Code.

13 SEC. 7. Section 10705 of the Insurance Code is amended to
14 read:

15 10705. Upon the effective date of this act:

16 (a) No group or individual policy or contract or certificate of
17 group insurance or statement of group coverage providing benefits
18 to employees of small employers as defined in this chapter shall
19 be issued or delivered by a carrier subject to the jurisdiction of the
20 commissioner regardless of the situs of the contract or master
21 policyholder or of the domicile of the carrier nor, except as
22 otherwise provided in Sections 10270.91 and 10270.92, shall a
23 carrier provide coverage subject to this chapter until a copy of the
24 form of the policy, contract, certificate, or statement of coverage
25 is filed with and approved by the commissioner in accordance with
26 Sections 10290 and 10291, and the carrier has complied with the
27 requirements of Section 10717.

28 (b) (1) Each carrier, except a self-funded employer, shall fairly
29 and affirmatively offer, market, and sell all of the carrier's benefit
30 plan designs that are sold to, offered through, or sponsored by,
31 small employers or associations that include small employers to
32 all small employers in each geographic region in which the carrier
33 makes coverage available or provides benefits.

34 (2) A carrier contracting to participate in the Voluntary Alliance
35 Uniting Employers Purchasing Program shall be deemed to be in
36 compliance with paragraph (1) for a benefit plan design offered
37 through the program in those geographic regions in which the
38 carrier participates in the program and the benefit plan design is
39 offered exclusively through the program.

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

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

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

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

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

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

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

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

13 (7) 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 (8) For purposes of paragraphs (4) and (5), 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 (c) Each carrier shall make available to each small employer
40 all benefit plan designs that the carrier offers or sells to small

1 employers or to associations that include small employers.
2 Notwithstanding subdivision (d) of Section 10700, for purposes
3 of this subdivision, companies that are affiliated companies or that
4 are eligible to file a consolidated income tax return shall be treated
5 as one carrier.

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

7 (1) Prepare a brochure that summarizes all of its benefit plan
8 designs and make this summary available to small employers,
9 agents and brokers upon request. The summary shall include for
10 each benefit plan design 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 preexisting
15 condition or affiliation period is imposed, and a telephone number
16 that can be called for more detailed benefit information. Carriers
17 are required to keep the information contained in the brochure
18 accurate and up to date, and, upon updating the brochure, send
19 copies to agents and brokers representing the carrier. Any entity
20 that provides administrative services only with regard to a benefit
21 plan design written or issued by another carrier shall not be
22 required to prepare a summary brochure which includes that benefit
23 plan design.

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

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

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

1 brochure, send copies of the updated brochure to agents and brokers
2 representing the carrier for the purpose of selling health benefit
3 plans.

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

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

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

14 (A) Advise the small employer of the carrier's obligation to sell
15 to any small employer any of the benefit plan designs it offers to
16 small employers and provide them, upon request, with the actual
17 rates that would be charged to that employer for a given benefit
18 plan design.

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

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

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

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

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

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

4 (C) Notify the small employer that, from July 1, 1993, to July
5 1, 1996, actual rates may be 20 percent higher or lower than the
6 sum of the standard employee risk rates, and from July 1, 1996,
7 and thereafter, actual rates may be 10 percent higher or lower than
8 the sum of the standard employee risk rates depending on how the
9 carrier assesses the risk of the small employer's group.

10 (D) Notify the small employer that, upon request, the agent or
11 broker will submit information to the carrier to ascertain the small
12 employer's sum of the risk adjusted standard employee risk rate
13 for any benefit plan design the carrier offers.

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

17 (f) No carrier, agent, or broker shall induce or otherwise
18 encourage a small employer to separate or otherwise exclude an
19 eligible employee from a health benefit plan which, in the case of
20 an eligible employee meeting the definition in paragraph (1) of
21 subdivision (f) of Section 10700, is provided in connection with
22 the employee's employment or which, in the case of an eligible
23 employee as defined in paragraph (2) of subdivision (f) of Section
24 17000, is provided in connection with a guaranteed association.

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

27 (1) The small employer as defined by paragraph (1) of
28 subdivision (w) of Section 10700 offers health benefits to 100
29 percent of its eligible employees as defined in paragraph (1) of
30 subdivision (f) of Section 10700. Employees who waive coverage
31 on the grounds that they have other group coverage shall not be
32 counted as eligible employees.

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

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

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

1 employer or the small employer's—~~employees.~~ *employees, or*
2 *because the small employer is or will implement a health*
3 *reimbursement arrangement to supplement the benefits of the*
4 *health benefit plan for its employees.*

5 (2) Encourage or direct small employers to seek coverage from
6 another carrier or the program because of the health status, claims
7 experience, industry, occupation, or geographic location within
8 the carrier's approved service area of the small employer or the
9 small employer's—~~employees.~~ *employees, or because the small*
10 *employer is or will implement a health reimbursement arrangement*
11 *to supplement the benefits of the health benefit plan for its*
12 *employees.*

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

30 (j) Except in the case of a late insured, or for satisfaction of a
31 preexisting condition clause in the case of initial coverage of an
32 eligible employee, a disability insurer may not exclude any eligible
33 employee or dependent who would otherwise be entitled to health
34 care services on the basis of any of the following: the health status,
35 the medical condition, including both physical and mental illnesses,
36 the claims experience, the medical history, the genetic information,
37 or the disability or evidence of insurability, including conditions
38 arising out of acts of domestic violence of that employee or
39 dependent. No health benefit plan may limit or exclude coverage
40 for a specific eligible employee or dependent by type of illness,

1 treatment, medical condition, or accident, except for preexisting
2 conditions as permitted by Section 10198.7 or 10708.

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

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

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

33 SEC. 8. Section 10753 of the Insurance Code is amended to
34 read:

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

38 (b) “Benefit plan design” means a specific health coverage
39 product issued by a carrier to small employers, to trustees of
40 associations that include small employers, or to individuals if the

1 coverage is offered through employment or sponsored by an
2 employer. It includes services covered and the levels of copayment
3 and deductibles, and it may include the professional providers who
4 are to provide those services and the sites where those services are
5 to be provided. A benefit plan design may also be an integrated
6 system for the financing and delivery of quality health care services
7 which has significant incentives for the covered individuals to use
8 the system. *A benefit plan design shall not prohibit the pairing of*
9 *a health coverage product issued by a carrier to a small employer*
10 *with a health reimbursement arrangement or other*
11 *employer-sponsored method for reimbursing employees for all or*
12 *part of their deductibles, copayments, or other out-of-pocket*
13 *medical expenses under the policy.*

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

18 (d) “Child” means a child described in Section 22775 of the
19 Government Code and subdivisions (n) to (p), inclusive, of Section
20 599.500 of Title 2 of the California Code of Regulations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 (o) “Creditable coverage” means:

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

1 without regard to fault and that is statutorily required to be
2 contained in any liability insurance policy or equivalent
3 self-insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 (r) "Guaranteed association" means a nonprofit organization
38 comprised of a group of individuals or employers who associate
39 based solely on participation in a specified profession or industry,
40 accepting for membership any individual or employer meeting its

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

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

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

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

1 association staff, retired members, retired employees of members,
2 and surviving spouses and dependents of deceased members.
3 However, if an association chooses to include those persons as
4 members of the guaranteed association, the association must so
5 elect in advance of purchasing coverage from a plan. Health plans
6 may require an association to adhere to the membership
7 composition it selects for up to 12 months.

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

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

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

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

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

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

25 (z) "Family" means the policyholder and his or her dependents.

26 (aa) *"Health reimbursement arrangement" means an*
27 *employer-sponsored method for reimbursing employees for all or*
28 *part of their deductibles, copayments, or other out-of-pocket*
29 *medical expenses. A health reimbursement arrangement includes,*
30 *but is not limited to, arrangements governed under Section 105,*
31 *125, or 223 of the Internal Revenue Code.*

32 SEC. 9. Section 10753.05 of the Insurance Code is amended
33 to read:

34 10753.05. (a) No group or individual policy or contract or
35 certificate of group insurance or statement of group coverage
36 providing benefits to employees of small employers as defined in
37 this chapter shall be issued or delivered by a carrier subject to the
38 jurisdiction of the commissioner regardless of the situs of the
39 contract or master policyholder or of the domicile of the carrier
40 nor, except as otherwise provided in Sections 10270.91 and

1 10270.92, shall a carrier provide coverage subject to this chapter
2 until a copy of the form of the policy, contract, certificate, or
3 statement of coverage is filed with and approved by the
4 commissioner in accordance with Sections 10290 and 10291, and
5 the carrier has complied with the requirements of Section 10753.17.

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

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

18 (3) A carrier shall provide enrollment periods consistent with
19 PPACA and described in Section 155.725 of Title 45 of the Code
20 of Federal Regulations. Commencing January 1, 2014, a carrier
21 shall provide special enrollment periods consistent with the special
22 enrollment periods described in Section 10965.3, to the extent
23 permitted by PPACA, except for the triggering events identified
24 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
25 the Code of Federal Regulations with respect to health benefit
26 plans offered through the Exchange.

27 (4) Nothing in this section shall be construed to require an
28 association, or a trust established and maintained by an association
29 to receive a master insurance policy issued by an admitted insurer
30 and to administer the benefits thereof solely for association
31 members, to offer, market, or sell a benefit plan design to those
32 who are not members of the association. However, if the
33 association markets, offers, or sells a benefit plan design to those
34 who are not members of the association it is subject to the
35 requirements of this section. This shall apply to an association that
36 otherwise meets the requirements of paragraph (8) formed by
37 merger of two or more associations after January 1, 1992, if the
38 predecessor organizations had been in active existence on January
39 1, 1992, and for at least five years prior to that date and met the
40 requirements of paragraph (5).

1 (5) A carrier which (A) effective January 1, 1992, and at least
2 20 years prior to that date, markets, offers, or sells benefit plan
3 designs only to all members of one association and (B) does not
4 market, offer, or sell any other individual, selected group, or group
5 policy or contract providing medical, hospital, and surgical benefits
6 shall not be required to market, offer, or sell to those who are not
7 members of the association. However, if the carrier markets, offers,
8 or sells any benefit plan design or any other individual, selected
9 group, or group policy or contract providing medical, hospital, and
10 surgical benefits to those who are not members of the association
11 it is subject to the requirements of this section.

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

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

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

1 benefit plans to all individual members and small employer
2 members in this state. Health coverage through an association that
3 is not related to employment shall be considered individual
4 coverage pursuant to Section 144.102(c) of Title 45 of the Code
5 of Federal Regulations.

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

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

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

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

37 (3) Provide copies of the current summary brochure to all agents
38 or brokers who represent the carrier and, upon updating the
39 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 (4) Notwithstanding subdivision (c) of Section 10753, 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) Every agent or broker representing one or more carriers for
8 the purpose of selling health benefit plans to small employers shall
9 do all of the following:

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

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

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

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

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

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

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

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

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

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

7 (f) No carrier, agent, or broker shall induce or otherwise
8 encourage a small employer to separate or otherwise exclude an
9 eligible employee from a health benefit plan which, in the case of
10 an eligible employee meeting the definition in paragraph (1) of
11 subdivision (f) of Section 10753, is provided in connection with
12 the employee's employment or which, in the case of an eligible
13 employee as defined in paragraph (2) of subdivision (f) of Section
14 10753, is provided in connection with a guaranteed association.

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

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

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

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

27 (1) Encourage or direct small employers to refrain from filing
28 an application for coverage with a carrier because of the health
29 status, claims experience, industry, occupation, or geographic
30 location within the carrier's approved service area of the small
31 employer or the small employer's ~~employees~~ *employees, or*
32 *because the small employer is or will implement a health*
33 *reimbursement arrangement to supplement the benefits of the*
34 *health benefit plan for its employees.*

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

1 *is or will implement a health reimbursement arrangement to*
2 *supplement the benefits of the health benefit plan for its employees.*

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

10 This subdivision shall be enforced in the same manner as Section
11 790.03, including through Sections 790.035 and 790.05.

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

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

35 (A) Health status.

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

37 (C) Claims experience.

38 (D) Receipt of health care.

39 (E) Medical history.

40 (F) Genetic information.

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

3 (H) Disability.

4 (I) Any other health status-related factor as determined by any
5 federal regulations, rules, or guidance issued pursuant to Section
6 2705 of the federal Public Health Service Act.

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

13 (k) (1) A carrier shall consider as a single risk pool for rating
14 purposes in the small employer market the claims experience of
15 all insureds in all nongrandfathered small employer health benefit
16 plans offered by the carrier in this state, whether offered as health
17 care service plan contracts or health insurance policies, including
18 those insureds and enrollees who enroll in coverage through the
19 Exchange and insureds and enrollees covered by the carrier outside
20 of the Exchange.

21 (2) At least each calendar year, and no more frequently than
22 each calendar quarter, a carrier shall establish an index rate for the
23 small employer market in the state based on the total combined
24 claims costs for providing essential health benefits, as defined
25 pursuant to Section 1302 of PPACA and Section 10112.27, within
26 the single risk pool required under paragraph (1). The index rate
27 shall be adjusted on a marketwide basis based on the total expected
28 marketwide payments and charges under the risk adjustment and
29 reinsurance programs established for the state pursuant to Sections
30 1343 and 1341 of PPACA and Exchange user fees, as described
31 in subdivision (d) of Section 156.80 of Title 45 of the Code of
32 Federal Regulations. The premium rate for all of the
33 nongrandfathered health benefit plans within the single risk pool
34 required under paragraph (1) shall use the applicable marketwide
35 adjusted index rate, subject only to the adjustments permitted under
36 paragraph (3).

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

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

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

5 (C) The benefits provided under the health benefit plan that are
6 in addition to the essential health benefits, as defined pursuant to
7 Section 1302 of PPACA. These additional benefits shall be pooled
8 with similar benefits within the single risk pool required under
9 paragraph (1) and the claims experience from those benefits shall
10 be utilized to determine rate variations for health benefit plans that
11 offer those benefits in addition to essential health benefits.

12 (D) Administrative costs, excluding any user fees required by
13 the Exchange.

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

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

22 (m) (1) Except as provided in paragraph (2), this section shall
23 become inoperative if Section 2702 of the federal Public Health
24 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201
25 of PPACA, is repealed, in which case, 12 months after the repeal,
26 carriers subject to this section shall instead be governed by Section
27 10705 to the extent permitted by federal law, and all references in
28 this chapter to this section shall instead refer to Section 10705,
29 except for purposes of paragraph (2).

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

33 SEC. 10. Section 10755 of the Insurance Code is amended to
34 read:

35 10755. As used in this chapter, the following definitions shall
36 apply:

37 (a) "Agent or broker" means a person or entity licensed under
38 Chapter 5 (commencing with Section 1621) of Part 2 of Division
39 1.

(b) “Benefit plan design” means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system. *A benefit plan design shall not prohibit the pairing of a health coverage product issued by a carrier to a small employer with a health reimbursement arrangement or other employer-sponsored method for reimbursing employees for all or part of their deductibles, copayments, or other out-of-pocket medical expenses under the policy.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (C) He or she has lost or will lose coverage under another
39 employer health benefit plan as a result of termination of
40 employment of the individual or of a person through whom the

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

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

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

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

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

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

1 period informing members that failure to elect coverage during
2 the initial enrollment period permits the plan to impose, at the time
3 of the member's later decision to elect coverage, an exclusion from
4 eligibility for coverage until the next open enrollment period,
5 unless the member can demonstrate that he or she meets the
6 requirements of subparagraphs (A), (C), and (D) of paragraph (1)
7 or meets the requirements of paragraph (2) or (3). This exclusion
8 from eligibility for coverage shall not be considered a waiting
9 period in violation of Section 10198.7 or 10755.08.

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

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

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

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

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

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

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

32 (l) “Creditable coverage” means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (p) “Risk category” means the following characteristics of an
4 eligible employee: age, geographic region, and family size of the
5 employee, plus the benefit plan design 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 health benefit plan will be primary or secondary to benefits
19 provided by the federal Medicare Program pursuant to Title XVIII
20 of the federal Social Security Act.

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

23 (A) Single.

24 (B) Married couple or registered domestic partners.

25 (C) One adult and child or children.

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

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

39 (B) In determining rates for small employers, a carrier that does
40 not operate statewide shall use no more than the number of

1 geographic regions in the state than is determined by the following
2 formula: the population, as determined in the last federal census,
3 of all counties which are included in their entirety in a carrier's
4 service area divided by the total population of the state, as
5 determined in the last federal census, multiplied by nine. The
6 resulting number shall be rounded to the nearest whole integer.
7 No region may be smaller than an area in which the first three
8 digits of all its ZIP Codes are in common within a county and no
9 county may be divided into more than two regions. The area
10 encompassed in a geographic region shall be separate and distinct
11 from areas encompassed in other geographic regions. Geographic
12 regions may be noncontiguous. No carrier shall have less than one
13 geographic area.

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

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

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

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

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

20 (r) “Standard employee risk rate” means the rate applicable to
21 an eligible employee in a particular risk category in a small
22 employer group.

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

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

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

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

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

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

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

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

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

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

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

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

14 (ab) *“Health reimbursement arrangement” means an*
15 *employer-sponsored method for reimbursing employees for all or*
16 *part of their deductibles, copayments, or other out-of-pocket*
17 *medical expenses. A health reimbursement arrangement includes,*
18 *but is not limited to, arrangements governed under Section 105,*
19 *125, or 223 of the Internal Revenue Code.*

20 SEC. 11. Section 10755.05 of the Insurance Code is amended
21 to read:

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

26 (2) Nothing in this section shall be construed to require an
27 association, or a trust established and maintained by an association
28 to receive a master insurance policy issued by an admitted insurer
29 and to administer the benefits thereof solely for association
30 members, to offer, market or sell a benefit plan design to those
31 who are not members of the association. However, if the
32 association markets, offers or sells a benefit plan design to those
33 who are not members of the association it is subject to the
34 requirements of this section. This shall apply to an association that
35 otherwise meets the requirements of paragraph (6) formed by
36 merger of two or more associations after January 1, 1992, if the
37 predecessor organizations had been in active existence on January
38 1, 1992, and for at least five years prior to that date and met the
39 requirements of paragraph (3).

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

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

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

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

1 benefit plans to all individual members and small employer
2 members in this state.

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

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

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

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

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

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

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

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

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

(1) Encourage or direct small employers to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's ~~employees~~ *employees, or because the small employer is or will implement a health reimbursement arrangement to supplement the benefits of the health benefit plan for its employees.*

(2) Encourage or direct small employers to seek coverage from another carrier or the California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's ~~employees~~ *employees, or because the small employer is or will implement a health reimbursement arrangement to supplement the benefits of the health benefit plan for its employees.*

(f) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the

1 small employer or the small employer's ~~employees~~. *employees,*
2 *or because the small employer is or will implement a health*
3 *reimbursement arrangement to supplement the benefits of the*
4 *health benefit plan for its employees.* This subdivision shall not
5 apply with respect to a compensation arrangement that provides
6 compensation to an agent or broker on the basis of percentage of
7 premium, provided that the percentage shall not vary because of
8 the health status, claims experience, industry, occupation, or
9 geographic area of the small ~~employer~~. *employer, or because the*
10 *small employer is or will implement a health reimbursement*
11 *arrangement to supplement the benefits of the health benefit plan*
12 *for its employees.*

13 (g) A policy or contract that covers a small employer, as defined
14 in Section 1304(b) of PPACA and in subdivision (q) of Section
15 10755 shall not establish rules for eligibility, including continued
16 eligibility, of an individual, or dependent of an individual, to enroll
17 under the terms of the plan based on any of the following health
18 status-related factors:

- 19 (1) Health status.
- 20 (2) Medical condition, including physical and mental illnesses.
- 21 (3) Claims experience.
- 22 (4) Receipt of health care.
- 23 (5) Medical history.
- 24 (6) Genetic information.
- 25 (7) Evidence of insurability, including conditions arising out of
26 acts of domestic violence.
- 27 (8) Disability.
- 28 (9) Any other health status-related factor as determined by any
29 federal regulations, rules, or guidance issued pursuant to Section
30 2705 of the federal Public Health Service Act.

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

36 SEC. 12. No reimbursement is required by this act pursuant to
37 Section 6 of Article XIII B of the California Constitution because
38 the only costs that may be incurred by a local agency or school
39 district will be incurred because this act creates a new crime or
40 infraction, eliminates a crime or infraction, or changes the penalty

- 1 for a crime or infraction, within the meaning of Section 17556 of
- 2 the Government Code, or changes the definition of a crime within
- 3 the meaning of Section 6 of Article XIII B of the California
- 4 Constitution.

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