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 8.02. Grandfathered Small Employer Health Insurance [10755 - 10755.18.7] *(Chapter 8.02 added by Stats. 2012, Ch. 852, Sec. 15.)*

ARTICLE 2. Small Employer Carrier Requirements [10755.02 - 10755.18.7] *(Article 2 added by Stats. 2012, Ch. 852, Sec. 15.)*

10755.02. (a) This chapter shall apply only to grandfathered health benefit plans and only with respect to plan years commencing on or after January 1, 2014.

(b) All carriers 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. 15. (AB 1083) Effective January 1, 2013.)

10755.02.1. 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. 15. (AB 1083) Effective January 1, 2013.)

10755.03. 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 10755.

(Added by Stats. 2012, Ch. 852, Sec. 15. (AB 1083) Effective January 1, 2013.)

10755.04. (a) The department may adopt emergency regulations implementing this chapter no later than August 31, 2013. The department may readopt any emergency regulation authorized by this section that is the same as or substantially equivalent to an emergency regulation previously adopted under this section.

(b) The initial adoption of emergency regulations implementing this section and the one readoption of emergency regulations authorized by this section shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the one readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(c) This section shall become operative on January 1, 2013.

(Added by Stats. 2012, Ch. 852, Sec. 15. (AB 1083) Effective January 1, 2013.)

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

(2) 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 (6) 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 (3).

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

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

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

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

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

(c) 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 health benefit 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, standard employee risk rates, 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 benefit plan design written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan design.

(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 benefit plan design written or issued by another carrier shall not be required to prepare an evidence of coverage for that benefit plan design.

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

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

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

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

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

(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.

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

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

(1) Health status.

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

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

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

(8) Disability.

(9) 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.

(h) 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.

(Amended by Stats. 2014, Ch. 195, Sec. 15. (SB 1034) Effective January 1, 2015.)

10755.05.1. (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 10755, 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 10755, (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. 15. (AB 1083) Effective January 1, 2013.)

10755.06. Every carrier shall file with the commissioner the reasonable participation requirements that will be required in renewing its health benefit plans. Participation requirements of a health benefit plan 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 of a health benefit plan 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 (d) of Section 10755 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 (t) of Section 10755 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. 15. (AB 1083) Effective January 1, 2013.)

10755.08. 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. 17. (SB 1034) Effective January 1, 2015.)

10755.09. Nothing in this chapter shall be construed as prohibiting a carrier from restricting enrollment of late enrollees to open enrollment periods consistent with federal law.

(Added by Stats. 2012, Ch. 852, Sec. 15. (AB 1083) Effective January 1, 2013.)

10755.11. No carrier shall be required by the provisions of this chapter:

(a) To include in a health benefit plan an otherwise eligible employee or dependent, when the eligible employee or dependent does not work or reside within a carrier's approved service area, except as provided in Section 10755.02.1.

(b) To offer coverage to an eligible employee, as defined in paragraph (2) of subdivision (e) of Section 10755, who within 12 months of application for coverage terminated from a health benefit plan offered by the carrier.

(Added by Stats. 2012, Ch. 852, Sec. 15. (AB 1083) Effective January 1, 2013.)

10755.13. All grandfathered health benefit plans 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) 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 health benefit plan 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 nongrandfathered small employer health benefit plans which it markets and satisfies the requirements of Section 10714.

(f) If coverage is made available through a bona fide association pursuant to subdivision (q) of Section 10755 or a guaranteed association pursuant to subdivision (s) of Section 10755, 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. 15. (AB 1083) Effective January 1, 2013.)

10755.14. Premiums for grandfathered health benefit plans written or administered by carriers on or after the January 1, 2014, 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 110 percent or less than 90 percent.

(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.

(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 rate may not be more than 110 percent or less than 90 percent. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

(2) The premium charged a small employer for in force business shall be equal to the sum of the risk adjusted employee risk rates. The standard employee risk rates shall be in effect for 12 months.

(c) (1) For any small employer, a carrier may, with the consent of the small employer, establish composite employee and dependent rates for renewal of in force business. The composite rates shall be determined as the average of the risk adjusted employee risk rates for the small employer, as determined in accordance with the requirements of subdivisions (a) and (b). The sum of the composite rates so determined shall be equal to the sum of the risk adjusted employee risk rates for the small employer.

(2) The composite rates shall be used for all employees and dependents covered throughout a rating period of 12 months, except that a carrier may reserve the right to redetermine the composite rates if the enrollment under the health benefit plan changes by more than a specified percentage during the rating period. Any redetermination of the composite rates shall be based on the same risk adjusted employee risk rates used to determine the initial composite rates for the rating period. If a carrier reserves the right to redetermine the rates and the enrollment changes more than the specified percentage, the carrier shall redetermine the composite rates if the redetermined rates would result in a lower premium for the small employer. A carrier reserving the right to redetermine the composite rates based upon a change in enrollment shall use the same specified percentage to measure that change with respect to all small employers electing composite rates.

(Added by Stats. 2012, Ch. 852, Sec. 15. (AB 1083) Effective January 1, 2013.)

10755.15. Carriers shall apply standard employee risk rates consistently with respect to all small employers.

(Added by Stats. 2012, Ch. 852, Sec. 15. (AB 1083) Effective January 1, 2013.)

10755.16. In connection with the renewal of any grandfathered health benefit plan to small employers:

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

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

(b) The provisions concerning the carrier's ability to change premium rates and the factors other than claim experience which affect changes in premium rates.

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

(d) Provisions relating to the prohibition of any preexisting condition provision.

(e) Provisions relating to the small employer's right to apply for any nongrandfathered 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, consistent with the requirements of PPACA.

(f) The availability, upon request, of a listing of all the carrier's nongrandfathered health benefit plans, offered inside or outside the California Health Benefit Exchange, including the rates for each benefit plan design.

(Added by Stats. 2012, Ch. 852, Sec. 15. (AB 1083) Effective January 1, 2013.)

10755.17. (a) No carrier shall 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 grandfathered health benefit plans currently in force in this state, identified by form number, and, if previously approved by the commissioner, the date approved by the commissioner as well as 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 10755.05, carriers may submit both the policy form and the standard employee risk rates for each risk category at the same time.

(2) Either:

(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 renew or revise a grandfathered health benefit plan lawfully provided pursuant to subdivision (a), and no carrier shall change the risk categories, risk adjustment factors, or standard employee risk rates for a grandfathered health benefit plan 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) Either:

(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 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.

(c) Notwithstanding any provision to the contrary, when a carrier is changing the standard employee risk rates of a health benefit plan lawfully provided under subdivision (a) or (b) but is not changing the risk categories or risk adjustment factors which have been previously authorized, the carrier need not comply with the requirements of paragraph (2) of subdivision (b), but instead shall submit the revised standard employee risk rates for the health benefit plan prior to renewing the health benefit plan.

(d) When submitting filings under subdivision (a), (b), or (c), a carrier may also file with the commissioner at the time of the filings a statement of the standard employee risk rate for each risk category the carrier intends to use for each month in the 12 months subsequent to the date of the filing. Once the requirements of the applicable subdivision (a), (b), or (c), have been met, these rates shall be used by the carrier for the 12-month period unless the carrier is otherwise informed by the commissioner in his or her response to the filings submitted under subdivision (a), (b), or (c), provided that any subsequent change in the standard employee risk rates charged by the carrier which differ from those previously filed with the commissioner must be newly filed in accordance with this subdivision and provided that the carrier does not change the risk categories or risk adjustment factors for the health benefit plan.

(e) If the commissioner notifies the carrier, in writing, that the carrier's risk categories or risk adjustment 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, benefit plan design, risk categories, or risk adjustment factors in conjunction with the health 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.

(Added by Stats. 2012, Ch. 852, Sec. 15. (AB 1083) Effective January 1, 2013.)

10755.18. (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. 15. (AB 1083) Effective January 1, 2013.)

10755.18.5. (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. 15. (AB 1083) Effective January 1, 2013.)

10755.18.6. (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 risk adjusted employee risk rates after the carrier has determined the qualified association's risk adjusted employee risk rates pursuant to Section 10755.14. 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. 15. (AB 1083) Effective January 1, 2013.)

10755.18.7. 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. 15. (AB 1083) Effective January 1, 2013.)