

AMENDED IN ASSEMBLY MAY 19, 2015

AMENDED IN ASSEMBLY MAY 6, 2015

AMENDED IN SENATE APRIL 6, 2015

AMENDED IN SENATE FEBRUARY 26, 2015

**SENATE BILL**

**No. 125**

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**Introduced by Senator Hernandez**

January 16, 2015

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An act to amend Sections 1357.500, 1399.849, 127660, 127662, and 127664 of, and to repeal and add Section 127665 of, the Health and Safety Code, and to amend Sections 10753 and 10965.3 of the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 125, as amended, Hernandez. Health care coverage.

(1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms as of January 1, 2014. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual.

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 a health care service plan or health insurer, on and after October 1,

2013, to offer, market, and sell all of the plan's insurer's health benefit plans that are sold in the individual market for policy years on or after January 1, 2014, to all individuals and dependents in each service area in which the plan or insurer provides or arranges for the provision of health care services, as specified, but requires plans and insurers to limit enrollment in individual health benefit plans to specified open enrollment and special enrollment periods. Existing law requires a plan or insurer to provide annual enrollment periods for policy years on or after January 1, 2016, from October 15 to December 7, inclusive, of the preceding calendar year.

This bill would instead require that those annual enrollment periods extend from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive. Because a willful violation of that requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(2) PPACA requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA, in connection with state health benefit exchanges, defines a small employer to mean an employer who employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, and requires the number of employees, for purposes of determining the size of the employer, to be determined using a counting method in which full-time equivalents are treated as full-time employees for plan years beginning on or after January 1, 2016.

Existing law establishes the California Health Benefit Exchange within state government for the purpose of facilitating the purchase of qualified health plans through the Exchange by qualified individuals and small employers. 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 plan contracts or 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. For plan years commencing on or after January 1, 2016, existing law defines a small employer to mean any person, firm, proprietary or nonprofit organization, partnership, public agency, or association that is actively engaged in business or service, that, on at least ~~50 percent~~ 50% of its working days during the preceding

calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible full-time employees, as specified.

This bill would revise the definition of small employer, for plan years commencing on or after January 1, 2016, to instead require the use of the full-time equivalent employee counting method for determining the size of the employer, as specified under PPACA.

(3) Existing law establishes the California Health Benefit Review Program to assess legislation that proposes to mandate or repeal a mandated health benefit or service, as defined. Existing law requests the University of California to provide the analysis to the appropriate policy and fiscal committees of the Legislature within 60 days after receiving a request for the analysis. Existing law also requests that the university report to the Governor and the Legislature on the implementation of the program by January 1, 2014.

This bill would request the University of California to include essential health benefits and the impact on the California Health Benefit Exchange in the analysis prepared under the program. The bill would further request that the University of California assess legislation that impacts health insurance benefit design, cost sharing, premiums, and other health insurance topics. The bill would request that the university provide the analysis to the appropriate policy and fiscal committees of the Legislature not later than 60 days, or in a manner and pursuant to a timeline agreed to by the Legislature and the program, after receiving the request, as specified. The bill would also extend the date by which the university is requested to report to the Governor and the Legislature on the implementation program until January 1, 2017.

Existing law establishes the Health Care Benefits Fund to support the university in implementing the program. Existing law imposes an annual charge on health care service plans and health insurers, as specified, to be deposited into the fund. Existing law prohibits the total annual assessment pursuant to that provision from exceeding \$2,000,000. Under existing law, the fund and the program are repealed as of December 31, 2015.

This bill would extend until June 30, 2017, the operative date of the program and the fund, including the annual charge on health care service plans and health insurers. The bill would repeal the above-described provisions as of January 1, 2018.

(4) 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.

(5) This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

1 SECTION 1. Section 1357.500 of the Health and Safety Code  
2 is amended to read:

3 1357.500. As used in this article, the following definitions shall  
4 apply:

5 (a) “Child” means a child described in Section 22775 of the  
6 Government Code and subdivisions (n) to (p), inclusive, of Section  
7 599.500 of Title 2 of the California Code of Regulations.

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

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

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

1 work at least 20 hours but not more than 29 hours are deemed to  
2 be eligible employees if all four of the following apply:

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

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

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

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

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

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

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

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

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

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

11 (i) “Creditable coverage” means:

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

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

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

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

33 (5) ~~40 U.S.C. Chapter 55~~ (commencing with Section 1071) of  
 34 *Title 10 of the United States Code* (Civilian Health and Medical  
 35 Program of the Uniformed Services (CHAMPUS)).

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

38 (7) A health plan offered under ~~5 U.S.C. Chapter 89~~  
 39 (commencing with Section 8901) of *Title 5 of the United States*  
 40 *Code* (Federal Employees Health Benefits Program (FEHBP)).

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

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

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

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

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

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

1 purpose of determining eligibility, the size of a small employer  
2 shall be determined annually. Except as otherwise specifically  
3 provided in this article, provisions of this article 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 paragraph 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 (l),  
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 (3) For plan years commencing on or after January 1, 2016, the  
21 definition of small employer, for purposes of determining ~~the~~  
22 ~~number of employees;~~ *employer eligibility in the small employer*  
23 *market, the number of employees* shall be determined using the  
24 method for counting full-time equivalent employees set forth in  
25 Section 4980H(c)(2) of the Internal Revenue Code.

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

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

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

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

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

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

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

3 (p) “Nongrandfathered small employer health care service plan  
4 contract” means a small employer health care service plan contract  
5 that is not a grandfathered health plan.

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

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

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

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

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

21 (v) “Family” means the subscriber and his or her dependent or  
22 dependents.

23 (w) “Health benefit plan” means a health care service plan  
24 contract that provides medical, hospital, and surgical benefits for  
25 the covered eligible employees of a small employer and their  
26 dependents. The term does not include coverage of Medicare  
27 services pursuant to contracts with the United States government,  
28 Medicare supplement coverage, or coverage under a specialized  
29 health care service plan contract.

30 SEC. 2. Section 1399.849 of the Health and Safety Code is  
31 amended to read:

32 1399.849. (a) (1) On and after October 1, 2013, a plan shall  
33 fairly and affirmatively offer, market, and sell all of the plan’s  
34 health benefit plans that are sold in the individual market for policy  
35 years on or after January 1, 2014, to all individuals and dependents  
36 in each service area in which the plan provides or arranges for the  
37 provision of health care services. A plan shall limit enrollment in  
38 individual health benefit plans to open enrollment periods, annual  
39 enrollment periods, and special enrollment periods as provided in  
40 subdivisions (c) and (d).

1 (2) A plan shall allow the subscriber of an individual health  
2 benefit plan to add a dependent to the subscriber’s plan at the  
3 option of the subscriber, consistent with the open enrollment,  
4 annual enrollment, and special enrollment period requirements in  
5 this section.

6 (b) An individual health benefit plan issued, amended, or  
7 renewed on or after January 1, 2014, shall not impose any  
8 preexisting condition provision upon any individual.

9 (c) (1) A plan shall provide an initial open enrollment period  
10 from October 1, 2013, to March 31, 2014, inclusive, an annual  
11 enrollment period for the policy year beginning on January 1, 2015,  
12 from November 15, 2014, to February 15, 2015, inclusive, and  
13 annual enrollment periods for policy years beginning on or after  
14 January 1, 2016, from November 1, of the preceding calendar year,  
15 to January 31 of the benefit year, inclusive.

16 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code  
17 of Federal Regulations, for individuals enrolled in noncalendar  
18 year individual health plan contracts, a plan shall also provide a  
19 limited open enrollment period beginning on the date that is 30  
20 calendar days prior to the date the policy year ends in 2014.

21 (d) (1) Subject to paragraph (2), commencing January 1, 2014,  
22 a plan shall allow an individual to enroll in or change individual  
23 health benefit plans as a result of the following triggering events:

24 (A) He or she or his or her dependent loses minimum essential  
25 coverage. For purposes of this paragraph, the following definitions  
26 shall apply:

27 (i) “Minimum essential coverage” has the same meaning as that  
28 term is defined in subsection (f) of Section 5000A of the Internal  
29 Revenue Code (26 U.S.C. Sec. 5000A).

30 (ii) “Loss of minimum essential coverage” includes, but is not  
31 limited to, loss of that coverage due to the circumstances described  
32 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the  
33 Code of Federal Regulations and the circumstances described in  
34 Section 1163 of Title 29 of the United States Code. “Loss of  
35 minimum essential coverage” also includes loss of that coverage  
36 for a reason that is not due to the fault of the individual.

37 (iii) “Loss of minimum essential coverage” does not include  
38 loss of that coverage due to the individual’s failure to pay  
39 premiums on a timely basis or situations allowing for a rescission,  
40 subject to clause (ii) and Sections 1389.7 and 1389.21.

- 1 (B) He or she gains a dependent or becomes a dependent.  
2 (C) He or she is mandated to be covered as a dependent pursuant  
3 to a valid state or federal court order.  
4 (D) He or she has been released from incarceration.  
5 (E) His or her health coverage issuer substantially violated a  
6 material provision of the health coverage contract.  
7 (F) He or she gains access to new health benefit plans as a result  
8 of a permanent move.  
9 (G) He or she was receiving services from a contracting provider  
10 under another health benefit plan, as defined in Section 1399.845  
11 of this code or Section 10965 of the Insurance Code, for one of  
12 the conditions described in subdivision (c) of Section 1373.96 of  
13 this code and that provider is no longer participating in the health  
14 benefit plan.  
15 (H) He or she demonstrates to the Exchange, with respect to  
16 health benefit plans offered through the Exchange, or to the  
17 department, with respect to health benefit plans offered outside  
18 the Exchange, that he or she did not enroll in a health benefit plan  
19 during the immediately preceding enrollment period available to  
20 the individual because he or she was misinformed that he or she  
21 was covered under minimum essential coverage.  
22 (I) He or she is a member of the reserve forces of the United  
23 States military returning from active duty or a member of the  
24 California National Guard returning from active duty service under  
25 Title 32 of the United States Code.  
26 (J) With respect to individual health benefit plans offered  
27 through the Exchange, in addition to the triggering events listed  
28 in this paragraph, any other events listed in Section 155.420(d) of  
29 Title 45 of the Code of Federal Regulations.  
30 (2) With respect to individual health benefit plans offered  
31 outside the Exchange, an individual shall have 60 days from the  
32 date of a triggering event identified in paragraph (1) to apply for  
33 coverage from a health care service plan subject to this section.  
34 With respect to individual health benefit plans offered through the  
35 Exchange, an individual shall have 60 days from the date of a  
36 triggering event identified in paragraph (1) to select a plan offered  
37 through the Exchange, unless a longer period is provided in Part  
38 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
39 A of Title 45 of the Code of Federal Regulations.

1 (e) With respect to individual health benefit plans offered  
2 through the Exchange, the effective date of coverage required  
3 pursuant to this section shall be consistent with the dates specified  
4 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
5 Regulations, as applicable. A dependent who is a registered  
6 domestic partner pursuant to Section 297 of the Family Code shall  
7 have the same effective date of coverage as a spouse.

8 (f) With respect to individual health benefit plans offered outside  
9 the Exchange, the following provisions shall apply:

10 (1) After an individual submits a completed application form  
11 for a plan contract, the health care service plan shall, within 30  
12 days, notify the individual of the individual's actual premium  
13 charges for that plan established in accordance with Section  
14 1399.855. The individual shall have 30 days in which to exercise  
15 the right to buy coverage at the quoted premium charges.

16 (2) With respect to an individual health benefit plan for which  
17 an individual applies during the initial open enrollment period  
18 described in subdivision (c), when the subscriber submits a  
19 premium payment, based on the quoted premium charges, and that  
20 payment is delivered or postmarked, whichever occurs earlier, by  
21 December 15, 2013, coverage under the individual health benefit  
22 plan shall become effective no later than January 1, 2014. When  
23 that payment is delivered or postmarked within the first 15 days  
24 of any subsequent month, coverage shall become effective no later  
25 than the first day of the following month. When that payment is  
26 delivered or postmarked between December 16, 2013, to December  
27 31, 2013, inclusive, or after the 15th day of any subsequent month,  
28 coverage shall become effective no later than the first day of the  
29 second month following delivery or postmark of the payment.

30 (3) With respect to an individual health benefit plan for which  
31 an individual applies during the annual open enrollment period  
32 described in subdivision (c), when the individual submits a  
33 premium payment, based on the quoted premium charges, and that  
34 payment is delivered or postmarked, whichever occurs later, by  
35 December 15, coverage shall become effective as of the following  
36 January 1. When that payment is delivered or postmarked within  
37 the first 15 days of any subsequent month, coverage shall become  
38 effective no later than the first day of the following month. When  
39 that payment is delivered or postmarked between December 16 to  
40 December 31, inclusive, or after the 15th day of any subsequent

1 month, coverage shall become effective no later than the first day  
2 of the second month following delivery or postmark of the  
3 payment.

4 (4) With respect to an individual health benefit plan for which  
5 an individual applies during a special enrollment period described  
6 in subdivision (d), the following provisions shall apply:

7 (A) When the individual submits a premium payment, based  
8 on the quoted premium charges, and that payment is delivered or  
9 postmarked, whichever occurs earlier, within the first 15 days of  
10 the month, coverage under the plan shall become effective no later  
11 than the first day of the following month. When the premium  
12 payment is neither delivered nor postmarked until after the 15th  
13 day of the month, coverage shall become effective no later than  
14 the first day of the second month following delivery or postmark  
15 of the payment.

16 (B) Notwithstanding subparagraph (A), in the case of a birth,  
17 adoption, or placement for adoption, the coverage shall be effective  
18 on the date of birth, adoption, or placement for adoption.

19 (C) Notwithstanding subparagraph (A), in the case of marriage  
20 or becoming a registered domestic partner or in the case where a  
21 qualified individual loses minimum essential coverage, the  
22 coverage effective date shall be the first day of the month following  
23 the date the plan receives the request for special enrollment.

24 (g) (1) A health care service plan shall not establish rules for  
25 eligibility, including continued eligibility, of any individual to  
26 enroll under the terms of an individual health benefit plan based  
27 on any of the following factors:

28 (A) Health status.

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

30 (C) Claims experience.

31 (D) Receipt of health care.

32 (E) Medical history.

33 (F) Genetic information.

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

36 (H) Disability.

37 (I) Any other health status-related factor as determined by any  
38 federal regulations, rules, or guidance issued pursuant to Section  
39 2705 of the federal Public Health Service Act (Public Law 78-410).

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

8 (h) (1) A health care service plan shall consider as a single risk  
9 pool for rating purposes in the individual market the claims  
10 experience of all insureds and all enrollees in all nongrandfathered  
11 individual health benefit plans offered by that health care service  
12 plan in this state, whether offered as health care service plan  
13 contracts or individual health insurance policies, including those  
14 insureds and enrollees who enroll in individual coverage through  
15 the Exchange and insureds and enrollees who enroll in individual  
16 coverage outside of the Exchange. Student health insurance  
17 coverage, as that coverage is defined in Section 147.145(a) of Title  
18 45 of the Code of Federal Regulations, shall not be included in a  
19 health care service plan's single risk pool for individual coverage.

20 (2) Each calendar year, a health care service plan shall establish  
21 an index rate for the individual market in the state based on the  
22 total combined claims costs for providing essential health benefits,  
23 as defined pursuant to Section 1302 of PPACA, within the single  
24 risk pool required under paragraph (1). The index rate shall be  
25 adjusted on a marketwide basis based on the total expected  
26 marketwide payments and charges under the risk adjustment and  
27 reinsurance programs established for the state pursuant to Sections  
28 1343 and 1341 of PPACA and Exchange user fees, as described  
29 in subdivision (d) of Section 156.80 of Title 45 of the Code of  
30 Federal Regulations. The premium rate for all of the health benefit  
31 plans in the individual market within the single risk pool required  
32 under paragraph (1) shall use the applicable marketwide adjusted  
33 index rate, subject only to the adjustments permitted under  
34 paragraph (3).

35 (3) A health care service plan may vary premium rates for a  
36 particular health benefit plan from its index rate based only on the  
37 following actuarially justified plan-specific factors:

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

1 (B) The health benefit plan’s provider network, delivery system  
2 characteristics, and utilization management practices.

3 (C) The benefits provided under the health benefit plan that are  
4 in addition to the essential health benefits, as defined pursuant to  
5 Section 1302 of PPACA and Section 1367.005. These additional  
6 benefits shall be pooled with similar benefits within the single risk  
7 pool required under paragraph (1) and the claims experience from  
8 those benefits shall be utilized to determine rate variations for  
9 plans that offer those benefits in addition to essential health  
10 benefits.

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

14 (E) Administrative costs, excluding user fees required by the  
15 Exchange.

16 (i) This section shall only apply with respect to individual health  
17 benefit plans for policy years on or after January 1, 2014.

18 (j) This section shall not apply to a grandfathered health plan.

19 (k) If Section 5000A of the Internal Revenue Code, as added  
20 by Section 1501 of PPACA, is repealed or amended to no longer  
21 apply to the individual market, as defined in Section 2791 of the  
22 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),  
23 subdivisions (a), (b), and (g) shall become inoperative 12 months  
24 after that repeal or amendment.

25 SEC. 3. Section 127660 of the Health and Safety Code is  
26 amended to read:

27 127660. (a) The Legislature hereby requests the University of  
28 California to establish the California Health Benefit Review  
29 Program to assess legislation proposing to mandate a benefit or  
30 service, as defined in subdivision (d), and legislation proposing to  
31 repeal a mandated benefit or service, as defined in subdivision (e),  
32 and to prepare a written analysis with relevant data on the  
33 following:

34 (1) Public health impacts, including, but not limited to, all of  
35 the following:

36 (A) The impact on the health of the community, including the  
37 reduction of communicable disease and the benefits of prevention  
38 such as those provided by childhood immunizations and prenatal  
39 care.

1 (B) The impact on the health of the community, including  
2 diseases and conditions where disparities in outcomes associated  
3 with the social determinants of health as well as gender, race,  
4 sexual orientation, or gender identity are established in  
5 peer-reviewed scientific and medical literature.

6 (C) The extent to which the benefit or service reduces premature  
7 death and the economic loss associated with disease.

8 (2) Medical impacts, including, but not limited to, all of the  
9 following:

10 (A) The extent to which the benefit or service is generally  
11 recognized by the medical community as being effective in the  
12 screening, diagnosis, or treatment of a condition or disease, as  
13 demonstrated by a review of scientific and peer-reviewed medical  
14 literature.

15 (B) The extent to which the benefit or service is generally  
16 available and utilized by treating physicians.

17 (C) The contribution of the benefit or service to the health status  
18 of the population, including the results of any research  
19 demonstrating the efficacy of the benefit or service compared to  
20 alternatives, including not providing the benefit or service.

21 (D) The extent to which mandating or repealing the benefits or  
22 services would not diminish or eliminate access to currently  
23 available health care benefits or services.

24 (3) Financial impacts, including, but not limited to, all of the  
25 following:

26 (A) The extent to which the coverage or repeal of coverage will  
27 increase or decrease the benefit or cost of the benefit or service.

28 (B) The extent to which the coverage or repeal of coverage will  
29 increase the utilization of the benefit or service, or will be a  
30 substitute for, or affect the cost of, alternative benefits or services.

31 (C) The extent to which the coverage or repeal of coverage will  
32 increase or decrease the administrative expenses of health care  
33 service plans and health insurers and the premium and expenses  
34 of subscribers, enrollees, and policyholders.

35 (D) The impact of this coverage or repeal of coverage on the  
36 total cost of health care.

37 (E) The potential cost or savings to the private sector, including  
38 the impact on small employers as defined in paragraph (1) of  
39 subdivision (l) of Section 1357, the Public Employees' Retirement  
40 System, other retirement systems funded by the state or by a local

1 government, individuals purchasing individual health insurance,  
2 and publicly funded state health insurance programs, including  
3 the Medi-Cal program and the Healthy Families Program.

4 (F) The extent to which costs resulting from lack of coverage  
5 or repeal of coverage are or would be shifted to other payers,  
6 including both public and private entities.

7 (G) The extent to which mandating or repealing the proposed  
8 benefit or service would not diminish or eliminate access to  
9 currently available health care benefits or services.

10 (H) The extent to which the benefit or service is generally  
11 utilized by a significant portion of the population.

12 (I) The extent to which health care coverage for the benefit or  
13 service is already generally available.

14 (J) The level of public demand for health care coverage for the  
15 benefit or service, including the level of interest of collective  
16 bargaining agents in negotiating privately for inclusion of this  
17 coverage in group contracts, and the extent to which the mandated  
18 benefit or service is covered by self-funded employer groups.

19 (K) In assessing and preparing a written analysis of the financial  
20 impact of legislation proposing to mandate a benefit or service and  
21 legislation proposing to repeal a mandated benefit or service  
22 pursuant to this paragraph, the Legislature requests the University  
23 of California to use a certified actuary or other person with relevant  
24 knowledge and expertise to determine the financial impact.

25 (4) The impact on essential health benefits, as defined in Section  
26 1367.005 of this code and Section 10112.27 of the Insurance Code,  
27 and the impact on the California Health Benefit Exchange.

28 (b) The Legislature further requests that the California Health  
29 Benefit Review Program assess legislation that impacts health  
30 insurance benefit design, cost sharing, premiums, and other health  
31 insurance topics.

32 (c) The Legislature requests that the University of California  
33 provide every analysis to the appropriate policy and fiscal  
34 committees of the Legislature not later than 60 days, or in a manner  
35 and pursuant to a timeline agreed to by the Legislature and the  
36 California Health Benefit Review Program, after receiving a request  
37 made pursuant to Section 127661. In addition, the Legislature  
38 requests that the university post every analysis on the Internet and  
39 make every analysis available to the public upon request.

1 (d) As used in this section, “legislation proposing to mandate a  
2 benefit or service” means a proposed statute that requires a health  
3 care service plan or a health insurer, or both, to do any of the  
4 following:

5 (1) Permit a person insured or covered under the policy or  
6 contract to obtain health care treatment or services from a particular  
7 type of health care provider.

8 (2) Offer or provide coverage for the screening, diagnosis, or  
9 treatment of a particular disease or condition.

10 (3) Offer or provide coverage of a particular type of health care  
11 treatment or service, or of medical equipment, medical supplies,  
12 or drugs used in connection with a health care treatment or service.

13 (e) As used in this section, “legislation proposing to repeal a  
14 mandated benefit or service” means a proposed statute that, if  
15 enacted, would become operative on or after January 1, 2008, and  
16 would repeal an existing requirement that a health care service  
17 plan or a health insurer, or both, do any of the following:

18 (1) Permit a person insured or covered under the policy or  
19 contract to obtain health care treatment or services from a particular  
20 type of health care provider.

21 (2) Offer or provide coverage for the screening, diagnosis, or  
22 treatment of a particular disease or condition.

23 (3) Offer or provide coverage of a particular type of health care  
24 treatment or service, or of medical equipment, medical supplies,  
25 or drugs used in connection with a health care treatment or service.

26 SEC. 4. Section 127662 of the Health and Safety Code is  
27 amended to read:

28 127662. (a) In order to effectively support the University of  
29 California and its work in implementing this chapter, there is  
30 hereby established in the State Treasury, the Health Care Benefits  
31 Fund. The university’s work in providing the bill analyses shall  
32 be supported from the fund.

33 (b) For the 2010–11 to 2016–17 fiscal years, inclusive, each  
34 health care service plan, except a specialized health care service  
35 plan, and each health insurer, as defined in Section 106 of the  
36 Insurance Code, shall be assessed an annual fee in an amount  
37 determined through regulation. The amount of the fee shall be  
38 determined by the Department of Managed Health Care and the  
39 Department of Insurance in consultation with the university and  
40 shall be limited to the amount necessary to fund the actual and

1 necessary expenses of the university and its work in implementing  
2 this chapter. The total annual assessment on health care service  
3 plans and health insurers shall not exceed two million dollars  
4 (\$2,000,000).

5 (c) The Department of Managed Health Care and the Department  
6 of Insurance, in coordination with the university, shall assess the  
7 health care service plans and health insurers, respectively, for the  
8 costs required to fund the university's activities pursuant to  
9 subdivision (b).

10 (1) Health care service plans shall be notified of the assessment  
11 on or before June 15 of each year with the annual assessment notice  
12 issued pursuant to Section 1356. The assessment pursuant to this  
13 section is separate and independent of the assessments in Section  
14 1356.

15 (2) Health insurers shall be noticed of the assessment in  
16 accordance with the notice for the annual assessment or quarterly  
17 premium tax revenues.

18 (3) The assessed fees required pursuant to subdivision (b) shall  
19 be paid on an annual basis no later than August 1 of each year.  
20 The Department of Managed Health Care and the Department of  
21 Insurance shall forward the assessed fees to the Controller for  
22 deposit in the Health Care Benefits Fund immediately following  
23 their receipt.

24 (4) "Health insurance," as used in this subdivision, does not  
25 include Medicare supplement, vision-only, dental-only, or  
26 CHAMPUS supplement insurance, or hospital indemnity,  
27 accident-only, or specified disease insurance that does not pay  
28 benefits on a fixed benefit, cash payment only basis.

29 SEC. 5. Section 127664 of the Health and Safety Code is  
30 amended to read:

31 127664. The Legislature requests the University of California  
32 to submit a report to the Governor and the Legislature by January  
33 1, 2017, regarding the implementation of this chapter. This report  
34 shall be submitted in compliance with Section 9795 of the  
35 Government Code.

36 SEC. 6. Section 127665 of the Health and Safety Code is  
37 repealed.

38 SEC. 7. Section 127665 is added to the Health and Safety Code,  
39 to read:

1 127665. This chapter shall become inoperative on July 1, 2017,  
2 and, as of January 1, 2018, is repealed, unless a later enacted  
3 statute, that becomes operative on or before January 1, 2018,  
4 deletes or extends the dates on which it becomes inoperative and  
5 is repealed.

6 SEC. 8. Section 10753 of the Insurance Code is amended to  
7 read:

8 10753. (a) “Agent or broker” means a person or entity licensed  
9 under Chapter 5 (commencing with Section 1621) of Part 2 of  
10 Division 1.

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

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

26 (d) “Child” means a child described in Section 22775 of the  
27 Government Code and subdivisions (n) to (p), inclusive, of Section  
28 599.500 of Title 2 of the California Code of Regulations.

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

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

37 (1) Any permanent employee who is actively engaged on a  
38 full-time basis in the conduct of the business of the small employer  
39 with a normal workweek of an average of 30 hours per week over  
40 the course of a month, in the small employer’s regular place of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35 (o) “Creditable coverage” means:

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

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

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

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

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

17 (5) ~~40 U.S.C. Chapter 55~~ (commencing with Section 1071) *of*  
18 *Title 10 of the United States Code* (Civilian Health and Medical  
19 Program of the Uniformed Services (CHAMPUS)).

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

22 (7) A health plan offered under ~~5 U.S.C. Chapter 89~~  
23 (commencing with Section 8901) *of Title 5 of the United States*  
24 *Code* (Federal Employees Health Benefits Program (FEHBP)).

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

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

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

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

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

39 (A) For plan years commencing on or after January 1, 2014,  
40 and on or before December 31, 2015, any person, firm, proprietary

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

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

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

1 an employer with one employee shall include sole proprietors,  
2 certain owners of “S” corporations, or other individuals, shall be  
3 consistent with Section 1304 of PPACA.

4 (3) For plan years commencing on or after January 1, 2016, the  
5 definition of small employer, for purposes of determining ~~the~~  
6 ~~number of employees,~~ *employer eligibility in the small employer*  
7 *market, the number of employees* shall be determined using the  
8 method for counting full-time equivalent employees set forth in  
9 Section 4980H(c)(2) of the Internal Revenue Code.

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

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

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

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

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

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

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

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

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

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

36 (y) “Registered domestic partner” means a person who has  
37 established a domestic partnership as described in Section 297 of  
38 the Family Code.

39 (z) “Family” means the policyholder and his or her dependents.

1 SEC. 9. Section 10965.3 of the Insurance Code is amended to  
2 read:

3 10965.3. (a) (1) On and after October 1, 2013, a health insurer  
4 shall fairly and affirmatively offer, market, and sell all of the  
5 insurer's health benefit plans that are sold in the individual market  
6 for policy years on or after January 1, 2014, to all individuals and  
7 dependents in each service area in which the insurer provides or  
8 arranges for the provision of health care services. A health insurer  
9 shall limit enrollment in individual health benefit plans to open  
10 enrollment periods, annual enrollment periods, and special  
11 enrollment periods as provided in subdivisions (c) and (d).

12 (2) A health insurer shall allow the policyholder of an individual  
13 health benefit plan to add a dependent to the policyholder's health  
14 benefit plan at the option of the policyholder, consistent with the  
15 open enrollment, annual enrollment, and special enrollment period  
16 requirements in this section.

17 (b) An individual health benefit plan issued, amended, or  
18 renewed on or after January 1, 2014, shall not impose any  
19 preexisting condition provision upon any individual.

20 (c) (1) A health insurer shall provide an initial open enrollment  
21 period from October 1, 2013, to March 31, 2014, inclusive, an  
22 annual enrollment period for the policy year beginning on January  
23 1, 2015, from November 15, 2014, to February 15, 2015, inclusive,  
24 and annual enrollment periods for policy years beginning on or  
25 after January 1, 2016, from November 1, of the preceding calendar  
26 year, to January 31 of the benefit year, inclusive.

27 (2) Pursuant to Section 147.104(b)(2) of Title 45 of the Code  
28 of Federal Regulations, for individuals enrolled in noncalendar  
29 year individual health plan contracts, a health insurer shall also  
30 provide a limited open enrollment period beginning on the date  
31 that is 30 calendar days prior to the date the policy year ends in  
32 2014.

33 (d) (1) Subject to paragraph (2), commencing January 1, 2014,  
34 a health insurer shall allow an individual to enroll in or change  
35 individual health benefit plans as a result of the following triggering  
36 events:

37 (A) He or she or his or her dependent loses minimum essential  
38 coverage. For purposes of this paragraph, both of the following  
39 definitions shall apply:

1 (i) “Minimum essential coverage” has the same meaning as that  
2 term is defined in subsection (f) of Section 5000A of the Internal  
3 Revenue Code (26 U.S.C. Sec. 5000A).

4 (ii) “Loss of minimum essential coverage” includes, but is not  
5 limited to, loss of that coverage due to the circumstances described  
6 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the  
7 Code of Federal Regulations and the circumstances described in  
8 Section 1163 of Title 29 of the United States Code. “Loss of  
9 minimum essential coverage” also includes loss of that coverage  
10 for a reason that is not due to the fault of the individual.

11 (iii) “Loss of minimum essential coverage” does not include  
12 loss of that coverage due to the individual’s failure to pay  
13 premiums on a timely basis or situations allowing for a rescission,  
14 subject to clause (ii) and Sections 10119.2 and 10384.17.

15 (B) He or she gains a dependent or becomes a dependent.

16 (C) He or she is mandated to be covered as a dependent pursuant  
17 to a valid state or federal court order.

18 (D) He or she has been released from incarceration.

19 (E) His or her health coverage issuer substantially violated a  
20 material provision of the health coverage contract.

21 (F) He or she gains access to new health benefit plans as a result  
22 of a permanent move.

23 (G) He or she was receiving services from a contracting provider  
24 under another health benefit plan, as defined in Section 10965 of  
25 this code or Section 1399.845 of the Health and Safety Code, for  
26 one of the conditions described in subdivision (a) of Section  
27 10133.56 of this code and that provider is no longer participating  
28 in the health benefit plan.

29 (H) He or she demonstrates to the Exchange, with respect to  
30 health benefit plans offered through the Exchange, or to the  
31 department, with respect to health benefit plans offered outside  
32 the Exchange, that he or she did not enroll in a health benefit plan  
33 during the immediately preceding enrollment period available to  
34 the individual because he or she was misinformed that he or she  
35 was covered under minimum essential coverage.

36 (I) He or she is a member of the reserve forces of the United  
37 States military returning from active duty or a member of the  
38 California National Guard returning from active duty service under  
39 Title 32 of the United States Code.

1 (J) With respect to individual health benefit plans offered  
2 through the Exchange, in addition to the triggering events listed  
3 in this paragraph, any other events listed in Section 155.420(d) of  
4 Title 45 of the Code of Federal Regulations.

5 (2) With respect to individual health benefit plans offered  
6 outside the Exchange, an individual shall have 60 days from the  
7 date of a triggering event identified in paragraph (1) to apply for  
8 coverage from a health care service plan subject to this section.  
9 With respect to individual health benefit plans offered through the  
10 Exchange, an individual shall have 60 days from the date of a  
11 triggering event identified in paragraph (1) to select a plan offered  
12 through the Exchange, unless a longer period is provided in Part  
13 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
14 A of Title 45 of the Code of Federal Regulations.

15 (e) With respect to individual health benefit plans offered  
16 through the Exchange, the effective date of coverage required  
17 pursuant to this section shall be consistent with the dates specified  
18 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
19 Regulations, as applicable. A dependent who is a registered  
20 domestic partner pursuant to Section 297 of the Family Code shall  
21 have the same effective date of coverage as a spouse.

22 (f) With respect to an individual health benefit plan offered  
23 outside the Exchange, the following provisions shall apply:

24 (1) After an individual submits a completed application form  
25 for a plan, the insurer shall, within 30 days, notify the individual  
26 of the individual's actual premium charges for that plan established  
27 in accordance with Section 10965.9. The individual shall have 30  
28 days in which to exercise the right to buy coverage at the quoted  
29 premium charges.

30 (2) With respect to an individual health benefit plan for which  
31 an individual applies during the initial open enrollment period  
32 described in subdivision (c), when the policyholder submits a  
33 premium payment, based on the quoted premium charges, and that  
34 payment is delivered or postmarked, whichever occurs earlier, by  
35 December 15, 2013, coverage under the individual health benefit  
36 plan shall become effective no later than January 1, 2014. When  
37 that payment is delivered or postmarked within the first 15 days  
38 of any subsequent month, coverage shall become effective no later  
39 than the first day of the following month. When that payment is  
40 delivered or postmarked between December 16, 2013, to December

1 31, 2013, inclusive, or after the 15th day of any subsequent month,  
2 coverage shall become effective no later than the first day of the  
3 second month following delivery or postmark of the payment.

4 (3) With respect to an individual health benefit plan for which  
5 an individual applies during the annual open enrollment period  
6 described in subdivision (c), when the individual submits a  
7 premium payment, based on the quoted premium charges, and that  
8 payment is delivered or postmarked, whichever occurs later, by  
9 December 15, coverage shall become effective as of the following  
10 January 1. When that payment is delivered or postmarked within  
11 the first 15 days of any subsequent month, coverage shall become  
12 effective no later than the first day of the following month. When  
13 that payment is delivered or postmarked between December 16 to  
14 December 31, inclusive, or after the 15th day of any subsequent  
15 month, coverage shall become effective no later than the first day  
16 of the second month following delivery or postmark of the  
17 payment.

18 (4) With respect to an individual health benefit plan for which  
19 an individual applies during a special enrollment period described  
20 in subdivision (d), the following provisions shall apply:

21 (A) When the individual submits a premium payment, based  
22 on the quoted premium charges, and that payment is delivered or  
23 postmarked, whichever occurs earlier, within the first 15 days of  
24 the month, coverage under the plan shall become effective no later  
25 than the first day of the following month. When the premium  
26 payment is neither delivered nor postmarked until after the 15th  
27 day of the month, coverage shall become effective no later than  
28 the first day of the second month following delivery or postmark  
29 of the payment.

30 (B) Notwithstanding subparagraph (A), in the case of a birth,  
31 adoption, or placement for adoption, the coverage shall be effective  
32 on the date of birth, adoption, or placement for adoption.

33 (C) Notwithstanding subparagraph (A), in the case of marriage  
34 or becoming a registered domestic partner or in the case where a  
35 qualified individual loses minimum essential coverage, the  
36 coverage effective date shall be the first day of the month following  
37 the date the insurer receives the request for special enrollment.

38 (g) (1) A health insurer shall not establish rules for eligibility,  
39 including continued eligibility, of any individual to enroll under

1 the terms of an individual health benefit plan based on any of the  
2 following factors:

- 3 (A) Health status.
- 4 (B) Medical condition, including physical and mental illnesses.
- 5 (C) Claims experience.
- 6 (D) Receipt of health care.
- 7 (E) Medical history.
- 8 (F) Genetic information.
- 9 (G) Evidence of insurability, including conditions arising out  
10 of acts of domestic violence.
- 11 (H) Disability.

12 (I) Any other health status-related factor as determined by any  
13 federal regulations, rules, or guidance issued pursuant to Section  
14 2705 of the federal Public Health Service Act (Public Law 78-410).

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

22 (h) (1) A health insurer shall consider as a single risk pool for  
23 rating purposes in the individual market the claims experience of  
24 all insureds and enrollees in all nongrandfathered individual health  
25 benefit plans offered by that insurer in this state, whether offered  
26 as health care service plan contracts or individual health insurance  
27 policies, including those insureds and enrollees who enroll in  
28 individual coverage through the Exchange and insureds and  
29 enrollees who enroll in individual coverage outside the Exchange.  
30 Student health insurance coverage, as such coverage is defined in  
31 Section 147.145(a) of Title 45 of the Code of Federal Regulations,  
32 shall not be included in a health insurer's single risk pool for  
33 individual coverage.

34 (2) Each calendar year, a health insurer shall establish an index  
35 rate for the individual market in the state based on the total  
36 combined claims costs for providing essential health benefits, as  
37 defined pursuant to Section 1302 of PPACA, within the single risk  
38 pool required under paragraph (1). The index rate shall be adjusted  
39 on a marketwide basis based on the total expected marketwide  
40 payments and charges under the risk adjustment and reinsurance

1 programs established for the state pursuant to Sections 1343 and  
2 1341 of PPACA and Exchange user fees, as described in  
3 subdivision (d) of Section 156.80 of Title 45 of the Code of Federal  
4 Regulations. The premium rate for all of the health benefit plans  
5 in the individual market within the single risk pool required under  
6 paragraph (1) shall use the applicable marketwide adjusted index  
7 rate, subject only to the adjustments permitted under paragraph  
8 (3).

9 (3) A health insurer may vary premium rates for a particular  
10 health benefit plan from its index rate based only on the following  
11 actuarially justified plan-specific factors:

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

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

16 (C) The benefits provided under the health benefit plan that are  
17 in addition to the essential health benefits, as defined pursuant to  
18 Section 1302 of PPACA and Section 10112.27. These additional  
19 benefits shall be pooled with similar benefits within the single risk  
20 pool required under paragraph (1) and the claims experience from  
21 those benefits shall be utilized to determine rate variations for  
22 plans that offer those benefits in addition to essential health  
23 benefits.

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

27 (E) Administrative costs, excluding any user fees required by  
28 the Exchange.

29 (i) This section shall only apply with respect to individual health  
30 benefit plans for policy years on or after January 1, 2014.

31 (j) This section shall not apply to a grandfathered health plan.

32 (k) If Section 5000A of the Internal Revenue Code, as added  
33 by Section 1501 of PPACA, is repealed or amended to no longer  
34 apply to the individual market, as defined in Section 2791 of the  
35 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91),  
36 subdivisions (a), (b), and (g) shall become inoperative 12 months  
37 after the date of that repeal or amendment and individual health  
38 care benefit plans shall thereafter be subject to Sections 10901.2,  
39 10951, and 10953.

1 SEC. 10. No reimbursement is required by this act pursuant to  
2 Section 6 of Article XIII B of the California Constitution because  
3 the only costs that may be incurred by a local agency or school  
4 district will be incurred because this act creates a new crime or  
5 infraction, eliminates a crime or infraction, or changes the penalty  
6 for a crime or infraction, within the meaning of Section 17556 of  
7 the Government Code, or changes the definition of a crime within  
8 the meaning of Section 6 of Article XIII B of the California  
9 Constitution.

10 SEC. 11. This act is an urgency statute necessary for the  
11 immediate preservation of the public peace, health, or safety within  
12 the meaning of Article IV of the Constitution and shall go into  
13 immediate effect. The facts constituting the necessity are:

14 In order to maintain appropriate standards of accuracy and  
15 efficiency with respect to matters relating to health care coverage  
16 in California, by adjusting the next open enrollment period for the  
17 individual health care coverage market as needed to comply with  
18 federal law, and ensuring that the University of California is  
19 provided with sufficient advance notice regarding the continuing  
20 duties of the university to plan and carry out necessary health care  
21 benefit research and analysis as requested pursuant to this act, it  
22 is necessary that this act take effect immediately.