AMENDED IN SENATE JULY 14, 2011

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AMENDED IN ASSEMBLY MARCH 29, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1083

Introduced by Assembly Member Monning
(Principal coauthor: Assembly Member Feuer)

February 18, 2011

An act to amend Sections 1357, 1357.03, 1357.05, 1357.06, 1357.07, 1357.12, and 1357.14 of, and to amend, repeal, and add Sections 1357.15, 1357.50, 1357.51, and 1357.52 of, the Health and Safety Code, and to amend Sections 106, 10700, 10705, 10706, 10707, 10708, 10709, 10714, and 10716 of, and to amend, repeal, and add Sections 10198.6, 10198.7, 10198.9, and 10717 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1083, as amended, Monning. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, imposes various requirements, some of which take effect on January 1, 2014, on states, health plans, employers, and individuals regarding health care coverage. Pursuant to the requirements of that act, existing state law establishes the California Health Benefit Exchange for the

purpose of, among other things, making available qualified health plans to qualified individuals and employers, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health carriers by the Department of Insurance. Existing law provides for the regulation of health care service plans and health carriers that offer plan contracts or health benefit plans, respectively, to small employers with regard to eligible employees, as defined. Existing law prohibits a plan or solicitor or a carrier or agent or broker from encouraging or directing small employers to seek coverage from another plan or carrier or the Voluntary Alliance Uniting Employers Purchasing Program. Existing law also regulates provisions related to preexisting conditions and late enrollees, as defined.

For purposes of that coverage, this bill would change the definitions and criteria related to eligible employees and rating periods, and, on and after January 1, 2014, risk adjustment factors, age categories, and health status-related factors, as specified. The bill would change the definition of small employers on or after January 1, 2014, and would change the definition again on or after January 1, 2017, as specified. The bill would require employer contribution requirements to be consistent with the federal Patient Protection and Affordable Care Act. With regard to the sale of plan contracts or health benefit plans, the bill would prohibit specified persons or entities from encouraging or directing small employers to seek coverage from another plan or the voluntary purchasing pool established under the California Health Benefit Exchange. The bill would make other conforming changes to implement the federal act with regard to preexisting conditions, to become effective January 1, 2014, and would make other changes to preexisting condition provisions, notices, and provisions related to late enrollees.

Because a willful violation of the bill's provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 1357 of the Health and Safety Code is
2 amended to read:
3 1357. As used in this article:
4 (a) “Dependent” means the spouse or child of an eligible
5 employee, subject to applicable terms of the health care plan
6 contract covering the employee, and includes dependents of
7 guaranteed association members if the association elects to include
8 dependents under its health coverage at the same time it determines
9 its membership composition pursuant to subdivision (o).
10 (b) “Eligible employee” means either of the following:
11 (1) Any permanent employee who is actively engaged on a
12 full-time basis in the conduct of the business of the small employer
13 with a normal workweek of an average of 30 hours per week over
14 the course of a month, at the small employer’s regular places of
15 business, who has met any statutorily authorized applicable waiting
16 period requirements. The term includes sole proprietors or partners
17 of a partnership, if they are actively engaged on a full-time basis
18 in the small employer’s business and included as employees under
19 a health care plan contract of a small employer, but does not
20 include employees who work on a part-time, temporary, or
21 substitute basis. It includes any eligible employee, as defined in
22 this paragraph, who obtains coverage through a guaranteed
23 association. Employees of employers purchasing through a
24 guaranteed association shall be deemed to be eligible employees
25 if they would otherwise meet the definition except for the number
26 of persons employed by the employer. Permanent employees who
27 work at least 20 hours but not more than 29 hours are deemed to
28 be eligible employees if all four of the following apply:
29 (A) They otherwise meet the definition of an eligible employee
30 except for the number of hours worked.
31 (B) The employer offers the employees health coverage under
32 a health benefit plan.
33 (C) All similarly situated individuals are offered coverage under
34 the health benefit plan.

1 (D) The employee must have worked at least 20 hours per
2 normal workweek for at least 50 percent of the weeks in the
3 previous calendar quarter. The health care service plan may request
4 any necessary information to document the hours and time period
5 in question, including, but not limited to, payroll records and
6 employee wage and tax filings.
7 (2) Any member of a guaranteed association as defined in
8 subdivision (o).
9 (c) "In force business" means an existing health benefit plan
10 contract issued by the plan to a small employer.
11 (d) "Late enrollee" means an eligible employee or dependent
12 who has declined enrollment in a health benefit plan offered by a
13 small employer at the time of the initial enrollment period provided
14 under the terms of the health benefit plan and who subsequently
15 requests enrollment in a health benefit plan of that small employer,
16 provided that the initial enrollment period shall be a period of at
17 least 30 days. It also means any member of an association that is
18 a guaranteed association as well as any other person eligible to
19 purchase through the guaranteed association when that person has
20 failed to purchase coverage during the initial enrollment period
21 provided under the terms of the guaranteed association's plan
22 contract and who subsequently requests enrollment in the plan,
23 provided that the initial enrollment period shall be a period of at
24 least 30 days. However, an eligible employee, any other person
25 eligible for coverage through a guaranteed association pursuant to
26 subdivision (o), or an eligible dependent shall not be considered
27 a late enrollee if any of the following is applicable:
28 (1) The individual meets all of the following requirements:
29 (A) He or she was covered under another employer health
30 benefit plan, the Healthy Families Program, the Access for Infants
31 and Mothers (AIM) Program, the Medi-Cal program, or the
32 California Health Benefit Exchange at the time the individual was
33 eligible to enroll.
34 (B) He or she certified at the time of the initial enrollment that
35 coverage under another employer health benefit plan, the Healthy
36 Families Program, the AIM Program, the Medi-Cal program, or
37 the California Health Benefit Exchange was the reason for
38 declining enrollment, provided that, if the individual was covered
39 under another employer health plan, the individual was given the
40 opportunity to make the certification required by this subdivision

and was notified that failure to do so could result in later treatment as a late enrollee.

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

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

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

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

(4) (A) Until December 31, 2013, in the case of an eligible employee, as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(B) Until December 31, 2013, in the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the

association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

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

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

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

(7) The individual is an eligible employee who previously declined coverage under an employer health benefit plan and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on his or her behalf and on behalf of his or her dependent within 30 days following the date of marriage, birth, adoption, or placement for adoption, in

1 which case the effective date of coverage shall be the first day of
2 the month following the date the completed request for enrollment
3 is received in the case of marriage, or the date of birth, or the date
4 of adoption or placement for adoption, whichever applies. Notice
5 of the special enrollment rights contained in this paragraph shall
6 be provided by the employer to an employee at or before the time
7 the employee is offered an opportunity to enroll 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 at the time of the
12 previous enrollment period. That individual may enroll himself or
13 herself or his or her dependents for plan coverage during a special
14 open enrollment opportunity if his or her dependents have lost or
15 will lose coverage under that other employer health benefit plan.
16 The special open enrollment opportunity shall be requested by the
17 employee not more than 30 days after the date that the other health
18 coverage is exhausted or terminated. Upon enrollment, coverage
19 shall be effective not later than the first day of the first calendar
20 month beginning after the date the request for enrollment is
21 received. Notice of the special enrollment rights contained in this
22 paragraph shall be provided by the employer to an employee at or
23 before the time the employee is offered an opportunity to enroll
24 in plan coverage.
25 (e) “New business” means a health care service plan contract
26 issued to a small employer that is not the plan’s in force business.
27 (f) (1) Until December 31, 2013, “preexisting condition
28 provision” means a contract provision that excludes coverage for
29 charges or expenses incurred during a specified period following
30 the employee’s effective date of coverage, as to a condition for
31 which medical advice, diagnosis, care, or treatment was
32 recommended or received during a specified period immediately
33 preceding the effective date of coverage.
34 (2) On and after January 1, 2014, no health care service plan
35 shall limit or exclude coverage for any individual based on a
36 preexisting condition whether or not any medical advice, diagnosis,
37 care, or treatment was recommended or received before that date.
38 *A preexisting condition provision includes any limitation or*
39 *exclusion of benefits, including a denial of coverage, applicable*
40 *to an individual as a result of information relating an individual’s*

health status before the individual's effective date of coverage under a group health plan, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

(g) "Creditable coverage" means:

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

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

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

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

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

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

(7) A state health benefits risk pool.

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

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

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

(11) Any other creditable coverage as defined by subdivision (c) of Section ~~2701~~ *2704* of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(h) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than 12 months. *This subdivision shall be implemented to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.*

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

(j) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. Effective January 1, 2014, no risk adjustment factor shall be used in the determination of rates.

(k) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

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

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

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided

1 by the Medicare Program pursuant to Title XVIII of the federal
2 Social Security Act (42 U.S.C. Sec. 1395 et seq.). Effective January
3 1, 2014, the rate for age shall not vary by more than three to one
4 for adults.
5 (2) Small employer health care service plans shall base rates to
6 small employers using no more than the following family size
7 categories:
8 (A) Single.
9 (B) Married couple.
10 (C) One adult and child or children.
11 (D) Married couple and child or children.
12 (3) (A) In determining rates for small employers, a plan that
13 operates statewide shall use no more than nine geographic regions
14 in the state, have no region smaller than an area in which the first
15 three digits of all its ZIP Codes are in common within a county,
16 and divide no county into more than two regions. Plans shall be
17 deemed to be operating statewide if their coverage area includes
18 90 percent or more of the state's population. Geographic regions
19 established pursuant to this section shall, as a group, cover the
20 entire state, and the area encompassed in a geographic region shall
21 be separate and distinct from areas encompassed in other
22 geographic regions. Geographic regions may be noncontiguous.
23 (B) (i) In determining rates for small employers, a plan that
24 does not operate statewide shall use no more than the number of
25 geographic regions in the state that is determined by the following
26 formula: the population, as determined in the last federal census,
27 of all counties that are included in their entirety in a plan's service
28 area divided by the total population of the state, as determined in
29 the last federal census, multiplied by nine. The resulting number
30 shall be rounded to the nearest whole integer. No region may be
31 smaller than an area in which the first three digits of all its ZIP
32 Codes are in common within a county and no county may be
33 divided into more than two regions. The area encompassed in a
34 geographic region shall be separate and distinct from areas
35 encompassed in other geographic regions. Geographic regions
36 may be noncontiguous. No plan shall have less than one geographic
37 area.
38 (ii) If the formula in clause (i) results in a plan that operates in
39 more than one county having only one geographic region, then the
40 formula in clause (i) shall not apply and the plan may have two

1 geographic regions, provided that no county is divided into more
2 than one region.
3 Nothing in this section shall be construed to require a plan to
4 establish a new service area or to offer health coverage on a
5 statewide basis, outside of the plan's existing service area.
6 (*l*) "Small employer" means any of the following:
7 (1) Until December 31, 2013, any person, firm, proprietary or
8 nonprofit corporation, partnership, public agency, or association
9 that is actively engaged in business or service, that, on at least 50
10 percent of its working days during the preceding calendar quarter
11 or preceding calendar year, employed at least two, but no more
12 than 50, eligible employees, the majority of whom were employed
13 within this state, that was not formed primarily for purposes of
14 buying health care service plan contracts, and in which a bona fide
15 employer-employee relationship exists. On or after January 1,
16 2014, and until December 31, 2015, any person, firm, proprietary
17 or nonprofit corporation, partnership, public agency, or association
18 that is actively engaged in business or service, that, on at least 50
19 percent of its working days during the preceding calendar quarter
20 or preceding calendar year, employed at least one, but no more
21 than 50, eligible employees, the majority of whom were employed
22 within this state, that was not formed primarily for purposes of
23 buying health care service plan contracts, and in which a bona fide
24 employer-employee relationship exists. On or after January 1,
25 2016, any person, firm, proprietary or nonprofit corporation,
26 partnership, public agency, or association that is actively engaged
27 in business or service, that, on at least 50 percent of its working
28 days during the preceding calendar quarter or preceding calendar
29 year, employed at least one, but no more than 100, eligible
30 employees, the majority of whom were employed within this state,
31 that was not formed primarily for purposes of buying health care
32 service plan contracts, and in which a bona fide employer-employee
33 relationship exists. In determining whether to apply the calendar
34 quarter or calendar year test, a health care service plan shall use
35 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 care service plan contract to a small employer pursuant to this

1 article, and for the purpose of determining eligibility, the size of
2 a small employer shall be determined annually. Except as otherwise
3 specifically provided in this article, provisions of this article that
4 apply to a small employer shall continue to apply until the plan
5 contract anniversary following the date the employer no longer
6 meets the requirements of this definition. It includes any small
7 employer as defined in this paragraph who purchases coverage
8 through a guaranteed association, and any employer purchasing
9 coverage for employees through a guaranteed association. This
10 paragraph shall be implemented to the extent consistent with the
11 federal Patient Protection and Affordable Care Act (Public Law
12 111-148) and any rules, regulations, or guidance issued consistent
13 with that law.
14 (2) Any guaranteed association, as defined in subdivision (n),
15 that purchases health coverage for members of the association.
16 (3) On or after January 1, 2014, a self-employed individual who
17 obtains at least 50 percent of annual income from self-employment
18 as demonstrated through personal income tax filings for the current
19 or prior year. To the extent permitted under the federal Patient
20 Protection and Affordable Care Act (Public Law 111-148) and
21 any rules, regulations, or guidance issued consistent with that law,
22 a self-employed individual whose modified annual gross income
23 is anticipated to be less than 400 percent of the federal poverty
24 level may at his or her discretion seek to enroll as an individual
25 rather than a small employer through the California Health Benefit
26 Exchange to the extent permitted under the federal Patient
27 Protection and Affordable Care Act (Public Law 111-148) and
28 any rules, regulations, or guidance issued consistent with that law.
29 (m) "Standard employee risk rate" means the rate applicable to
30 an eligible employee in a particular risk category in a small
31 employer group.
32 (n) "Guaranteed association" means a nonprofit organization
33 comprised of a group of individuals or employers who associate
34 based solely on participation in a specified profession or industry,
35 accepting for membership any individual or employer meeting its
36 membership criteria, and that (1) includes one or more small
37 employers as defined in paragraph (1) of subdivision (*l*), (2) does
38 not condition membership directly or indirectly on the health or
39 claims history of any person, (3) uses membership dues solely for
40 and in consideration of the membership and membership benefits,

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

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

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

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

(p) "Affiliation period" means a period that, under the terms of the health care service plan contract, must expire before health care services under the contract become effective. *On or after January 1, 2014 affiliation periods are prohibited.*

(q) "Waiting period" means the period that is required to pass with respect to the employee before the employee is eligible to be covered for benefits under the terms of the policy. However, such periods shall not be based upon the health status of the employee or dependent. A health plan may permit a waiting period of up to 90 days as a condition of enrollment if applied equally to all full-time employees, consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

SEC. 2. Section 1357.03 of the Health and Safety Code is amended to read:

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

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

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

(4) A plan contracting to participate in the voluntary purchasing pool for small employers offered through the California Health Benefit Exchange shall be deemed in compliance with the requirements of paragraph (1) for a contract offered through the California Health Benefit Exchange in those geographic regions in which plans participate in the California Health Benefit Exchange.

(5) (A) A plan shall be deemed to meet the requirements of paragraphs (1) and (2) with respect to a plan contract that qualifies

1 as a grandfathered health plan under Section 1251 of PPACA if
2 all of the following requirements are met:
3 (i) The plan offers to renew the plan contract, unless the plan
4 withdraws the plan contract from the small employer market
5 pursuant to subdivision (e) of Section 1357.11.
6 (ii) The plan provides appropriate notice of the grandfathered
7 status of the contract in any materials provided to an enrollee of
8 the contract describing the benefits provided under the contract,
9 as required under PPACA.
10 (iii) The plan makes no changes to the benefits covered under
11 the plan contract other than those required by a state or federal
12 law, regulation, rule, or guidance and those permitted to be made
13 to a grandfathered health plan under PPACA.
14 (B) For purposes of this paragraph, "PPACA" means the federal
15 Patient Protection and Affordable Care Act (Public Law 111-148),
16 as amended by the federal Health Care and Education
17 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
18 regulations, or guidance issued thereunder. For purposes of this
19 paragraph, a "grandfathered health plan" shall have the meaning
20 set forth in Section 1251 of PPACA.
21 (b) Every plan shall file with the director the reasonable
22 employee participation requirements and employer contribution
23 requirements that will be applied in offering its plan contracts.
24 Participation requirements shall be applied uniformly among all
25 small employer groups, except that a plan may vary application
26 of minimum employee participation requirements by the size of
27 the small employer group and whether the employer contributes
28 100 percent of the eligible employee's premium. Employer
29 contribution requirements shall not vary by employer size.
30 Employer contribution requirements shall be consistent with the
31 federal Patient Protection and Affordable Care Act (Public Law
32 111-148). A health care service plan shall not establish a
33 participation requirement that (1) requires a person who meets the
34 definition of a dependent in subdivision (a) of Section 1357 to
35 enroll as a dependent if he or she is otherwise eligible for coverage
36 and wishes to enroll as an eligible employee and (2) allows a plan
37 to reject an otherwise eligible small employer because of the
38 number of persons that waive coverage due to coverage through
39 another employer. Members of an association eligible for health
40 coverage under subdivision (o) of Section 1357, but not electing

any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

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

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

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

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

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

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

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

(2) Encourage or direct small employers to seek coverage from another plan or the voluntary purchasing pool established under 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.

(e) 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

1 health care service plan contract to be varied because of the health
2 status, claims experience, industry, occupation, or geographic
3 location of the small employer or small employer's employees.
4 This subdivision does not apply to a compensation arrangement
5 that provides compensation to a solicitor on the basis of percentage
6 of premium, provided that the percentage shall not vary because
7 of the health status, claims experience, industry, occupation, or
8 geographic area of the small employer.
9 (f) A policy or contract that covers one or more employees shall
10 not establish rules for eligibility, including continued eligibility,
11 of an individual, or dependent of an individual, to enroll under the
12 terms of the plan based on any of the following health status-related
13 factors:
14 (1) Health status.
15 (2) Medical condition, including physical and mental illnesses.
16 (3) Claims experience.
17 (4) Receipt of health care.
18 (5) Medical history.
19 (6) Genetic information.
20 (7) Evidence of insurability, including conditions arising out of
21 acts of domestic violence.
22 (8) Disability.
23 (9) Any other health status-related factor as determined by the
24 department.
25 (g) A plan shall comply with the requirements of Section 1374.3.
26 SEC. 3. Section 1357.05 of the Health and Safety Code is
27 amended to read:
28 1357.05. (a) Until December 31, 2013, except in the case of
29 a late enrollee, or for satisfaction of a preexisting condition clause
30 in the case of initial coverage of an eligible employee, a plan may
31 not exclude any eligible employee or dependent who would
32 otherwise be entitled to health care services on the basis of an
33 actual or expected health condition of that employee or dependent.
34 No plan contract may limit or exclude coverage for a specific
35 eligible employee or dependent by type of illness, treatment,
36 medical condition, or accident, except for preexisting conditions
37 as permitted by Section 1357.06.
38 (b) On or after January 1, 2014, a plan may not exclude any
39 eligible employee or dependent who would otherwise be entitled
40 to health care services on the basis of an actual or expected health

condition of that employee or dependent. No plan contract may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 1357.06.

SEC. 4. Section 1357.06 of the Health and Safety Code is amended to read:

1357.06. (a) (1) Until December 31, 2013, preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(2) Notwithstanding paragraph (1), a plan contract offered to a small employer shall not impose any preexisting condition provision upon any child under 19 years of age.

(3) On or after January 1, 2014, ~~preexisting condition provisions of a plan contract shall not exclude coverage following the individual's effective date of coverage for a condition based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.~~ *a health plan shall not impose a preexisting condition provision upon any individual.*

(b) (1) Until December 31, 2013, a plan that does not utilize a preexisting condition provision may impose ~~a waiting or~~ *an* affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the ~~waiting or~~ affiliation period no premiums shall be charged to the enrollee or the subscriber.

(2) On or after January 1, 2014, no ~~waiting or~~ affiliation period based on a preexisting condition, health status, or any other factor prohibited under subdivision (f) of Section 1357.03 shall be imposed.

(3) A plan contract may permit a waiting period of up to 90 days as a condition of enrollment if applied equally to all full-time employees and if consistent with the federal Patient Protection and

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

(c) Until December 31, 2013, in determining whether a preexisting condition provision or ~~a waiting or~~ affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any ~~waiting or~~ affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any affiliation or employer-imposed ~~waiting or~~ affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any ~~waiting or~~ affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(d) Until December 31, 2013, in addition to the preexisting condition exclusions authorized by subdivision (a) and the ~~waiting or~~ affiliation period authorized by subdivision (b), health plans providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association ~~a waiting or~~ *an* affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the ~~waiting or~~ affiliation period, no premiums shall be charged to the enrollee or the subscriber.

(e) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section ~~2701~~ *2704* of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

(f) A health care service plan issuing group coverage may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

SEC. 5. Section 1357.07 of the Health and Safety Code is amended to read:

1357.07. (a) Until December 31, 2013, no plan contract may exclude ~~late enrollees~~ *a late enrollee* from coverage for more than 12 months from the date of the late ~~enrollees~~ *enrollee's* application for coverage. No premium shall be charged to the late enrollee until the exclusion period has ended.

(b) On or after January 1, 2014, no plan contract may exclude a late enrollee from coverage for more than 90 days from the date of the late enrollee's application for coverage to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law. No premium shall be charged to the late enrollee until the exclusion period has ended.

SEC. 6. Section 1357.12 of the Health and Safety Code is amended to read:

1357.12. Premiums for contracts offered or delivered by plans on or after the effective date of this article shall be subject to the following requirements:

(a) (1) The premium for new business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. Effective January 1, 2014, no risk adjustment factor shall be used in the determination of rates.

(2) The premium charged a small employer for new business shall be equal to the sum of the risk adjusted employee risk rates.

(3) The standard employee risk rates applied to a small employer for new business shall be in effect for no less than 12 months. *This subdivision shall be implemented to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.*

(b) (1) The premium for in force business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rates may not be more than 120

1 percent or less than 80 percent of the plan's applicable standard
2 employee risk rate until July 1, 1996. Effective July 1, 1996, this
3 factor may not be more than 110 percent or less than 90 percent.
4 The factor effective July 1, 1996, shall apply to in force business
5 at the earlier of either the time of renewal or July 1, 1997. Until
6 December 31, 2013, the risk adjustment factor applied to a small
7 employer may not increase by more than 10 percentage points
8 from the risk adjustment factor applied in the prior rating period.
9 Effective January 1, 2014, no risk adjustment factor shall be used
10 in the determination of rates. The risk adjustment factor for a small
11 employer may not be modified more frequently than every 12
12 months.
13 (2) The premium charged a small employer for in force business
14 shall be equal to the sum of the risk adjusted employee risk rates.
15 The standard employee risk rates shall be in effect for no less than
16 six months.
17 (3) For a contract that a plan has discontinued offering, the risk
18 adjustment factor applied to the standard employee risk rates for
19 the first rating period of the new contract that the small employer
20 elects to purchase shall be no greater than the risk adjustment factor
21 applied in the prior rating period to the discontinued contract.
22 However, the risk adjusted employee risk rate may not be more
23 than 120 percent or less than 80 percent of the plan's applicable
24 standard employee risk rate until July 1, 1996. Effective July 1,
25 1996, this factor may not be more than 110 percent or less than 90
26 percent. The factor effective July 1, 1996, shall apply to in force
27 business at the earlier of either the time of renewal or July 1, 1997.
28 Effective January 1, 2014, no risk adjustment factor shall be used
29 in the determination of rates. The risk adjustment factor for a small
30 employer may not be modified more frequently than every 12
31 months.
32 (c) (1) For any small employer, a plan may, with the consent
33 of the small employer, establish composite employee and
34 dependent rates for either new business or renewal of in force
35 business. The composite rates shall be determined as the average
36 of the risk adjusted employee risk rates for the small employer, as
37 determined in accordance with the requirements of subdivisions
38 (a) and (b). The sum of the composite rates so determined shall be
39 equal to the sum of the risk adjusted employee risk rates for the
40 small employer.

1 (2) The composite rates shall be used for all employees and
2 dependents covered throughout a rating period of no less than six
3 months nor more than 12 months, except that a plan may reserve
4 the right to redetermine the composite rates if the enrollment under
5 the contract changes by more than a specified percentage during
6 the rating period. Any redetermination of the composite rates shall
7 be based on the same risk adjusted employee risk rates used to
8 determine the initial composite rates for the rating period. If a plan
9 reserves the right to redetermine the rates and the enrollment
10 changes more than the specified percentage, the plan shall
11 redetermine the composite rates if the redetermined rates would
12 result in a lower premium for the small employer. A plan reserving
13 the right to redetermine the composite rates based upon a change
14 in enrollment shall use the same specified percentage to measure
15 that change with respect to all small employers electing composite
16 rates.
17 SEC. 7. Section 1357.14 of the Health and Safety Code is
18 amended to read:
19 1357.14. In connection with the offering for sale of any plan
20 contract to a small employer, each plan shall make a reasonable
21 disclosure, as part of its solicitation and sales materials, of the
22 following:
23 (a) Until December 31, 2013, the extent to which premium rates
24 for a specified small employer are established or adjusted in part
25 based upon the actual or expected variation in service costs or
26 actual or expected variation in health condition of the employees
27 and dependents of the small employer.
28 (b) The provisions concerning the plan's right to change
29 premium rates and the factors other than provision of services
30 experience that affect changes in premium rates.
31 (c) Provisions relating to the guaranteed issue and renewal of
32 contracts.
33 (d) Until December 31, 2013, provisions relating to the effect
34 of any preexisting condition provision.
35 (e) Provisions relating to the small employer's right to apply
36 for any contract written, issued, or administered by the plan at the
37 time of application for a new health care service plan contract, or
38 at the time of renewal of a health care service plan contract.

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

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

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

(1) Prepare a brochure that summarizes all of its plan contracts offered to small employers and to make this summary available to any small employer and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, and, until December 31, 2013, an explanation of the manner in which creditable coverage is calculated if a preexisting condition or affiliation period is imposed. The summary shall also include a ~~phone~~ *telephone* number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.

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

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

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

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

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

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

(A) Advise the small employer of the plan's obligation to sell to any small employer any plan contract it offers to small employers and provide them, upon request, with the actual rates that would be charged to that employer for a given contract.

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

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

(D) Notify the small employer of the availability of coverage through the California Health Benefit Exchange and the availability of tax credits for certain employers, and effective January 1, 2014, the availability of tax credits through the Exchange.

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

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

(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the small employer with the benefit summary required in paragraph (1) of

1 subdivision (h) and the sum of the standard employee risk rates
2 for that particular employer.
3 (B) Notify the small employer that, upon request, the solicitor
4 or solicitor firm will provide the small employer with an evidence
5 of coverage brochure for each contract the plan offers.
6 (C) Until December 31, 2013, notify the small employer that
7 actual rates may be 10 percent higher or lower than the sum of the
8 standard employee risk rates, depending on how the plan assesses
9 the risk of the small employer's group.
10 (D) Until December 31, 2013, notify the small employer that,
11 upon request, the solicitor or solicitor firm will submit information
12 to the plan to ascertain the small employer's sum of the risk
13 adjusted employee risk rate for any contract the plan offers. On or
14 after July 1, 2013, notify the small employer of the employee rate
15 effective January 1, 2014.
16 (E) Obtain a signed statement from the small employer
17 acknowledging that the small employer has received the disclosures
18 required by this section.
19 SEC. 8. Section 1357.15 of the Health and Safety Code is
20 amended to read:
21 1357.15. (a) At least 60 calendar days prior to renewing or
22 amending a plan contract subject to this article which will be in
23 force on the operative date of this article, a plan shall file a notice
24 of material modification with the director in accordance with the
25 provisions of Section 1352. The notice of material modification
26 shall include a statement certifying that the plan is in compliance
27 with subdivision (j) of Section 1357 and Section 1357.12. For rates
28 in effect until January 1, 2014, the certified statement shall set
29 forth the standard employee risk rate for each risk category and
30 the highest and lowest risk adjustment factors that will be used in
31 setting the rates at which the contract will be renewed or amended.
32 Any action by the director, as permitted under Section 1352, to
33 disapprove, suspend, or postpone the plan's use of a plan contract
34 shall be in writing, specifying the reasons that the plan contract
35 does not comply with the requirements of this chapter.
36 (b) At least 60 calendar days prior to offering a plan contract
37 subject to this article, all plans shall file a notice of material
38 modification with the director in accordance with the provisions
39 of Section 1352. The notice of material modification shall include
40 a statement certifying that the plan is in compliance with

1 subdivision (j) of Section 1357 and Section 1357.12. For rates in
2 effect until January 1, 2014, the certified statement shall set forth
3 the standard employee risk rate for each risk category and the
4 highest and lowest risk adjustment factors that will be used in
5 setting the rates at which the contract will be offered. Plans that
6 will be offering to a small employer plan contracts approved by
7 the director prior to the effective date of this article shall file a
8 notice of material modification in accordance with this subdivision.
9 Any action by the director, as permitted under Section 1352, to
10 disapprove, suspend, or postpone the plan's use of a plan contract
11 shall be in writing, specifying the reasons that the plan contract
12 does not comply with the requirements of this chapter.
13 (c) Prior to making any changes in the risk categories or standard
14 employee risk rates filed with the director pursuant to subdivision
15 (a) or (b), the plan shall file as an amendment a statement setting
16 forth the changes and certifying that the plan is in compliance with
17 subdivision (j) of Section 1357 and Section 1357.12. A plan may
18 commence offering plan contracts utilizing the changed risk
19 categories set forth in the certified statement on the 31st day from
20 the date of the filing, or at an earlier time determined by the
21 director, unless the director disapproves the amendment by written
22 notice, stating the reasons therefor. If only the standard employee
23 risk rate is being changed, and not the risk categories, a plan may
24 commence offering plan contracts utilizing the changed standard
25 employee risk rate upon filing the certified statement unless the
26 director disapproves the amendment by written notice.
27 (d) Periodic changes to the standard employee risk rate that a
28 plan proposes to implement over the course of up to 12 consecutive
29 months may be filed in conjunction with the certified statement
30 filed under subdivision (a), (b), or (c).
31 (e) Each plan shall maintain at its principal place of business
32 all of the information required to be filed with the director pursuant
33 to this section.
34 (f) Each plan shall make available to the director, on request,
35 the risk adjustment factor used in determining the rate for any
36 particular small employer.
37 (g) Nothing in this section shall be construed to limit the
38 director's authority to enforce the rating practices set forth in this
39 article.

1 (h) This section shall remain in effect only until January 1, 2014,
2 and as of that date is repealed, unless a later enacted statute, that
3 is enacted before January 1, 2014, deletes or extends that date.
4 SEC. 9. Section 1357.15 is added to the Health and Safety
5 Code, to read:
6 1357.15. (a) At least 60 calendar days prior to renewing or
7 amending a plan contract subject to this article which will be in
8 force on the operative date of this article, a plan shall file a notice
9 of material modification with the director in accordance with the
10 provisions of Section 1352. The notice of material modification
11 shall include a statement certifying that the plan is in compliance
12 with subdivision (j) of Section 1357 and Section 1357.12. Any
13 action by the director, as permitted under Section 1352, to
14 disapprove, suspend, or postpone the plan's use of a plan contract
15 shall be in writing, specifying the reasons that the plan contract
16 does not comply with the requirements of this chapter.
17 (b) At least 60 calendar days prior to offering a plan contract
18 subject to this article, all plans shall file a notice of material
19 modification with the director in accordance with the provisions
20 of Section 1352. The notice of material modification shall include
21 a statement certifying that the plan is in compliance with
22 subdivision (j) of Section 1357 and Section 1357.12. Plans that
23 will be offering to a small employer plan contracts approved by
24 the director prior to the effective date of this article shall file a
25 notice of material modification in accordance with this subdivision.
26 Any action by the director, as permitted under Section 1352, to
27 disapprove, suspend, or postpone the plan's use of a plan contract
28 shall be in writing, specifying the reasons that the plan contract
29 does not comply with the requirements of this chapter.
30 (c) Prior to making any changes in the risk categories or standard
31 employee risk rates filed with the director pursuant to subdivision
32 (a) or (b), the plan shall file as an amendment a statement setting
33 forth the changes and certifying that the plan is in compliance with
34 subdivision (j) of Section 1357 and Section 1357.12. A plan may
35 commence offering plan contracts utilizing the changed risk
36 categories set forth in the certified statement on the 31st day from
37 the date of the filing, or at an earlier time determined by the
38 director, unless the director disapproves the amendment by written
39 notice, stating the reasons therefor. If only the standard employee
40 risk rate is being changed, and not the risk categories, a plan may

commence offering plan contracts utilizing the changed standard employee risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.

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

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

(f) This section shall become operative on January 1, 2014.

SEC. 10. Section 1357.50 of the Health and Safety Code is amended to read:

1357.50. For purposes of this article:

(a) "Health benefit plan" means any individual or group insurance policy or health care service plan contract that provides medical, hospital, and surgical benefits. 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, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an 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 employer, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

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

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

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

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan. The health benefit plan shall enroll a dependent child within 30 days after receipt of a court order or request from the district attorney, either parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, the employer, or the group administrator. In the case of children who are eligible for Medicaid, the State Department of Health Care Services may also make the request.

(4) The plan cannot produce a written statement from the employer stating that, prior to declining coverage, the individual

or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

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

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

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

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or

1 herself or his or her dependents for plan coverage during a special
2 open enrollment opportunity if his or her dependents have lost or
3 will lose coverage under that other employer health benefit plan.
4 The special open enrollment opportunity shall be requested by the
5 employee not more than 30 days after the date that the other health
6 coverage is exhausted or terminated. Upon enrollment, coverage
7 shall be effective not later than the first day of the first calendar
8 month beginning after the date the request for enrollment is
9 received. Notice of the special enrollment rights contained in this
10 paragraph shall be provided by the employer to an employee at or
11 before the time the employee is offered an opportunity to enroll
12 in plan coverage.
13 (c) Until December 31, 2013, "preexisting condition provision"
14 means a contract provision that excludes coverage for charges or
15 expenses incurred during a specified period following the enrollee's
16 effective date of coverage, as to a condition for which medical
17 advice, diagnosis, care, or treatment was recommended or received
18 during a specified period immediately preceding the effective date
19 of coverage.
20 (d) "Creditable coverage" means:
21 (1) Any individual or group policy, contract, or program that is
22 written or administered by a disability insurance company,
23 nonprofit hospital service plan, health care service plan, fraternal
24 benefits society, self-insured employer plan, or any other entity,
25 in this state or elsewhere, and that arranges or provides medical,
26 hospital, and surgical coverage not designed to supplement other
27 private or governmental plans. The term includes continuation or
28 conversion coverage but does not include accident only, credit,
29 coverage for onsite medical clinics, disability income, Medicare
30 supplement, long-term care insurance, dental, vision, coverage
31 issued as a supplement to liability insurance, insurance arising out
32 of a workers' compensation or similar law, automobile medical
33 payment insurance, or insurance under which benefits are payable
34 with or without regard to fault and that is statutorily required to
35 be contained in any liability insurance policy or equivalent
36 self-insurance.
37 (2) The Medicare Program pursuant to Title XVIII of the federal
38 Social Security Act (42 U.S.C. Sec. 1395 et seq.).
39 (3) The Medicaid Program pursuant to Title XIX of the federal
40 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

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

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

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

(7) A state health benefits risk pool.

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

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

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

(11) Any other creditable coverage as defined by subdivision (c) of Section ~~2701~~ *2704* of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

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

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

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

SEC. 11. Section 1357.50 is added to the Health and Safety Code, to read:

1357.50. For purposes of this article:

(a) "Health benefit plan" means any individual or group insurance policy or health care service plan contract that provides essential health benefits as defined consistent with Section 1302 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement,

1 long-term care insurance, 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. The term does not include a grandfathered plan as
8 defined in Section 1251 of the federal Patient Protection and
9 Affordable Care Act (Public Law 111-148).
10 (b) "Late enrollee" means an eligible employee or dependent
11 who has declined health coverage under a health benefit plan
12 offered through employment or sponsored by an employer at the
13 time of the initial enrollment period provided under the terms of
14 the health benefit plan, and who subsequently requests enrollment
15 in a health benefit plan of that employer, provided that the initial
16 enrollment period shall be a period of at least 30 days. However,
17 an eligible employee or dependent shall not be considered a late
18 enrollee if any of the following is applicable:
19 (1) The individual meets all of the following requirements:
20 (A) The individual was covered under another employer health
21 benefit plan, the Healthy Families Program, the Access for Infants
22 and Mothers (AIM) Program, the Medi-Cal program, or the
23 California Health Benefit Exchange, at the time the individual was
24 eligible to enroll.
25 (B) The individual certified, at the time of the initial enrollment,
26 that coverage under another employer health benefit plan, the
27 Healthy Families Program, the AIM Program, the Medi-Cal
28 program, or the California Health Benefit Exchange was the reason
29 for declining enrollment provided that, if the individual was
30 covered under another employer health benefit plan, the individual
31 was given the opportunity to make the certification required by
32 this subdivision and was notified that failure to do so could result
33 in later treatment as a late enrollee.
34 (C) The individual has lost or will lose coverage under another
35 employer health benefit plan as a result of termination of
36 employment of the individual or of a person through whom the
37 individual was covered as a dependent, change in employment
38 status of the individual or of a person through whom the individual
39 was covered as a dependent, termination of the other plan's
40 coverage, cessation of an employer's contribution toward an

1 ~~employee~~ *employee's* or dependent's coverage, death of a person
2 through whom the individual was covered as a dependent, legal
3 separation, or divorce; or the individual has lost or will lose
4 coverage under the Healthy Families Program, the AIM Program,
5 the Medi-Cal program, or the California Health Benefit Exchange.
6 (D) The individual requests enrollment within 30 days after
7 termination of coverage, or cessation of employer contribution
8 toward coverage provided under another employer health benefit
9 plan, or requests enrollment within 60 days after termination of
10 Medi-Cal program coverage, AIM Program coverage, Healthy
11 Families Program coverage, or coverage through the California
12 Health Benefit Exchange.
13 (2) The individual is employed by an employer that offers
14 multiple health benefit plans and the individual elects a different
15 plan during an open enrollment period.
16 (3) A court has ordered that coverage be provided for a spouse
17 or minor child under a covered employee's health benefit plan.
18 The health benefit plan shall enroll a dependent child within 30
19 days after receipt of a court order or request from the district
20 attorney, either parent or the person having custody of the child
21 as defined in Section 3751.5 of the Family Code, the employer,
22 or the group administrator. In the case of children who are eligible
23 for Medicaid, the State Department of Health Care Services may
24 also make the request.
25 (4) The plan cannot produce a written statement from the
26 employer stating that, prior to declining coverage, the individual
27 or the person through whom the individual was eligible to be
28 covered as a dependent was provided with, and signed
29 acknowledgment of, explicit written notice in boldface type
30 specifying that failure to elect coverage during the initial
31 enrollment period permits the plan to impose, at the time of the
32 individual's later decision to elect coverage, an exclusion from
33 coverage for a period of 12 months as well as a six-month
34 preexisting condition exclusion, unless the individual meets the
35 criteria specified in paragraph (1), (2), or (3).
36 (5) The individual is an employee or dependent who meets the
37 criteria described in paragraph (1) and was under a COBRA
38 continuation provision, and the coverage under that provision has
39 been exhausted. For purposes of this section, the definition of

1 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
2 apply.
3 (6) The individual is a dependent of an enrolled eligible
4 employee who has lost or will lose his or her coverage under the
5 Healthy Families Program, the AIM Program, the Medi-Cal
6 program, or the California Health Benefit Exchange, and requests
7 enrollment within 60 days of termination of that coverage.
8 (7) The individual is an eligible employee who previously
9 declined coverage under an employer health benefit plan and who
10 has subsequently acquired a dependent who would be eligible for
11 coverage as a dependent of the employee through marriage, birth,
12 adoption, or placement for adoption, and who enrolls for coverage
13 under that employer health benefit plan on his or her behalf, and
14 on behalf of his or her dependent within 30 days following the
15 date of marriage, birth, adoption, or placement for adoption, in
16 which case the effective date of coverage shall be the first day of
17 the month following the date the completed request for enrollment
18 is received in the case of marriage, or the date of birth, or the date
19 of adoption or placement for adoption, whichever applies. Notice
20 of the special enrollment rights contained in this paragraph shall
21 be provided by the employer to an employee at or before the time
22 the employee is offered an opportunity to enroll in plan coverage.
23 (8) The individual is an eligible employee who has declined
24 coverage for himself or herself or his or her dependents during a
25 previous enrollment period because his or her dependents were
26 covered by another employer health benefit plan at the time of the
27 previous enrollment period. That individual may enroll himself or
28 herself or his or her dependents for plan coverage during a special
29 open enrollment opportunity if his or her dependents have lost or
30 will lose coverage under that other employer health benefit plan.
31 The special open enrollment opportunity shall be requested by the
32 employee not more than 30 days after the date that the other health
33 coverage is exhausted or terminated. Upon enrollment, coverage
34 shall be effective not later than the first day of the first calendar
35 month beginning after the date the request for enrollment is
36 received. Notice of the special enrollment rights contained in this
37 paragraph shall be provided by the employer to an employee at or
38 before the time the employee is offered an opportunity to enroll
39 in plan coverage.

(c) On or after January 1, 2014, a plan contract shall not establish any preexisting condition exclusion or limitation for any individual or dependent of an individual, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. A preexisting condition exclusion includes any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan, or group or individual health insurance coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

(d) "Creditable coverage" means:

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

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

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

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

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

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 Public Health Service
9 Act, as amended by Public Law 104-191, the Health Insurance
10 Portability and Accountability Act of 1996.
11 (10) A health benefit plan under Section 5(e) of the Peace Corps
12 Act (22 U.S.C. Sec. 2504(e)).
13 (11) Any other creditable coverage as defined by subdivision
14 (c) of Section ~~2701~~ *2704* of Title XXVII of the federal Public
15 Health Service Act (42 U.S.C. Sec. 300gg-3(c)).
16 *(e) "Waiting period" means the period that is required to pass*
17 *with respect to the employee before the employee is eligible to be*
18 *covered for benefits under the terms of the policy. However, such*
19 *periods shall not be based upon health status of the employee or*
20 *dependent. A health plan may permit a waiting period of up to 90*
21 *days as a condition of enrollment if applied equally to all full-time*
22 *employees, consistent with the federal Patient Protection and*
23 *Affordable Care Act (Public Law 111-148) and any rules,*
24 *regulations, or guidance issued consistent with that law.*
25 ~~(e)~~
26 *(f)* This section shall become operative on January 1, 2014.
27 SEC. 12. Section 1357.51 of the Health and Safety Code is
28 amended to read:
29 1357.51. (a) Until December 31, 2013, no plan contract that
30 covers three or more enrollees shall exclude coverage for any
31 individual on the basis of a preexisting condition provision for a
32 period greater than six months following the individual's effective
33 date of coverage. Preexisting condition provisions contained in
34 plan contracts may relate only to conditions for which medical
35 advice, diagnosis, care, or treatment, including use of prescription
36 drugs, was recommended or received from a licensed health
37 practitioner during the six months immediately preceding the
38 effective date of coverage.
39 (b) Until December 31, 2013, no plan contract that covers one
40 or two individuals shall exclude coverage on the basis of a

preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall the plan limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a plan contract for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) Notwithstanding subdivision (b), a plan contract for individual coverage that is not a grandfathered health plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

(d) Until December 31, 2013, a plan that does not utilize a preexisting condition provision may impose ~~a waiting or~~ *an* affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the ~~waiting or~~ affiliation period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) Until December 31, 2013, a plan that does not utilize a preexisting condition provision in plan contracts that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No plan may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(f) Until December 31, 2013, in determining whether a preexisting condition provision, a waivered condition provision, or ~~a waiting or~~ *an* affiliation period applies to any enrollee, a plan

1 shall credit the time the enrollee was covered under creditable
2 coverage, provided that the enrollee becomes eligible for coverage
3 under the succeeding plan contract within 62 days of termination
4 of prior coverage, exclusive of any ~~waiting or~~ affiliation period,
5 and applies for coverage under the succeeding plan within the
6 applicable enrollment period. A plan shall also credit any time that
7 an eligible employee must wait before enrolling in the plan,
8 including any postenrollment or employer-imposed ~~waiting or~~
9 affiliation period.
10 However, if a person's employment has ended, the availability
11 of health coverage offered through employment or sponsored by
12 an employer has terminated, or an employer's contribution toward
13 health coverage has terminated, a plan shall credit the time the
14 person was covered under creditable coverage if the person
15 becomes eligible for health coverage offered through employment
16 or sponsored by an employer within 180 days, exclusive of any
17 ~~waiting or~~ affiliation period, and applies for coverage under the
18 succeeding plan contract within the applicable enrollment period.
19 (g) Until December 31, 2013, no plan shall exclude late enrollees
20 from coverage for more than 12 months from the date of the late
21 enrollee's application for coverage. No plan shall require any
22 premium or other periodic charge to be paid by or on behalf of a
23 late enrollee during the period of exclusion from coverage
24 permitted by this subdivision.
25 (h) A health care service plan issuing group coverage may not
26 impose a preexisting condition exclusion upon a condition relating
27 to benefits for pregnancy or maternity care.
28 (i) An individual's period of creditable coverage shall be
29 certified pursuant to subsection (e) of Section ~~2701~~ *2704* of Title
30 XXVII of the federal Public Health Service Act (42 U.S.C. Sec.
31 300gg-3(e)).
32 (j) This section shall remain in effect only until January 1, 2014,
33 and as of that date is repealed, unless a later enacted statute, that
34 is enacted before January 1, 2014, deletes or extends that date.
35 SEC. 13. Section 1357.51 is added to the Health and Safety
36 Code, to read:
37 1357.51. (a) No plan contract that covers one or more enrollees
38 shall exclude coverage for any individual on the basis of a
39 preexisting condition.

1 (b) (1) A plan contract for group coverage shall not impose any
2 preexisting condition provision upon any individual. *A preexisting*
3 *condition provision includes any limitation or exclusion of benefits,*
4 *including a denial of coverage, applicable to an individual as a*
5 *result of information relating to an individual's health status before*
6 *the individual's effective date of coverage under a group or*
7 *individual health plan such as a condition identified as a result of*
8 *a preenrollment questionnaire or physical examination given to*
9 *the individual, or review of medical records relating to the*
10 *preenrollment period.*
11 (2) A plan contract for individual coverage that is not a
12 grandfathered health plan within the meaning of Section 1251 of
13 the federal Patient Protection and Affordable Care Act (Public
14 Law 111-148) shall not impose any preexisting condition provision
15 upon any individual.
16 (c) A plan may impose a 90-day waiting period from the date
17 of the late enrollee's application for coverage. A plan contract may
18 permit a waiting period of up to 90 days as a condition of
19 enrollment if applied equally to all full-time employees and if
20 consistent with the federal Patient Protection and Affordable Care
21 Act (Public Law 111-148) and any rules, regulations, or guidance
22 issued consistent with that law.
23 (d) A health care service plan issuing group coverage may not
24 impose a preexisting condition exclusion based on health
25 status-related factors, including, but not limited to, the following:
26 (1) Health status.
27 (2) Medical condition, including both physical and mental
28 illnesses.
29 (3) Claims experience.
30 (4) Receipt of medical care.
31 (5) Medical history.
32 (6) Genetic information.
33 (7) Evidence of insurability, including conditions arising from
34 domestic violence.
35 (8) Disability.
36 (9) Any other health status-related factor determined appropriate
37 by the federal government.
38 (10) Any other health status-related factor determined
39 appropriate by the director.

(e) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section ~~2701~~ *2704* of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

(f) This section shall become operative on January 1, 2014.

SEC. 14. Section 1357.52 of the Health and Safety Code is amended to read:

1357.52. (a) Until December 31, 2013, except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a plan may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability including conditions arising out of acts of domestic violence of that employee or dependent. No plan contract may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 1357.06.

(b) On or after January 1, 2014, a plan may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence, of that employee or dependent. No plan contract may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident.

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

SEC. 15. Section 1357.52 is added to the Health and Safety Code, to read:

1357.52. A plan may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims

1 experience, the medical history, the genetic information, or the
2 disability or evidence of insurability including conditions arising
3 out of acts of domestic violence of that employee or dependent.
4 No plan contract may limit or exclude coverage for a specific
5 eligible employee or dependent by type of illness, treatment,
6 medical condition, or accident.
7 This section shall become operative on January 1, 2014.
8 SEC. 15.5. Section 106 of the Insurance Code is amended to
9 read:
10 106. (a) Disability insurance includes insurance appertaining
11 to injury, disablement or death resulting to the insured from
12 accidents, and appertaining to disablements resulting to the insured
13 from sickness.
14 (b) In statutes that become effective on or after January 1, 2002,
15 the term "health insurance" for purposes of this code shall mean
16 an individual or group disability insurance policy that provides
17 coverage for hospital, medical, or surgical benefits. The term
18 "health insurance" shall not include any of the following kinds of
19 insurance:
20 (1) Accidental death and accidental death and dismemberment.
21 (2) Disability insurance, including hospital indemnity, accident
22 only, and specified disease insurance that pays benefits on a fixed
23 benefit, cash payment only basis.
24 (3) Credit disability, as defined in subdivision (2) of Section
25 779.2.
26 (4) Coverage issued as a supplement to liability insurance.
27 (5) Disability income, as defined in subdivision (i) of Section
28 799.01.
29 (6) Insurance under which benefits are payable with or without
30 regard to fault and that is statutorily required to be contained in
31 any liability insurance policy or equivalent self-insurance.
32 (7) Insurance arising out of a workers' compensation or similar
33 law.
34 (8) Long-term care.
35 (c) In a statute that becomes effective on or after January 1,
36 2008, the term "specialized health insurance policy" as used in
37 this code shall mean a policy of health insurance for covered
38 benefits in a single specialized area of health care, including
39 dental-only, vision-only, and behavioral health-only policies.

(d) In a statute that becomes effective on or after January 1, 2014, the term "health insurance" for purposes of this code shall mean an individual or group disability insurance policy that provides essential health benefits consistent with Section 1302 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and regulations adopted pursuant thereto. This shall not apply to coverage that is grandfathered coverage consistent with Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). *The term "health insurance" shall not include a specialized health insurance policy, Medicare supplement, or coverage of Medicare services pursuant to contracts with the United States government.*

(e) In statutes effective on or after January 1, 2012, the term "health insurer" shall mean a disability insurer that sells "health insurance" within the meaning of this section.

SEC. 16. Section 10198.6 of the Insurance Code is amended to read:

10198.6. For purposes of this article:

(a) "Health benefit plan" means any group or individual policy or contract that provides medical, hospital, or surgical benefits. 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, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an 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 employer, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

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

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

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

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

(4) The carrier cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in boldface type

1 specifying that failure to elect coverage during the initial
2 enrollment period permits the carrier to impose, at the time of the
3 individual's later decision to elect coverage, an exclusion from
4 coverage for a period of 12 months as well as a six-month
5 preexisting condition exclusion, unless the individual meets the
6 criteria specified in paragraph (1), (2), or (3).
7 (5) The individual is an employee or dependent who meets the
8 criteria described in paragraph (1) and was under a COBRA
9 continuation provision and the coverage under that provision has
10 been exhausted. For purposes of this section, the definition of
11 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
12 apply.
13 (6) The individual is a dependent of an enrolled eligible
14 employee who has lost or will lose his or her coverage under the
15 Healthy Families Program, the AIM Program, or the Medi-Cal
16 program, and requests enrollment within 60 days of termination
17 of that coverage.
18 (c) Until December 31, 2013, "preexisting condition provision"
19 means a policy provision that excludes coverage for charges or
20 expenses incurred during a specified period following the insured's
21 effective date of coverage, as to a condition for which medical
22 advice, diagnosis, care, or treatment was recommended or received
23 during a specified period immediately preceding the effective date
24 of coverage.
25 (d) "Creditable coverage" means:
26 (1) Any individual or group policy, contract, or program, that
27 is written or administered by a disability insurance company, health
28 care service plan, fraternal benefits society, self-insured employer
29 plan, or any other entity, in this state or elsewhere, and that
30 arranges or provides medical, hospital, and surgical coverage not
31 designed to supplement other private or governmental plans. The
32 term includes continuation or conversion coverage but does not
33 include accident only, credit, coverage for onsite medical clinics,
34 disability income, Medicare supplement, long-term care insurance,
35 dental, vision, coverage issued as a supplement to liability
36 insurance, insurance arising out of a workers' compensation or
37 similar law, automobile medical payment insurance, or insurance
38 under which benefits are payable with or without regard to fault
39 and that is statutorily required to be contained in any liability
40 insurance policy or equivalent self-insurance.

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

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

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

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

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

(7) A state health benefits risk pool.

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

(9) A public health plan as defined in federal regulations authorized by Section ~~2701~~ *2704*(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

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

(11) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

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

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

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

SEC. 17. Section 10198.6 is added to the Insurance Code, to read:

10198.6. For purposes of this article:

(a) "Health benefit plan" means any group or individual policy or contract that provides ~~essential health benefits as defined consistent with Section 1302 of the federal Patient Protection and~~

~~Affordable Care Act (Public Law 111-148)~~ *health insurance, as defined in Section 106, and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity*. 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, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) "Late enrollee" means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an 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 employer, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

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

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

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

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

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

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

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

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her coverage under the

1 Healthy Families Program, the AIM Program, the Medi-Cal
2 program, or the California Health Benefit Exchange, and requests
3 enrollment within 60 days of termination of that coverage.
4 (c) On or after January 1, 2014, a policy shall not establish any
5 preexisting condition exclusion or limitation for any individual or
6 dependent of an individual, whether or not any medical advice,
7 diagnosis, care, or treatment was recommended or received before
8 that date. A preexisting condition exclusion includes any limitation
9 or exclusion of benefits, including a denial of coverage, applicable
10 to an individual as a result of information relating to an individual's
11 health status before the individual's effective date of coverage
12 under a group health plan, or group or individual health insurance
13 coverage, such as a condition identified as a result of a
14 preenrollment questionnaire or physical examination given to the
15 individual, or review of medical records relating to the
16 preenrollment period.
17 (d) "Creditable coverage" means:
18 (1) Any individual or group policy, contract or program, that is
19 written or administered by a disability insurance company, health
20 care service plan, fraternal benefits society, self-insured employer
21 plan, or any other entity, in this state or elsewhere, and that
22 arranges or provides medical, hospital, and surgical coverage not
23 designed to supplement other private or governmental plans. The
24 term includes continuation or conversion coverage but does not
25 include accident only, credit, coverage for onsite medical clinics,
26 disability income, Medicare supplement, long-term care insurance,
27 dental, vision, coverage issued as a supplement to liability
28 insurance, insurance arising out of a workers' compensation or
29 similar law, automobile medical payment insurance, or insurance
30 under which benefits are payable with or without regard to fault
31 and that is statutorily required to be contained in any liability
32 insurance policy or equivalent self-insurance.
33 (2) The federal Medicare Program pursuant to Title XVIII of
34 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).
35 (3) The Medicaid Program pursuant to Title XIX of the federal
36 Social Security Act (42 U.S.C. Sec. 1396 et seq.).
37 (4) Any other publicly sponsored program, provided in this state
38 or elsewhere, of medical, hospital, and surgical care.

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

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

(7) A state health benefits risk pool.

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

(9) A public health plan as defined in federal regulations authorized by Section ~~2701~~ *2704*(c)(1)(I) of the federal Public Health Service Act, as amended by Public Law 104-191, the federal Health Insurance Portability and Accountability Act of 1996.

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

(11) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(e) "Waiting period" means the period that is required to pass with respect to the employee before the employee is eligible to be covered for benefits under the terms of the policy. However, such periods shall not be based upon health status of the employee or dependent. A health plan may permit a waiting period of up to 90 days as a condition of enrollment if applied equally to all full-time employees, consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

~~(e)~~

(f) This section shall become operative on January 1, 2014.

SEC. 18. Section 10198.7 of the Insurance Code is amended to read:

10198.7. (a) Until December 31, 2013, no health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except

for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) Until December 31, 2013, no health benefit plan that covers one or two individuals and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a health benefit plan for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) Notwithstanding subdivision (b), a health benefit plan for individual coverage that is a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

(d) Until December 31, 2013, a carrier that does not utilize a preexisting condition provision may impose ~~a waiting or~~ *an* affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the ~~waiting or~~ affiliation period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) Until December 31, 2013, a carrier that does not utilize a preexisting condition provision in health plans that cover one or two individuals may impose a contract provision excluding

coverage for waivered conditions. No carrier may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(f) Until December 31, 2013, in determining whether a preexisting condition provision, a waivered condition provision, or ~~a waiting or~~ *an* affiliation period applies to any person, all health benefit plans shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any ~~waiting or~~ affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A health benefit plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any affiliation or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated*,* or~~,~~ an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any ~~waiting or~~ affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period.

(g) Until December 31, 2013, no health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by

or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(h) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section ~~2701~~ *2704* of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

(i) A group health benefit plan may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

(j) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

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

SEC. 19. Section 10198.7 is added to the Insurance Code, to read:

10198.7. (a) No health benefit plan that covers one or more enrollees *and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity* shall exclude coverage for any individual on the basis of a preexisting condition.

(b) (1) A health benefit plan for group coverage *that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity* shall not impose any preexisting condition provision upon any individual.

(2) A health benefit plan for individual coverage that is a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any individual.

(c) A health benefit plan may impose a 90-day waiting period from the date of the late enrollee's application for coverage. A group health benefit plan may permit a waiting period of up to 90 days as a condition of enrollment if applied equally to all full-time employees and if consistent with the federal Patient Protection and

1 Affordable Care Act (Public Law 111-148) and any rules,
2 regulations, or guidance issued consistent with that law.
3 (d) An individual's period of creditable coverage shall be
4 certified pursuant to subsection (e) of Section ~~2701~~ *2704* of Title
5 XXVII of the federal Public Health Service Act (42 U.S.C. Sec.
6 300gg-3(e)).
7 (e) A group health benefit plan may not impose a preexisting
8 condition exclusion *or establish rules for eligibility, including*
9 *continued eligibility, of any individual to enroll under the terms*
10 *of that plan or coverage* based on health status-related factors, *in*
11 *relation to the individual or a dependent of the individual,*
12 including, but not limited to, the following:
13 (1) Health status.
14 (2) Medical condition, including both physical and mental
15 illnesses.
16 (3) Claims experience.
17 (4) Receipt of medical care.
18 (5) Medical history.
19 (6) Genetic information.
20 (7) Evidence of insurability, including conditions arising from
21 domestic violence.
22 (8) Disability.
23 (9) Any other health status-related factor determined appropriate
24 by the federal government.
25 (10) Any other health status-related factor determined
26 appropriate by the commissioner.
27 (f) Any entity providing aggregate or specific stop loss coverage
28 or any other assumption of risk with reference to a health benefit
29 plan shall provide that the plan meets all requirements of this article
30 concerning waiting periods, preexisting condition provisions, and
31 late enrollees.
32 (g) This section shall become operative on January 1, 2014.
33 SEC. 20. Section 10198.9 of the Insurance Code is amended
34 to read:
35 10198.9. (a) (1) Until December 31, 2013, except in the case
36 of a late enrollee, or for satisfaction of a preexisting condition
37 clause in the case of initial coverage of an eligible employee, a
38 disability insurer may not exclude any eligible employee or
39 dependent who would otherwise be entitled to health care services
40 on the basis of any of the following: the health status, the medical

condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 10198.7.

(2) On or after January 1, 2014, a health insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident.

(b) For purposes of this section, "health benefit plan" shall have the same meaning as in Section 10198.6 and subdivision (a) of Section 10198.61.

(c) For purposes of this section, "eligible employee" shall have the same meaning as in Section 10700 except that it shall apply to any health benefit plan covering one or more eligible employees.

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

SEC. 21. Section 10198.9 is added to the Insurance Code, to read:

10198.9. (a) A ~~health insurer may~~ *policy of health insurance, as defined in Section 106, that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall* not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage

1 for a specific eligible employee or dependent by type of illness,
2 treatment, medical condition, or accident.
3 (b) For purposes of this section, "health benefit plan" shall have
4 the same meaning as in Section 10198.6 and subdivision (a) of
5 Section 10198.61.
6 (c) For purposes of this section, "eligible employee" shall have
7 the same meaning as in Section 10700 except that it shall apply to
8 any health benefit plan covering one or more eligible employees.
9 (d) This section shall become operative on January 1, 2014.
10 SEC. 22. Section 10700 of the Insurance Code is amended to
11 read:
12 10700. As used in this chapter:
13 (a) "Agent or broker" means a person or entity licensed under
14 Chapter 5 (commencing with Section 1621) of Part 2 of Division
15 1.
16 (b) "Benefit plan design" means a specific health coverage
17 product issued by a carrier to small employers, to trustees of
18 associations that include small employers, or to individuals if the
19 coverage is offered through employment or sponsored by an
20 employer. It includes services covered and the levels of copayment
21 and deductibles, and it may include the professional providers who
22 are to provide those services and the sites where those services are
23 to be provided. A benefit plan design may also be an integrated
24 system for the financing and delivery of quality health care services
25 which has significant incentives for the covered individuals to use
26 the system.
27 (c) "Board" means the Major Risk Medical Insurance Board.
28 (d) "Carrier" means any disability insurance company or any
29 other entity that writes, issues, or administers health benefit plans
30 that cover the employees of small employers, regardless of the
31 situs of the contract or master policyholder. For the purposes of
32 Articles 3 (commencing with Section 10719) and 4 (commencing
33 with Section 10730), "carrier" also includes health care service
34 plans.
35 (e) "Dependent" means the spouse or child of an eligible
36 employee, subject to applicable terms of the health benefit plan
37 covering the employee, and includes dependents of guaranteed
38 association members if the association elects to include dependents
39 under its health coverage at the same time it determines its
40 membership composition pursuant to subdivision (z).

1 (f) "Eligible employee" means either of the following:
2 (1) Any permanent employee who is actively engaged on a
3 full-time basis in the conduct of the business of the small employer
4 with a normal workweek of an average of 30 hours per week over
5 the course of a month, in the small employer's regular place of
6 business, who has met any statutorily authorized applicable waiting
7 period requirements. The term includes sole proprietors or partners
8 of a partnership, if they are actively engaged on a full-time basis
9 in the small employer's business, and they are included as
10 employees under a health benefit plan of a small employer, but
11 does not include employees who work on a part-time, temporary,
12 or substitute basis. It includes any eligible employee, as defined
13 in this paragraph, who obtains coverage through a guaranteed
14 association. Employees of employers purchasing through a
15 guaranteed association shall be deemed to be eligible employees
16 if they would otherwise meet the definition except for the number
17 of persons employed by the employer. A permanent employee
18 who works at least 20 hours but not more than 29 hours is deemed
19 to be an eligible employee if all four of the following apply:
20 (A) The employee otherwise meets the definition of an eligible
21 employee except for the number of hours worked.
22 (B) The employer offers the employee health coverage under a
23 health benefit plan.
24 (C) All similarly situated individuals are offered coverage under
25 the health benefit plan.
26 (D) The employee must have worked at least 20 hours per
27 normal workweek for at least 50 percent of the weeks in the
28 previous calendar quarter. The insurer may request any necessary
29 information to document the hours and time period in question,
30 including, but not limited to, payroll records and employee wage
31 and tax filings.
32 (2) Any member of a guaranteed association as defined in
33 subdivision (z).
34 (g) "Enrollee" means an eligible employee or dependent who
35 receives health coverage through the program from a participating
36 carrier.
37 (h) "Financially impaired" means, for the purposes of this
38 chapter, a carrier that, on or after the effective date of this chapter,
39 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 shall be a period of at least 30 days. However, an eligible employee, another person eligible for coverage through a guaranteed association pursuant to subdivision (z), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

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

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants

1 and Mothers (AIM) Program, the Medi-Cal program, or the
2 California Health Benefit Exchange, at the time the individual was
3 eligible to enroll.
4 (B) He or she certified at the time of the initial enrollment that
5 coverage under another employer health benefit plan, the Healthy
6 Families Program, the AIM Program, the Medi-Cal program, or
7 the California Health Benefit Exchange was the reason for
8 declining enrollment provided that, if the individual was covered
9 under another employer health plan, the individual was given the
10 opportunity to make the certification required by this subdivision
11 and was notified that failure to do so could result in later treatment
12 as a late enrollee.
13 (C) He or she has lost or will lose coverage under another
14 employer health benefit plan as a result of termination of
15 employment of the individual or of a person through whom the
16 individual was covered as a dependent, change in employment
17 status of the individual, or of a person through whom the individual
18 was covered as a dependent, the termination of the other plan's
19 coverage, cessation of an employer's contribution toward an
20 ~~employee~~ *employee's* or dependent's coverage, death of the person
21 through whom the individual was covered as a dependent, legal
22 separation, or divorce; or he or she has lost or will lose coverage
23 under the Healthy Families Program, the AIM Program, the
24 Medi-Cal program, or the California Health Benefit Exchange.
25 (D) He or she requests enrollment within 30 days after
26 termination of coverage or employer contribution toward coverage
27 provided under another employer health benefit plan, or requests
28 enrollment within 60 days after termination of Medi-Cal program
29 coverage, AIM Program coverage, Healthy Families Program
30 coverage, or coverage through the California Health Benefit
31 Exchange.
32 (2) The individual is employed by an employer who offers
33 multiple health benefit plans and the individual elects a different
34 plan during an open enrollment period.
35 (3) A court has ordered that coverage be provided for a spouse
36 or minor child under a covered employee's health benefit plan.
37 (4) (A) Until December 31, 2013, in the case of an eligible
38 employee as defined in paragraph (1) of subdivision (f), the carrier
39 cannot produce a written statement from the employer stating that
40 the individual or the person through whom an individual was

1 eligible to be covered as a dependent, prior to declining coverage,
2 was provided with, and signed acknowledgment of, an explicit
3 written notice in boldface type specifying that failure to elect
4 coverage during the initial enrollment period permits the carrier
5 to impose, at the time of the individual's later decision to elect
6 coverage, an exclusion from coverage for a period of 12 months
7 as well as a six-month preexisting condition exclusion unless the
8 individual meets the criteria specified in paragraph (1), (2), or (3).
9 (B) Until December 31, 2013, in the case of an eligible employee
10 who is a guaranteed association member, the plan cannot produce
11 a written statement from the guaranteed association stating that
12 the association sent a written notice in boldface type to all
13 potentially eligible association members at their last known address
14 prior to the initial enrollment period informing members that failure
15 to elect coverage during the initial enrollment period permits the
16 plan to impose, at the time of the member's later decision to elect
17 coverage, an exclusion from coverage for a period of 12 months
18 as well as a six-month preexisting condition exclusion unless the
19 member can demonstrate that he or she meets the requirements of
20 subparagraphs (A), (C), and (D) of paragraph (1) or meets the
21 requirements of paragraph (2) or (3).
22 (C) In the case of an employer or person who is not a member
23 of an association, was eligible to purchase coverage through a
24 guaranteed association, and did not do so, and would not be eligible
25 to purchase guaranteed coverage unless purchased through a
26 guaranteed association, the employer or person can demonstrate
27 that he or she meets the requirements of subparagraphs (A), (C),
28 and (D) of paragraph (1), or meets the requirements of paragraph
29 (2) or (3), or that he or she recently had a change in status that
30 would make him or her eligible and that application for coverage
31 was made within 30 days of the change.
32 (5) The individual is an employee or dependent who meets the
33 criteria described in paragraph (1) and was under a COBRA
34 continuation provision and the coverage under that provision has
35 been exhausted. For purposes of this section, the definition of
36 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
37 apply.
38 (6) The individual is a dependent of an enrolled eligible
39 employee who has lost or will lose his or her coverage under the
40 Healthy Families Program, the AIM Program, the Medi-Cal

1 program, or the California Health Benefit Exchange, and requests
2 enrollment within 60 days after termination of that coverage.
3 (7) The individual is an eligible employee who previously
4 declined coverage under an employer health benefit plan and who
5 has subsequently acquired a dependent who would be eligible for
6 coverage as a dependent of the employee through marriage, birth,
7 adoption, or placement for adoption, and who enrolls for coverage
8 under that employer health benefit plan on his or her behalf and
9 on behalf of his or her dependent within 30 days following the
10 date of marriage, birth, adoption, or placement for adoption, in
11 which case the effective date of coverage shall be the first day of
12 the month following the date the completed request for enrollment
13 is received in the case of marriage, or the date of birth, or the date
14 of adoption or placement for adoption, whichever applies. Notice
15 of the special enrollment rights contained in this paragraph shall
16 be provided by the employer to an employee at or before the time
17 the employee is offered an opportunity to enroll in plan coverage.
18 (8) The individual is an eligible employee who has declined
19 coverage for himself or herself or his or her dependents during a
20 previous enrollment period because his or her dependents were
21 covered by another employer health benefit plan at the time of the
22 previous enrollment period. That individual may enroll himself or
23 herself or his or her dependents for plan coverage during a special
24 open enrollment opportunity if his or her dependents have lost or
25 will lose coverage under that other employer health benefit plan.
26 The special open enrollment opportunity shall be requested by the
27 employee not more than 30 days after the date that the other health
28 coverage is exhausted or terminated. Upon enrollment, coverage
29 shall be effective not later than the first day of the first calendar
30 month beginning after the date the request for enrollment is
31 received. Notice of the special enrollment rights contained in this
32 paragraph shall be provided by the employer to an employee at or
33 before the time the employee is offered an opportunity to enroll
34 in plan coverage.
35 (m) "New business" means a health benefit plan issued to a
36 small employer that is not the carrier's in force business.
37 (n) "Participating carrier" means a carrier that has entered into
38 a contract with the program to provide health benefits coverage
39 under this part.

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

(p) "Program" means the Health Insurance Plan of California.

(q) (1) Until December 31, 2013, "preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(2) On and after January 1, 2014, no insurer shall limit or exclude coverage for any individual based on a preexisting condition whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. *A preexisting condition exclusion includes any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan, or group or individual health insurance coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.*

(r) "Creditable coverage" means:

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

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

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

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

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

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

(7) A state health benefits risk pool.

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

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

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

(11) Any other creditable coverage as defined by subsection (c) of Section ~~2701~~ *2704* of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(s) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than 12 months. *This subdivision shall be implemented to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.*

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

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

percent. Effective January 1, 2014, no risk adjustment factor shall be used in the determination of rates.

(v) "Risk category" means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

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

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

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the health benefit plan will be primary or secondary to benefits provided by the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act. Effective January 1, 2014, the rate for age shall not vary by more than three to one for adults.

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

(A) Single.
(B) Married couple.
(C) One adult and child or children.
(D) Married couple and child or children.

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

1 (B) In determining rates for small employers, a carrier that does
2 not operate statewide shall use no more than the number of
3 geographic regions in the state than is determined by the following
4 formula: the population, as determined in the last federal census,
5 of all counties which are included in their entirety in a carrier's
6 service area divided by the total population of the state, as
7 determined in the last federal census, multiplied by nine. The
8 resulting number shall be rounded to the nearest whole integer.
9 No region may be smaller than an area in which the first three
10 digits of all its ZIP Codes are in common within a county and no
11 county may be divided into more than two regions. The area
12 encompassed in a geographic region shall be separate and distinct
13 from areas encompassed in other geographic regions. Geographic
14 regions may be noncontiguous. No carrier shall have less than one
15 geographic area.
16 (w) "Small employer" means either of the following:
17 (1) Until December 31, 2013, any person, proprietary or
18 nonprofit firm, corporation, partnership, public agency, or
19 association that is actively engaged in business or service that, on
20 at least 50 percent of its working days during the preceding
21 calendar quarter, or preceding calendar year, employed at least 2,
22 but not more than 50, eligible employees, the majority of whom
23 were employed within this state, that was not formed primarily for
24 purposes of buying health insurance and in which a bona fide
25 employer-employee relationship exists. On or after January 1,
26 2014, and until December 31, 2015, any person, firm, proprietary
27 or nonprofit corporation, partnership, public agency, or association
28 that is actively engaged in business or service, that, on at least 50
29 percent of its working days during the preceding calendar quarter
30 or preceding calendar year, employed at least one, but no more
31 than 50, eligible employees, the majority of whom were employed
32 within this state, that was not formed primarily for purposes of
33 buying health insurance, and in which a bona fide
34 employer-employee relationship exists. On or after January 1,
35 2016, any person, firm, proprietary or nonprofit corporation,
36 partnership, public agency, or association that is actively engaged
37 in business or service, that, on at least 50 percent of its working
38 days during the preceding calendar quarter or preceding calendar
39 year, employed at least one, but no more than 100, eligible
40 employees, the majority of whom were employed within this state,

that was not formed primarily for purposes of buying health benefit plans, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, the insurer shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply until the health benefit plan anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association. This paragraph shall be implemented to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

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

(3) On or after January 1, 2014, a self-employed individual who obtains at least 50 percent of annual income from self-employment as demonstrated through personal income tax filings for the current or prior year. To the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules or guidance issued consistent with that law, a self-employed individual whose modified annual gross income is anticipated to be less than 400 percent of the federal poverty level may at his or her discretion seek to enroll as an individual rather than a small employer through the California Health Benefit Exchange to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

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

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

1 person is a member of the association and chooses to purchase
2 health coverage through the association. At the association's
3 discretion, it may also include employees of association members,
4 association staff, retired members, retired employees of members,
5 and surviving spouses and dependents of deceased members.
6 However, if an association chooses to include those persons as
7 members of the guaranteed association, the association must so
8 elect in advance of purchasing coverage from a plan. Health plans
9 may require an association to adhere to the membership
10 composition it selects for up to 12 months.
11 (aa) "Affiliation period" means a period that, under the terms
12 of the health benefit plan, must expire before health care services
13 under the plan become effective until December 31, 2013.
14 SEC. 23. Section 10705 of the Insurance Code is amended to
15 read:
16 10705. Upon the effective date of this act:
17 (a) No group or individual policy or contract or certificate of
18 group insurance or statement of group coverage providing benefits
19 to employees of small employers as defined in this chapter shall
20 be issued or delivered by a carrier subject to the jurisdiction of the
21 commissioner regardless of the situs of the contract or master
22 policyholder or of the domicile of the carrier nor, except as
23 otherwise provided in Sections 10270.91 and 10270.92, shall a
24 carrier provide coverage subject to this chapter until a copy of the
25 form of the policy, contract, certificate, or statement of coverage
26 is filed with and approved by the commissioner in accordance with
27 Sections 10290 and 10291, and the carrier has complied with the
28 requirements of Section 10717.
29 (b) (1) Each carrier, except a self-funded employer, shall fairly
30 and affirmatively offer, market, and sell all of the carrier's benefit
31 plan designs that are sold to, offered through, or sponsored by,
32 small employers or associations that include small employers to
33 all small employers in each geographic region in which the carrier
34 makes coverage available or provides benefits.
35 (2) A carrier contracting to participate in the California Health
36 Benefit Exchange shall be deemed to be in compliance with
37 paragraph (1) for a benefit plan design offered in those geographic
38 regions in which the carrier participates in the California Health
39 Benefit Exchange.

(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, and,
14 until January 1, 2014, an explanation of how creditable coverage
15 is calculated if a preexisting condition or affiliation period is
16 imposed. The summary shall also include a telephone number that
17 can be called for more detailed benefit information. Carriers are
18 required to keep the information contained in the brochure accurate
19 and up to date, and, upon updating the brochure, send copies to
20 agents and brokers representing the carrier. Any entity that provides
21 administrative services only with regard to a benefit plan design
22 written or issued by another carrier shall not be required to prepare
23 a summary brochure which includes that benefit 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 (D) Notify the small employer of the availability of coverage
28 through the California Health Benefit Exchange and the availability
29 of tax credits for certain employers, and effective January 1, 2014,
30 the availability of tax credits through the Exchange.
31 (2) When recommending a particular benefit plan design or
32 designs, advise the small employer that, upon request, the agent
33 will provide the small employer with the brochure required by
34 paragraph (1) of subdivision (d) containing the benefit plan design
35 or designs being recommended by the agent or broker.
36 (3) Prior to filing an application for a small employer for a
37 particular health benefit plan:
38 (A) For each of the benefit plan designs offered by the carrier
39 whose benefit plan design the agent or broker is presenting, provide
40 the small employer with the benefit summary required in paragraph

(1) of subdivision (d) and the sum of the standard employee risk rates for that particular employer.

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

(C) Until December 31, 2013, notify the small employer that actual rates may be 10 percent higher or lower than the sum of the standard employee risk rates depending on how the carrier assesses the risk of the small employer's group.

(D) Until December 31, 2013, notify the small employer that, upon request, the agent or broker will submit information to the carrier to ascertain the small employer's sum of the risk adjusted standard employee risk rate for any benefit plan design the carrier offers. On or after July 1, 2013, notify the small employer of the employee rate effective January 1, 2014.

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

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

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

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

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

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

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

status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(2) Encourage or direct small employers to seek coverage from another carrier 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.

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

(j) Except in the case of a late insured, or *until December 31, 2013,* for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a disability insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, *receipt of health care,* the genetic information, the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent, or any other health status-related factor as determined by the department. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 10198.7 or 10708. *However, this exception for preexisting conditions shall not apply after December 31, 2013.*

(k) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the

1 offering of health benefit plans to small employers in this state,
2 the third-party administrator shall be subject to this chapter.
3 (*l*) (1) With respect to the obligation to provide coverage newly
4 issued under subdivision (d), the carrier may cease enrolling new
5 small employer groups and new eligible employees as defined by
6 paragraph (2) of subdivision (f) of Section 10700 if it certifies to
7 the commissioner that the number of eligible employees and
8 dependents, of the employers newly enrolled or insured during the
9 current calendar year by the carrier equals or exceeds: (A) in the
10 case of a carrier that administers any self-funded health benefits
11 arrangement in California, 10 percent of the total number of eligible
12 employees, or eligible employees and dependents, respectively,
13 enrolled or insured in California by that carrier as of December
14 31 of the preceding year, or (B) in the case of a carrier that does
15 not administer any self-funded health benefit arrangements in
16 California, 8 percent of the total number of eligible employees, or
17 eligible employees and dependents, respectively, enrolled or
18 insured by the carrier in California as of December 31 of the
19 preceding year.
20 (2) Certification shall be deemed approved if not disapproved
21 within 45 days after submission to the commissioner. If that
22 certification is approved, the small employer carrier shall not offer
23 coverage to any small employers under any health benefit plans
24 during the remainder of the current year. If the certification is not
25 approved, the carrier shall continue to issue coverage as required
26 by subdivision (d) and be subject to administrative penalties as
27 established in Section 10718.
28 SEC. 24. Section 10706 of the Insurance Code is amended to
29 read:
30 10706. Every carrier shall file with the commissioner the
31 reasonable participation requirements and employer contribution
32 requirements that are to be included in its health benefit plans.
33 Participation requirements shall be applied uniformly among all
34 small employer groups, except that a carrier may vary application
35 of minimum employer participation requirements by the size of
36 the small employer group and whether the employer contributes
37 100 percent of the eligible employee's premium. Employer
38 contribution requirements shall not vary by employer size.
39 Employer contribution requirements shall be consistent with the
40 federal Patient Protection and Affordable Care Act (Public Law

1 111-148). A carrier shall not establish a participation requirement
2 that (1) requires a person who meets the definition of a dependent
3 in subdivision (e) of Section 10700 to enroll as a dependent if he
4 or she is otherwise eligible for coverage and wishes to enroll as
5 an eligible employee and (2) allows a carrier to reject an otherwise
6 eligible small employer because of the number of persons that
7 waive coverage due to coverage through another employer.
8 Members of an association eligible for health coverage eligible
9 under subdivision (z) of Section 10700 but not electing any health
10 coverage through the association shall not be counted as eligible
11 employees for purposes of determining whether the guaranteed
12 association meets a carrier's reasonable participation standards.
13 SEC. 25. Section 10707 of the Insurance Code is amended to
14 read:
15 10707. (a) Until December 31, 2013, except in the case of a
16 late enrollee, or for satisfaction of a preexisting condition clause
17 in the case of initial coverage of an eligible employee, a carrier
18 may not exclude any eligible employee or dependent who would
19 otherwise be covered, on the basis of an actual or expected health
20 condition of that employee or dependent. No health benefit plan
21 may limit or exclude coverage for a specific eligible employee or
22 dependent by type of illness, treatment, medical condition, or
23 accident, except for preexisting conditions as permitted by Section
24 10708.
25 (b) On or after January 1, 2014, a carrier may not exclude any
26 eligible employee or dependent who would otherwise by entitled
27 to health care services on the basis of an actual or expected health
28 condition of that employee or dependent. No health benefit plan
29 may limit or exclude coverage for a specific eligible employee or
30 dependent by type of illness, treatment, medical condition, or
31 accident.
32 SEC. 26. Section 10708 of the Insurance Code is amended to
33 read:
34 10708. (a) (1) Until December 31, 2013, health benefit plans
35 shall not exclude coverage for a period beyond six months
36 following the individual's effective date of coverage and may only
37 relate to conditions for which medical advice, diagnosis, care, or
38 treatment, including the use of prescription medications, was
39 recommended by or received from a licensed health practitioner

during the six months immediately preceding the effective date of coverage.

(2) Notwithstanding paragraph (1), a health benefit plan offered to a small employer shall not impose any preexisting condition provision upon any child under 19 years of age.

(3) On or after January 1, 2014, ~~preexisting condition provisions of a health benefit plan shall not exclude coverage following the individual's effective date of coverage for a condition based on the fact that the condition was present before the date of enrollment of the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.~~ *a health benefit plan offered to a small employer shall not impose any preexisting condition provision upon any individual.*

(b) (1) Until December 31, 2013, a carrier that does not utilize a preexisting condition provision may impose ~~a waiting or~~ *an* affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the ~~waiting or~~ affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the subscriber or enrollee.

(2) On or after January 1, 2014, no ~~waiting or~~ affiliation period based on a preexisting condition, health status, or any other factor prohibited under subdivision (f) of Section 1357.03 shall be imposed. A carrier may permit a waiting period of up to 90 days as a condition of enrollment if applied equally to all full-time employees and if consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

(c) Until December 31, 2013, in determining whether a preexisting condition provision or a waiting period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any ~~waiting or~~ affiliation period, and applies for coverage with the succeeding health benefit plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any postenrollment or employer-imposed ~~waiting or~~ affiliation period. However, if a person's employment has ended, the availability of

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

(d) Group health benefit plans may not impose a preexisting conditions exclusion to a condition relating to benefits for pregnancy or maternity care.

(e) (1) Until December 31, 2013, a carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning preexisting condition provisions and ~~waiting or~~ affiliation periods.

(2) On or after January 1, ~~2013~~ *2014*, a carrier providing aggregate or specific stoploss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning waiting periods.

(f) Until December 31, 2013, in addition to the preexisting condition exclusions authorized by subdivision (a) and the ~~waiting or~~ affiliation period authorized by subdivision (b), carriers providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association ~~a waiting or~~ *an* affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the ~~waiting or~~ affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the insured.

SEC. 27. Section 10709 of the Insurance Code is amended to read:

10709. (a) (1) Until December 31, 2013, no health benefit plan may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No premiums shall be charged to the late enrollee until the exclusion period has ended.

(2) On or after January 1, 2014, no health benefit plan may exclude late enrollees from coverage for more than 90 days from the date of the late ~~enrollees~~ *enrollee's* application for coverage. No premium shall be charged to the late enrollee until the exclusion period has ended.

(3) A health benefit plan may permit a waiting period of up to 90 days as a condition of enrollment if applied equally to all full-time employees and if consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

(b) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning late enrollees.

SEC. 28. Section 10714 of the Insurance Code is amended to read:

10714. Premiums for benefit plan designs written, issued, or administered by carriers on or after the effective date of this act, shall be subject to the following requirements:

(a) (1) The premium for new business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the carrier's standard employee risk rates. The risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the carrier's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, the risk adjusted employee risk rate may not be more than 110 percent or less than 90 percent. Effective January 1, 2014, no risk adjustment factor shall be used in the determination of rates.

(2) The premium charged a small employer for new business shall be equal to the sum of the risk adjusted employee risk rates.

(3) The standard employee risk rates applied to a small employer for new business shall be in effect for no less than 12 months. *This subdivision shall be implemented to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.*

(b) (1) The premium for in force business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the carrier's standard employee risk rates. The risk adjusted employee risk rates may not be more than

1 120 percent or less than 80 percent of the carrier's applicable
2 standard employee risk rate until July 1, 1996. Effective July 1,
3 1996, the risk adjusted employee risk rate may not be more than
4 110 percent or less than 90 percent. The factor effective July 1,
5 1996, shall apply to in force business at the earlier of either the
6 time of renewal or July 1, 1997. Until January 1, 2014, the risk
7 adjustment factor applied to a small employer may not increase
8 by more than 10 percentage points from the risk adjustment factor
9 applied in the prior rating period. On or after January 1, 2014, no
10 risk adjustment factor shall be used in the determination of rates.
11 The risk adjustment factor for a small employer may not be
12 modified more frequently than every 12 months.
13 (2) The premium charged a small employer for in force business
14 shall be equal to the sum of the risk adjusted employee risk rates.
15 The standard employee risk rates shall be in effect for no less than
16 12 months.
17 (3) For a benefit plan design that a carrier has discontinued
18 offering, the risk adjustment factor applied to the standard
19 employee risk rates for the first rating period of the new benefit
20 plan design that the small employer elects to purchase shall be no
21 greater than the risk adjustment factor applied in the prior rating
22 period to the discontinued benefit plan design. However, the risk
23 adjusted employee rate may not be more than 120 percent or less
24 than 80 percent of the carrier's applicable standard employee risk
25 rate until July 1, 1996. Effective July 1, 1996, the risk adjusted
26 employee risk rate may not be more than 110 percent or less than
27 90 percent. The factor effective July 1, 1996, shall apply to in force
28 business at the earlier of either the time of renewal or July 1, 1997.
29 On or after January 1, 2014, no risk adjustment factor shall be used
30 in the determination of rates. The risk adjustment factor for a small
31 employer may not be modified more frequently than every 12
32 months.
33 (c) (1) For any small employer, a carrier may, with the consent
34 of the small employer, establish composite employee and
35 dependent rates for either new business or renewal of in force
36 business. The composite rates shall be determined as the average
37 of the risk adjusted employee risk rates for the small employer, as
38 determined in accordance with the requirements of subdivisions
39 (a) and (b). The sum of the composite rates so determined shall be

1 equal to the sum of the risk adjusted employee risk rates for the
2 small employer.
3 (2) The composite rates shall be used for all employees and
4 dependents covered throughout a rating period of 12 months, except
5 that a carrier may reserve the right to redetermine the composite
6 rates if the enrollment under the health benefit plan changes by
7 more than a specified percentage during the rating period. Any
8 redetermination of the composite rates shall be based on the same
9 risk adjusted employee risk rates used to determine the initial
10 composite rates for the rating period. If a carrier reserves the right
11 to redetermine the rates and the enrollment changes more than the
12 specified percentage, the carrier shall redetermine the composite
13 rates if the redetermined rates would result in a lower premium
14 for the small employer. A carrier reserving the right to redetermine
15 the composite rates based upon a change in enrollment shall use
16 the same specified percentage to measure that change with respect
17 to all small employers electing composite rates.
18 SEC. 29. Section 10716 of the Insurance Code is amended to
19 read:
20 10716. In connection with the offering for sale of any benefit
21 plan design to small employers:
22 Each carrier shall make a reasonable disclosure, as part of its
23 solicitation and sales materials, of the following:
24 (a) Until December 31, 2013, the extent to which the premium
25 rates for a specified small employer are established or adjusted in
26 part based upon the actual or expected variation in claims costs or
27 actual or expected variation in health conditions of the employees
28 and dependents of the small employer.
29 (b) The provisions concerning the carrier's ability to change
30 premium rates and the factors other than claim experience which
31 affect changes in premium rates.
32 (c) Provisions relating to the guaranteed issue of policies and
33 contracts.
34 (d) Until December 31, 2013, provisions relating to the effect
35 of any preexisting condition provision.
36 (e) Provisions relating to the small employer's right to apply
37 for any benefit plan design written, issued, or administered by the
38 carrier at the time of application for a new health benefit plan, or
39 at the time of renewal of a health benefit plan.

(f) The availability, upon request, of a listing of all the carrier's benefit plan designs, including the rates for each benefit plan design.

SEC. 30. Section 10717 of the Insurance Code is amended to read:

10717. (a) No carrier shall provide or renew coverage subject to this chapter until it has done all of the following:

(1) A statement has been filed with the commissioner listing all of the carrier's benefit plan designs currently in force that are offered or proposed to be offered for sale in this state, identified by form number, and, if previously approved by the commissioner, the date approved by the commissioner as well as, until December 31, 2013, the standard employee risk rate for each risk category for each benefit plan design and the highest and lowest risk adjustment factors that the carrier intends to use in determining rates for each benefit plan design. When filing a new benefit plan design pursuant to Section 10705, carriers may submit both the policy form and, until December 31, 2013, the standard employee risk rates for each risk category at the same time.

(2) Until December 31, 2013:

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

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

(b) No carrier shall issue, deliver, renew, or revise a benefit plan design lawfully provided pursuant to subdivision (a), and no carrier shall change the risk categories, risk adjustment factors, or standard employee risk rates for any benefit plan design until all of the following requirements are met:

(1) The carrier files with the commissioner a statement of the specific changes which the carrier proposes in the risk categories, risk adjustment factors, or standard employee risk rates.

(2) Until December 31, 2013:

(A) Thirty days expires after such statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk

1 adjustment factors do not comply with the requirements of this
2 chapter.
3 (B) Prior to that time the commissioner gives the carrier written
4 notice that the carrier's risk categories and risk adjustment factors
5 as filed comply with the requirements of this chapter.
6 (c) Notwithstanding any provision to the contrary, until
7 December 31, 2013, when a carrier is changing the standard
8 employee risk rates of a benefit plan design lawfully provided
9 under subdivision (a) or (b) but is not changing the risk categories
10 or risk adjustment factors which have been previously authorized,
11 the carrier need not comply with the requirements of paragraph
12 (2) of subdivision (b), but instead shall submit the revised standard
13 employee risk rates for the benefit plan design prior to offering or
14 renewing the benefit plan design.
15 (d) When submitting filings under subdivision (a), (b), or (c),
16 a carrier may also file with the commissioner at the time of the
17 filings, until December 31, 2013, a statement of the standard
18 employee risk rate for each risk category the carrier intends to use
19 for each month in the 12 months subsequent to the date of the
20 filing. Once the requirements of the applicable subdivision (a),
21 (b), or (c), have been met, these rates, until December 31, 2013,
22 shall be used by the carrier for the 12-month period unless the
23 carrier is otherwise informed by the commissioner in his or her
24 response to the filings submitted under subdivision (a), (b), or (c),
25 provided that any subsequent change in the standard employee
26 risk rates charged by the carrier which differ from those previously
27 filed with the commissioner must be newly filed in accordance
28 with this subdivision and provided that the carrier does not change
29 the risk categories or risk adjustment factors for the benefit plan
30 design.
31 (e) Until December 31, 2013, if the commissioner notifies the
32 carrier, in writing, that the carrier's risk categories or risk
33 adjustment factors do not comply with the requirements of this
34 chapter, specifying the reasons for his or her opinion, it is unlawful
35 for the carrier, at any time after the receipt of such notice, to utilize
36 the noncomplying health benefit plan, benefit plan design, risk
37 categories, or risk adjustment factors in conjunction with the health
38 benefit plans or benefit plan designs for which the filing was made.

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

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

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

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

SEC. 31. Section 10717 is added to the Insurance Code, to read:

10717. (a) No carrier shall provide or renew coverage subject to this chapter until it has filed a statement with the commissioner listing all of the carrier's benefit plan designs currently in force that are offered or proposed to be offered for sale in this state, identified by form number, and, if previously approved by the commissioner, and the date approved by the commissioner.

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

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

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

(e) This section shall become operative on January 1, 2014.

SEC. 32. Nothing in this act shall preclude the Legislature from considering and adopting future legislation to allow premium ratings based on tobacco use and wellness incentives, to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law.

~~SEC. 32.~~

SEC. 33. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or
2 infraction, eliminates a crime or infraction, or changes the penalty
3 for a crime or infraction, within the meaning of Section 17556 of
4 the Government Code, or changes the definition of a crime within
5 the meaning of Section 6 of Article XIII B of the California
6 Constitution.

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