INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880 - 12880.8] *(Division 2 enacted by Stats. 1935, Ch. 145.)*

PART 2. LIFE AND DISABILITY INSURANCE [10110 - 11549] *(Part 2 enacted by Stats. 1935, Ch. 145.)*

CHAPTER 8.01. Nongrandfathered Small Employer Health Insurance [10753 - 10753.18.7] *(Chapter 8.01 added by Stats. 2012, Ch. 852, Sec. 14.)*

ARTICLE 2. Small Employer Carrier Requirements [10753.02 - 10753.18.7] *(Article 2 added by Stats. 2012, Ch. 852, Sec. 14.)*

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

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

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

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

10753.05. (a) A group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall not be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10753.17.

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

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

(3) A carrier shall provide enrollment periods consistent with PPACA and described in Section 155.725 of Title 45 of the Code of Federal Regulations. Commencing January 1, 2014, a carrier shall provide special enrollment periods consistent with the special enrollment periods described in Section 10965.3, to the extent permitted by PPACA, except for both of the following:

(A) The special enrollment period described in paragraph (3) of subdivision (c) of Section 10965.3.

(B) The triggering events identified in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of Federal Regulations with respect to health benefit plans offered through the Exchange.

(4) This section does not 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 section applies to an association that otherwise meets the requirements of paragraph (8) formed by merger of two or more associations after January 1, 1992, if the predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and met the requirements of paragraph (5).

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

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

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

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

(A) Health coverage through an association that is not related to employment shall be considered individual coverage. The status of each distinct member of an association shall determine whether that member's association coverage is individual, small group, or large group health insurance coverage.

(B) (i) Notwithstanding subparagraphs (A) and (C), an association of employers may offer a large group health insurance policy consistent with the Employee Retirement Income Security Act of 1974 (Public Law 93-406) (ERISA), as amended (29 U.S.C. Sec. 1001 et seq.), if all of the following requirements are met:

(I) The association is headquartered in this state and is a multiple employer welfare arrangement (MEWA) as defined under Section 3(40) of ERISA (29 U.S.C. Sec. 1002(40)).

(II) The MEWA is fully insured as described in Section 514 of ERISA (29 U.S.C. Sec. 1144) and is a bona fide association or group of employers that may act as an "employer" under Section 3(5) of ERISA.

(III) The MEWA was established prior to March 23, 2010, and has been in continuous existence since that date, and offers a large group health insurance policy in connection with an employee welfare benefit plan under Section 3(1) of ERISA (29 U.S.C. Sec. 1002(1)).

(IV) As of January 1, 2019, the large group health insurance policy offered to employees has continuously provided a level of coverage having an actuarial value equivalent to, or greater than, the platinum level of coverage, as described in

Section 10112.295, that is available through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code, and the large group health insurance policy provides coverage for essential health benefits consistent with Section 10112.27 and any rules or regulations adopted pursuant to that section.

(V) The large group health insurance policy includes coverage of employees, and their dependents, who are employed in designated job categories on a project-by-project basis for one or more participating employers, with no single project exceeding six months in duration, and who, in the course of that employment, are not covered by another group health insurance policy in which the employer participates. Employer members of the MEWA shall subsidize at least 51 percent of the cost of individual employee premiums of their employees.

(VI) The large group health insurance policy offers only fully insured benefits through a health insurer or disability insurer licensed by the department. The benefits offered under the large group health insurance policy shall be considered fully insured only if the terms of the health insurance policy provide for benefits, the amount of all of which the department determines are guaranteed under a policy of insurance issued by an insurer licensed by the department.

(VII) The number of total employees, including employees described in subclause (V), employed by all participating employers in each year is at least 101 employees.

(VIII) The MEWA and participating employers have a genuine organizational relationship unrelated to the provision of health care benefits, and the MEWA existed prior to the establishment of the employee welfare benefit plan.

(IX) The participating employers have a commonality of interests from being in the same line of business, unrelated to the provision of health care benefits, as demonstrated by membership in the same business league, as described in Section 501(c)(6) of the Internal Revenue Code (26 U.S.C. Sec. 501(c)(6)).

(X) Membership in the MEWA is open solely to employers, including the MEWA as an employer, and participating member employers exercise control, either directly or indirectly, over the employer welfare benefit plan, the MEWA, and the large group health insurance policy, in form and in substance.

(XI) The large group health insurance policy is treated as a single-risk-rated policy that is guaranteed issue and guaranteed renewable for employees and dependents. An employee or dependent is not charged premium rates based on health status and is not excluded from coverage based upon any preexisting condition. Employee and dependent eligibility are not directly or indirectly based on health or claims of any person. An employer is not excluded from participating in a MEWA or offering the large group health insurance policy based on health status or claims of any employee or dependent.

(XII) The MEWA files an application for registration with the department on or before June 1, 2022.

(ia) A MEWA that timely registers with the department and that is found to be in compliance with this clause shall annually file evidence of ongoing compliance with this clause with the department, in a form and manner set forth by the department.

(ib) Except as provided in subclause (III) of clause (ii), a MEWA that does not meet the requirements of sub-subclause (ia) shall be subject to the restrictions provided in subparagraph (A).

(ii) (I) On or after June 1, 2022, a health insurer shall not market, issue, amend, renew, or deliver large employer health insurance coverage to a MEWA that provides any benefit to a resident in this state unless the MEWA is registered with the department and is found to be in compliance with the requirements set forth in clause (i) or unless the MEWA filed an application for registration pursuant to clause (i) and the application is pending before the department. The department shall have the authority to determine compliance with the requirements set forth in clause (i).

(II) The department may issue guidance to health insurers and MEWAs regarding registration and compliance with clause (i). The guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(III) Clause (i) does not apply to, or in any way affect, a self-funded or partially self-funded multiple employer welfare arrangement that is regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1.

(C) (i) Notwithstanding subparagraphs (A) and (B), an association of employers may offer a large group health insurance policy to small group employer members of the association, consistent with the Employee Retirement Income Security Act of 1974 (Public Law 93-406) (ERISA), as amended (29 U.S.C. Sec. 1001 et seq.), if all of the following requirements are met:

(I) The association is headquartered in this state, was established prior to March 23, 2010, has been in continuous existence since that date, and is a bona fide association or group of employers under ERISA that may act as an employer under Section 3(5) of ERISA (29 U.S.C. Sec. 1002(5)). The association is the sponsor of a multiple employer welfare arrangement (MEWA) as defined under Section 3(40) of ERISA (29 U.S.C. Sec. 1002(40)).

(II) The MEWA is fully insured as described in Section 514 of ERISA (29 U.S.C. Sec. 1144), is headquartered in California, and is in full compliance with all applicable state and federal laws.

(III) The MEWA has offered a large group health insurance policy since January 1, 2012, in connection with an employee welfare benefit plan under Section 3(1) of ERISA (29 U.S.C. Sec. 1002(1)).

(IV) The large group health insurance policy offers to employees a level of coverage having an actuarial value or equivalent to, or greater than, the platinum level of coverage pursuant to Section 10112.297 available through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code, and provides coverage for essential health benefits consistent with Section 10112.27 and Article 22 (commencing with Section 2594) of Subchapter 3 of Chapter 5 of Title 10 of the California Code of Regulations.

(V) The large group health insurance policy includes coverage of common law employees, and their dependents, who are employed by an association member in the biomedical industry and whose employer has operations in California.

(VI) The large group health insurance policy offers only fully insured benefits through a health insurance policy with a health insurer that is licensed by the department.

(VII) The association members purchasing health coverage have a minimum of four full-time common law employees and are current employer members of the association sponsoring the MEWA. Employer members of the association subsidize employee premium by at least 51 percent.

(VIII) The association is an organization with business and organizational purposes unrelated to the provision of health care benefits and existed prior to the establishment of the MEWA offering the employee welfare benefit plan.

(IX) The participating member employers have a commonality of interests from being in the same industry, unrelated to the provision of health care benefits.

(X) Membership in the association is open solely to employers, and the participating member employers, either directly or indirectly, exercise control over the employee welfare benefit plan, the MEWA, and the large group health insurance policy, both in form and substance.

(XI) The large group health insurance policy is treated as a single-risk-rated contract that is guaranteed issued and renewable for member employers, as well as their employees and dependents. An employee or dependent is not charged premium rates based on health status and is not excluded from coverage based upon any preexisting condition. Employee and dependent eligibility are not directly or indirectly based on health status or claims of any person. An employer otherwise eligible for coverage is not excluded from participating in a MEWA, or offering or renewing the large group health insurance policy based on health status or claims of any employee or dependent.

(XII) The MEWA at all times covers at least 101 employees.

(XIII) The association and the MEWA file applications for registration with the department on or before June 1, 2022.

(ia) An association and the MEWA that timely register with the department prior to June 1, 2022, and that are found to be in compliance with this clause, shall annually file evidence of ongoing compliance with this clause with the department, in a form and manner set forth by the department.

(ib) Except as provided in subclause (III) of clause (ii), an association and MEWA that do not meet the requirements of sub-subclause (ia) shall be subject to the restrictions in subparagraph (A).

(ic) An association and MEWA that have registered with the department and fail to show ongoing compliance in its annual filing shall be subject to the restrictions in subparagraph (A).

(id) On or before June 30, 2026, the department shall provide the health policy committees of the Legislature the most recent filings made pursuant to sub-subclause (ia).

(ie) The filings to be submitted pursuant to sub-subclause (id) shall be submitted in compliance with Section 9795 of the Government Code.

(ii) (I) On or after June 1, 2022, an insurer shall not market, issue, amend, renew, or deliver large employer health insurance coverage to any association or MEWA that provides any benefit to a resident in this state unless the association and MEWA have registered with the department and are found to be in compliance with the requirements set forth in clause (i), or unless the association and MEWA filed applications for registration pursuant to clause (xiii) of clause (i) and the applications are pending before the department. The department shall have the authority to determine compliance with the requirements set forth under clause (i).

(II) The department may issue guidance to health insurers, associations, and MEWAs regarding registration and compliance with clause (i). The guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(III) Clause (i) does not apply to, or in any way affect, a self-funded or partially self-funded multiple employer welfare arrangement subject to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1.

(iii) (I) The department shall conduct an analysis of the impacts on the small employer health insurance market in California of health insurers currently issuing large group policies to small employers through MEWAs. The department shall post a report summarizing its analysis on its internet website by July 1, 2026.

(II) The purpose of the analysis is to determine the extent to which coverage of Californians in existing MEWAs has any detrimental impact on the affordability and access to small group health insurance for small businesses in California who do not purchase health insurance through a MEWA.

(III) The department may coordinate with the Department of Managed Health Care.

(IV) Health insurers and MEWAs shall comply with requests for information from the department to complete this analysis.

(V) The department may contract with a consultant or consultants with expertise to assist the department in its analysis. Contracts entered into pursuant to the authority in this subclause shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and the State Contract Act (Chapter 1 (commencing with Section 10100) of Part 2 of Division 2 of the Public Contract Code).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) A carrier, agent, or broker shall not induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10753, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section 10753, is provided in connection with a guaranteed association.

(g) A carrier shall not reject an application from a small employer for a health benefit plan provided:

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

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

(h) (1) A carrier or agent or broker shall not, directly or indirectly, engage in the following activities:

(A) 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.

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

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

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

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

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

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

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

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

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

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

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

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

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

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

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

(m) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.

(Amended (as amended by Stats. 2021, Ch. 764, Sec. 9.3) by Stats. 2024, Ch. 374, Sec. 3. (AB 2072) Effective January 1, 2025. Repealed as of January 1, 2030, by its own provisions. See later operative version, as amended by by Sec. 4 of Stats. 2024, Ch. 374.)

10753.05. (a) A group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall not be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10753.17.

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

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

(3) A carrier shall provide enrollment periods consistent with PPACA and described in Section 155.725 of Title 45 of the Code of Federal Regulations. Commencing January 1, 2014, a carrier shall provide special enrollment periods consistent with the special enrollment periods described in Section 10965.3, to the extent permitted by PPACA, except for both of the following:

(A) The special enrollment period described in paragraph (3) of subdivision (c) of Section 10965.3.

(B) The triggering events identified in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of Federal Regulations with respect to health benefit plans offered through the Exchange.

(4) This section does not 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 section applies 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 that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer, or sell any other individual, selected group, or group policy or contract providing medical, hospital, and surgical benefits shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers, or sells any benefit plan design or any other individual, selected group, or group policy or contract providing medical, hospital, and surgical benefits to those who are not members of the association, it is subject to the requirements of this section.

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

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

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

(A) Health coverage through an association that is not related to employment shall be considered individual coverage. The status of each distinct member of an association shall determine whether that member's association coverage is individual, small group, or large group health insurance coverage.

(B) Notwithstanding subparagraph (A), an association of employers may offer a large group health insurance policy consistent with the Employee Retirement Income Security Act of 1974 (Public Law 93-406) (ERISA), as amended (29 U.S.C. Sec. 1001 et seq.), if all of the following requirements are met:

(i) The association is headquartered in this state and is a multiple employer welfare arrangement (MEWA) as defined under Section 3(40) of ERISA (29 U.S.C. Sec. 1002(40)).

(ii) The MEWA is fully insured as described in Section 514 of ERISA (29 U.S.C. Sec. 1144) and is a bona fide association or group of employers that may act as an "employer" under Section 3(5) of ERISA.

(iii) The MEWA was established prior to March 23, 2010, and has been in continuous existence since that date, and offers a large group health insurance policy in connection with an employee welfare benefit plan under Section 3(1) of ERISA (29 U.S.C. Sec. 1002(1)).

(iv) As of January 1, 2019, the large group health insurance policy offered to employees has continuously provided a level of coverage having an actuarial value equivalent to, or greater than, the platinum level of coverage, as described in Section 10112.295, that is available through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code, and the large group health insurance policy provides coverage for essential health benefits consistent with Section 10112.27 and any rules or regulations adopted pursuant to that section.

(v) The large group health insurance policy includes coverage of employees, and their dependents, who are employed in designated job categories on a project-by-project basis for one or more participating employers, with no single project exceeding six months in duration, and who, in the course of that employment, are not covered by another group health insurance policy in which the employer participates. Employer members of the MEWA shall subsidize at least 51 percent of the cost of individual employee premiums of their employees.

(vi) The large group health insurance policy offers only fully insured benefits through a health insurer or disability insurer licensed by the department. The benefits offered under the large group health insurance policy shall be considered fully insured only if the terms of the health insurance policy provide for benefits, the amount of all of which the department determines are guaranteed under a policy of insurance issued by an insurer licensed by the department.

(vii) The number of total employees, including employees described in clause (v), employed by all participating employers in each year is at least 101 employees.

(viii) The MEWA and participating employers have a genuine organizational relationship unrelated to the provision of health care benefits, and the MEWA existed prior to the establishment of the employee welfare benefit plan.

(ix) The participating employers have a commonality of interests from being in the same line of business, unrelated to the provision of health care benefits, as demonstrated by membership in the same business league, as described in Section 501(c)(6) of the Internal Revenue Code (26 U.S.C. Sec. 501(c)(6)).

(x) Membership in the MEWA is open solely to employers, including the MEWA as an employer, and participating member employers exercise control, either directly or indirectly, over the employer welfare benefit plan, the MEWA, and the large group health insurance policy, in form and in substance.

(xi) The large group health insurance policy is treated as a single-risk-rated policy that is guaranteed issue and guaranteed renewable for employees and dependents. An employee or dependent is not charged premium rates based on health status and is not excluded from coverage based upon any preexisting condition. Employee and dependent eligibility are not directly or indirectly based on health or claims of any person. An employer is not excluded from participating in a MEWA or offering the large group health insurance policy based on health status or claims of any employee or dependent.

(xii) The MEWA files an application for registration with the department on or before June 1, 2022.

(I) A MEWA that timely registers with the department and that is found to be in compliance with this subparagraph shall annually file evidence of ongoing compliance with this subparagraph with the department, in a form and manner set forth by the department.

(II) Except as provided in clause (iii) of subparagraph (C), a MEWA that does not meet the requirements of subclause (I) shall be subject to the restrictions provided in subparagraph (A).

(C) (i) On or after June 1, 2022, a health insurer shall not market, issue, amend, renew, or deliver large employer health insurance coverage to a MEWA that provides any benefit to a resident in this state unless the MEWA is registered with the department and is found to be in compliance with the requirements set forth in subparagraph (B) or unless the MEWA filed an application for registration pursuant to subparagraph (B) and the application is pending before the department. The department shall have the authority to determine compliance with the requirements set forth in subparagraph (B).

(ii) The department may issue guidance to health insurers and MEWAs regarding registration and compliance with subparagraph (B). The guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(iii) Subparagraph (B) does not apply to, or in any way affect, a self-funded or partially self-funded multiple employer welfare arrangement that is regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) A carrier, agent, or broker shall not induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10753, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section 10753, is provided in connection with a guaranteed association.

(g) A carrier shall not reject an application from a small employer for a health benefit plan provided:

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

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

(h) (1) A carrier or agent or broker shall not, directly or indirectly, engage in the following activities:

(A) 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.

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

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

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

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

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

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

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

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

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

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

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

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

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

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

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

(m) This section shall become operative on January 1, 2030.

(Amended (as added by Stats. 2021, Ch. 736, Sec. 4.3) by Stats. 2024, Ch. 374, Sec. 4. (AB 2072) Effective January 1, 2025. Operative January 1, 2030, by its own provisions.)

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

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

10753.06. Every carrier shall file with the commissioner the reasonable participation requirements and employer contribution requirements that are to be included in its health benefit plans. Participation requirements shall be applied uniformly among all small employer groups, except that a carrier may vary application of minimum employer participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution

requirements shall not vary by employer size. A carrier shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (e) of Section 10753 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a carrier to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage eligible under subdivision (s) of Section 10753 but not electing any health coverage through the association shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a carrier's reasonable participation standards.

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

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

(c) (1) With respect to a small employer health benefit plan offered through the Exchange, a carrier shall apply coverage effective dates consistent with those required under Section 155.720 of Title 45 of the Code of Federal Regulations and of subdivision (e) of Section 10965.3.

(2) With respect to a small employer health benefit plan offered outside the Exchange for which an individual applies during a special enrollment period described in paragraph (3) of subdivision (b) of Section 10753.05, the following provisions shall apply:

(A) Coverage under the plan shall become effective no later than the first day of the first calendar month beginning after the date the carrier receives the request for special enrollment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, coverage under the plan shall become effective on the date of birth, adoption, or placement for adoption.

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

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

(Amended by Stats. 2015, Ch. 303, Sec. 372. (AB 731) Effective January 1, 2016.)

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

(Repealed and added by Stats. 2014, Ch. 195, Sec. 13. (SB 1034) Effective January 1, 2015.)

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

10753.11. (a) To the extent permitted by PPACA, a carrier shall not be required by the provisions of this chapter to do any of the following:

(1) Offer coverage to, or accept applications from, a small employer where the small employer is seeking coverage for eligible employees and dependents who do not live, work, or reside in a carrier's service areas.

(2) (A) Offer coverage to, or accept applications from, a small employer for a benefits plan design within an area if the commissioner has found all of the following:

(i) The carrier will not have the capacity within the area in its network of providers to deliver service adequately to the eligible employees and dependents of that employee because of its obligations to existing group contractholders and

enrollees.

(ii) The carrier is applying this paragraph uniformly to all employers without regard to the claims experience of those employers, and their employees and dependents, or any health status-related factor relating to those employees and dependents.

(iii) The action is not unreasonable or clearly inconsistent with the intent of this chapter.

(B) A carrier that cannot offer coverage to small employers in a specific service area because it is lacking sufficient capacity as described in this paragraph may not offer coverage in the applicable area to new employer groups until the later of the following dates:

(i) The 181st day after the date that coverage is denied pursuant to this paragraph.

(ii) The date the carrier notifies the commissioner that it has regained capacity to deliver services to small employers, and certifies to the commissioner that from the date of the notice it will enroll all small groups requesting coverage from the carrier until the carrier has met the requirements of subdivision (g) of Section 10753.05.

(C) Subparagraph (B) shall not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage as described in Sections 10273.4 and 10753.13.

(D) Coverage offered within a service area after the period specified in subparagraph (B) shall be subject to the requirements of this section.

(Amended by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 12. (AB 2 1x) Effective September 30, 2013.)

10753.12. (a) A carrier shall not be required to offer coverage or accept applications for benefit plan designs pursuant to this chapter where the carrier demonstrates to the satisfaction of the commissioner both of the following:

(1) The acceptance of an application or applications would place the carrier in a financially impaired condition.

(2) The carrier is applying this subdivision uniformly to all employers without regard to the claims experience of those employers and their employees and dependents or any health status-related factor relating to those employees and dependents.

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

(c) A carrier that has not offered coverage or accepted applications pursuant to this chapter shall not offer coverage or accept applications for any individual or group health benefit plan until the later of the following dates:

(1) The 181st day after the date that coverage is denied pursuant to this section.

(2) The date on which the carrier ceases to be financially impaired, as determined by the commissioner.

(d) Subdivision (c) shall not limit the carrier's ability to renew coverage already in force or relieve the carrier of the responsibility to renew that coverage as described in Sections 10273.4, 10273.6, and 10753.13.

(e) Coverage offered within a service area after the period specified in subdivision (c) shall be subject to the requirements of this section.

(Amended by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 13. (AB 2 1x) Effective September 30, 2013.)

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

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

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

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

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

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

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

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

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

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

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services and the age rating curve established by the Centers for Medicare and Medicaid Services pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)). Rates based on age shall be determined using the individual's age as of the date of the plan issuance or renewal, as applicable, and shall not vary by more than three to one for like individuals of different age who are 21 years of age or older as described in federal regulations adopted pursuant to Section 2701(a)(3) of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(a)(3)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Health Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and submit a report to the appropriate policy committees of the Legislature. The requirement for submitting a report imposed under this subparagraph is inoperative June 1, 2021, pursuant to Section 10231.5 of the Government Code.

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

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

(c) The total premium charged to a small employer pursuant to this section shall be determined by summing the premiums of covered employees and dependents in accordance with Section 147.102(c)(1) of Title 45 of the Code of Federal Regulations.

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

(Amended by Stats. 2021, Ch. 764, Sec. 10. (SB 326) Effective January 1, 2022.)

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

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

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

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

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

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

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

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

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

(2) Either:

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

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

(c) If the commissioner notifies the carrier, in writing, that the carrier's rating factors do not comply with the requirements of this chapter, specifying the reasons for his or her opinion, it is unlawful for the carrier, at any time after the receipt of such notice, to utilize the noncomplying health benefit plan or rating factors in conjunction with the health benefit plans or benefit plan designs for which the filing was made.

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

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

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

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

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

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

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

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

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

10753.18.5. (a) (1) In addition to any other remedy permitted by law, whenever the commissioner shall have reason to believe that any carrier, production agent, or other person or entity engaged in the business of insurance has violated this chapter, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the commissioner may issue and serve upon that entity an order to show cause containing a statement of the charges, a statement of the entity's potential liability under this chapter, and a notice of a public hearing thereon before the Administrative Law Bureau of the department to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the commissioner should issue an order to that entity to pay the penalty imposed by this chapter and such order or orders as shall be reasonably necessary to correct, eliminate, or remedy the alleged violations of this chapter, including, but not limited to, an order to cease and desist from the specified violations of this chapter.

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

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

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

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

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

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

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)

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

(Added by Stats. 2012, Ch. 852, Sec. 14. (AB 1083) Effective January 1, 2013.)