HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874] *(Chapter 2.2 added by Stats. 1975, Ch. 941.)*

ARTICLE 3.16. Nongrandfathered Small Employer Plans [1357.500 - 1357.516] *(Article 3.16 added by Stats. 2012, Ch. 852, Sec. 3.)*

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

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

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

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

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, at the small employer’s regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term does not include sole proprietors or the spouses of those sole proprietors, partners of a partnership or the spouses of those partners, or employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association are eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are eligible employees if all four of the following apply:

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

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

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

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

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

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

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

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

subsequently requests enrollment in the plan, except where that member or person qualifies for a special enrollment period provided pursuant to Section 1357.503.

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

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

(i) “Creditable coverage” means:

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

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

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

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

(5) Chapter 55 (commencing with Section 1071) of Title 10 of the United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

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

(7) A health plan offered under Chapter 89 (commencing with Section 8901) of Title 5 of the United States Code (Federal Employees Health Benefits Program (FEHBP)).

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

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

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

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

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

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a health care service plan shall use the test that ensures eligibility if only one test would establish eligibility. In determining the number of employees or eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer

as defined in this paragraph who purchases coverage through a guaranteed association, any employer purchasing coverage for employees through a guaranteed association, and any small employer as defined in this paragraph who purchases coverage through any arrangement.

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

(2) For plan years commencing on or after January 1, 2019, for purposes of determining whether an employer has one employee, sole proprietors and their spouses, and partners of a partnership and their spouses, are not employees.

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

(l) “Guaranteed association” means 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 employer meeting its membership criteria, and that (1) includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (k), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) 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 to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

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

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

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

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

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

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

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

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

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

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

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

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

(w) “Health benefit plan” means a health care service plan contract that provides medical, hospital, and surgical benefits for the covered eligible employees of a small employer and their dependents. The term does not include coverage of Medicare services

pursuant to contracts with the United States government, Medicare supplement coverage, or coverage under a specialized health care service plan contract.

(Amended by Stats. 2018, Ch. 700, Sec. 2. (SB 1375) Effective January 1, 2019.)

1357.501. This article shall apply only to nongrandfathered small employer health care service plan contracts and only with respect to plan years beginning on or after January 1, 2014.

(Added by Stats. 2012, Ch. 852, Sec. 3. (AB 1083) Effective January 1, 2013.)

1357.502. (a) A health care service plan providing or arranging for the provision of essential health benefits, as defined by the state pursuant to Section 1302 of PPACA, to small employers shall be subject to this article if either of the following conditions is met:

(1) Any portion of the premium 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 plan contract 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.

(b) This article shall not apply to health care service plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Care Services, long-term care coverage, or specialized health care service plan contracts.

(Added by Stats. 2012, Ch. 852, Sec. 3. (AB 1083) Effective January 1, 2013.)

1357.502.5. Nothing in this article shall be construed to preclude the application of this chapter to either of the following:

(a) An association, trust, or other organization acting as a “health care service plan” as defined under Section 1345.

(b) An association, trust, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.

(Added by Stats. 2012, Ch. 852, Sec. 3. (AB 1083) Effective January 1, 2013.)

1357.503. (a) (1) Each plan shall fairly and affirmatively offer, market, and sell all of the plan’s small employer health care service plan contracts to all small employers in each service area in which the plan provides or arranges for the provision of health care services.

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

(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 coverage.

(B) (i) Notwithstanding subparagraphs (A) and (C), an association of employers may offer a large group health care service plan contract 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 care service plan contract 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 care service plan contract 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 1367.008, that is available through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code, and the large group health care service plan contract provides coverage for essential health benefits consistent with Section 1367.005 and any rules or regulations adopted pursuant to that section.

(V) The large group health care service plan contract 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 care service plan contract 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 care service plan contract offers only fully insured benefits through a health care service plan licensed by the department or a health insurance policy with a disability insurer that is licensed by the Department of Insurance. The benefits offered under the large group health care service plan contract shall be considered fully insured only if the terms of the health care service plan contract provide for benefits, the amount of all of which the department determines are guaranteed under a health care service plan contract issued by a health care service plan 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 care service plan contract, in form and in substance.

(XI) The large group health care service plan contract is treated as a single-risk-rated contract 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 care service plan contract 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 care service plan shall not market, issue, amend, renew, or deliver large employer health care 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 care service plans 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 of the Insurance Code.

(C) (i) Notwithstanding subparagraphs (A) and (B), an association of employers may offer a large group health care service plan contract 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 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 care service plan 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 care service plan 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 1367.009 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 1367.005 and any rules or regulations pursuant to that section.

(V) The large group health care service plan 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 care service plan offers only fully insured benefits through an insurance contract with a health care service plan licensed by the Department of Managed Health Care.

(VII) 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 premiums 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 care service plan contract, both in form and substance.

(XI) The large group health care service plan contract 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 is not excluded from participating in a MEWA, or offering or renewing the large group health care service plan contract 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 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 provided in subparagraph (A).

(ic) An association and MEWA that have registered with the department and fail to show ongoing compliance in their 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, a health care service plan shall not market, issue, amend, renew, or deliver large employer health care service plan 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 (i) and the applications are 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 care service plans, 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 of the Insurance Code.

(iii) (I) The department shall conduct an analysis of the impacts on the small employer health insurance market in California of health care service plans currently issuing large group contracts 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 Insurance.

(IV) Health care service plans 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).

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

(b) A plan shall provide enrollment periods consistent with PPACA and described in Section 155.725 of Title 45 of the Code of Federal Regulations. Each plan shall provide special enrollment periods consistent with the special enrollment periods described in Section 1399.849, to the extent permitted by PPACA, except for both of the following:

(1) The special enrollment period described in paragraph (3) of subdivision (c) of Section 1399.849.

(2) 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 plan contracts offered through the Exchange.

(c) A plan or solicitor shall not induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with the employee’s employment or membership in a guaranteed association.

(d) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee 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 health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in Section 1357.500 to enroll as a dependent if the person is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan 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 under subdivision (m) of Section 1357.500, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan’s reasonable participation standards.

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

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

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

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

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

(f) A plan or solicitor shall not, directly or indirectly, engage in the following activities:

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

(2) Encourage or direct small employers to seek coverage from another plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(3) 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 an 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.

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

(h) (1) A policy or contract that covers a small employer, as defined in subsection (b) of Section 1304 of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the policy or contract 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 1389.1, a health care service plan shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire before enrollment under a small employer health care service plan contract. A health care service plan 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.

(i) (1) A health care service plan shall consider as a single-risk pool for rating purposes in the small employer market the claims experience of all enrollees in all nongrandfathered small employer health benefit plans offered by the health care service plan 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 health care service plan outside of the Exchange.

(2) At least each calendar year, and no more frequently than each calendar quarter, a health care service plan 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 1367.005, 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 small employer 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 health care service plan may vary premium rates for a particular nongrandfathered small employer health care service plan contract from its index rate based only on the following actuarially justified plan-specific factors:

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

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

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

(D) 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.

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

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

(k) 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. 2.3) by Stats. 2024, Ch. 374, Sec. 1. (AB 2072) Effective January 1, 2025. Repealed as of January 1, 2030, by its own provisions. See later operative version, as amended by Sec. 2 of Stats. 2024, Ch. 374.)

1357.503. (a) (1) Each plan shall fairly and affirmatively offer, market, and sell all of the plan's small employer health care service plan contracts to all small employers in each service area in which the plan provides or arranges for the provision of health care services.

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

(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 coverage.

(B) Notwithstanding subparagraph (A), an association of employers may offer a large group health care service plan contract 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 care service plan contract 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 care service plan contract 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 1367.008, that is available through the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code, and the large group health care service plan contract provides coverage for essential health benefits consistent with Section 1367.005 and any rules or regulations adopted pursuant to that section.

(v) The large group health care service plan contract 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 care service plan contract 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 care service plan contract offers only fully insured benefits through a health care service plan licensed by the department or a health insurance policy with a disability insurer that is licensed by the Department of Insurance. The benefits offered under the large group health care service plan contract shall be considered fully insured only if the terms of the health care service plan contract provide for benefits, the amount of all of which the department determines are guaranteed under a health care service plan contract issued by a health care service plan 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 care service plan contract, in form and in substance.

(xi) The large group health care service plan contract is treated as a single-risk-rated contract 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 care service plan contract 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 care service plan shall not market, issue, amend, renew, or deliver large employer health care 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 care service plans 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 of the Insurance Code.

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

(b) A plan shall provide enrollment periods consistent with PPACA and described in Section 155.725 of Title 45 of the Code of Federal Regulations. Each plan shall provide special enrollment periods consistent with the special enrollment periods described in Section 1399.849, to the extent permitted by PPACA, except for both of the following:

(1) The special enrollment period described in paragraph (3) of subdivision (c) of Section 1399.849.

(2) 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 plan contracts offered through the Exchange.

(c) A plan or solicitor shall not induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with the employee's employment or membership in a guaranteed association.

(d) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee 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 health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in Section 1357.500 to enroll as a dependent if the person is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan 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 under subdivision (m) of Section 1357.500, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

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

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

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

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

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

(f) A plan or solicitor shall not, directly or indirectly, engage in the following activities:

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

(2) Encourage or direct small employers to seek coverage from another plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(3) 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 an 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.

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

(h) (1) A policy or contract that covers a small employer, as defined in subsection (b) of Section 1304 of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the policy or contract 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 1389.1, a health care service plan shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire before enrollment under a small employer health care service plan contract. A health care service plan 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.

(i) (1) A health care service plan shall consider as a single-risk pool for rating purposes in the small employer market the claims experience of all enrollees in all nongrandfathered small employer health benefit plans offered by the health care service plan 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 health care service plan outside of the Exchange.

(2) At least each calendar year, and no more frequently than each calendar quarter, a health care service plan 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 1367.005, 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 small employer 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 health care service plan may vary premium rates for a particular nongrandfathered small employer health care service plan contract from its index rate based only on the following actuarially justified plan-specific factors:

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

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

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

(D) 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.

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

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

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

(Amended (as added by Stats. 2021, Ch. 736, Sec. 2.3) by Stats. 2024, Ch. 374, Sec. 2. (AB 2072) Effective January 1, 2025. Operative January 1, 2030, by its own provisions.)

1357.503.035. (a) For plan contracts subject to this article, an association that meets the definition of a guaranteed association, as set forth in Section 1357.500, 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 subdivision (m) of Section 1357.500, (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. 3. (AB 1083) Effective January 1, 2013.)

1357.504. (a) With respect to small employer health care service plan contracts offered outside the Exchange, after a small employer submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the employer of the employer's actual premium charges for that plan contract established in accordance with Section 1357.512. The employer shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(b) Except as provided in subdivision (c), when a small employer submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan contract 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 care service plan contract offered through the Exchange, a plan 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 1399.849.

(2) With respect to a small employer health care service plan contract offered outside the Exchange for which an individual applies during a special enrollment period described in subdivision (b) of Section 1357.503, the following provisions shall apply:

(A) Coverage under the plan contract shall become effective no later than the first day of the first calendar month beginning after the date the plan 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 contract shall become effective on the date of birth, adoption, or placement for adoption.

(d) During the first 30 days after the effective date of the plan contract, the small employer shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If a small employer notifies the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If a small employer notifies the plan of the change after the 15th day of a month, coverage under the new plan contract 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. 250. (AB 731) Effective January 1, 2016.)

1357.505. (a) Notwithstanding paragraph (2) of subdivision (a) of Section 1357.503, an association of employers may offer a large group health care service plan contract 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:

(1) The association was established prior to January 1, 1966, has been in continuous existence since that date, and is a bona fide association or group of employers 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)).

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

(3) The MEWA has offered a large group health care service plan contract 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)).

(4) The large group health care service plan contract offers to employees a level of coverage having an actuarial value equivalent to, or greater than, the platinum level of coverage pursuant to Section 1367.009 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 1367.005 and any rules or regulations pursuant to that section.

(5) The large group health care service plan contract includes coverage of common law employees, and their dependents, who are employed by an association member in the engineering, surveying, or design industry and whose employer has operations in California.

(6) The large group health care service plan offers only fully insured benefits through a health care service plan contract with a health care service plan licensed by the Department of Managed Health Care.

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

(8) 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.

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

(10) 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 care service plan contract, both in form and substance.

(11) The large group health care service plan contract 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 is not excluded from participating in a MEWA, or offering or renewing the large group health care service plan contract, based on the health status or claims of any employee or dependent.

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

(13) The association and the MEWA file applications for registration with the department on or before June 1, 2025.

(A) An association and MEWA that timely register with the department prior to June 1, 2025, and that are found to be in compliance with this subdivision, shall annually file evidence of ongoing compliance with this subdivision with the department, in a form and manner set forth by the department.

(B) Except as provided in paragraph (3) of subdivision (b), an association and MEWA that do not meet the requirements of subparagraph (A) shall be subject to the restrictions provided in subparagraph (A) of paragraph (2) of subdivision (a) of Section 1357.503.

(C) An association and MEWA that have registered with the department and fail to show ongoing compliance in their annual filing shall be subject to the restrictions in subparagraph (A) of paragraph (2) of subdivision (a) of Section 1357.503.

(D) By June 30, 2026, the department shall provide the health policy committees of the Legislature with the most recent filings made pursuant to subparagraph (A).

(E) The filings and recommendations to be submitted pursuant to subparagraph (D) shall be submitted in compliance with Section 9795 of the Government Code.

(F) (i) The department shall conduct an analysis of the impacts on the small employer health insurance market in California of health care service plans and health insurers currently issuing large group contracts and policies to small employers through MEWAs. 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 of and access to small group health insurance for small businesses in California who do not purchase health insurance through a MEWA. The department may coordinate with the Department of Insurance. Health care service plans, health insurers, and MEWAs shall comply with requests for information from the departments to complete this analysis. The department shall post a report summarizing its analysis on its internet website on or before July 1, 2026.

(ii) The department may contract with a consultant or consultants with expertise to assist the department in its analysis. Contracts entered into pursuant to this subparagraph 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).

(b) (1) On or after June 1, 2025, a health care service plan shall not market, issue, amend, renew, or deliver large employer health care service plan 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 subdivision (a), or unless the association and MEWA filed applications for registration pursuant to subdivision (a) and the applications are pending

before the department. The department shall have the authority to determine compliance with the requirements set forth in subdivision (a).

(2) The department may issue guidance to health care service plans, associations, and MEWAs regarding registration and compliance with subdivision (a). 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).

(3) Subdivision (a) 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 of the Insurance Code.

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

(Added by Stats. 2024, Ch. 398, Sec. 1. (AB 2434) Effective January 1, 2025. Repealed as of January 1, 2030, by its own provisions.)

1357.506. A small employer health care service plan contract 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. 4. (SB 1034) Effective January 1, 2015.)

1357.507. Nothing in this article shall be construed as prohibiting a health care service plan from restricting enrollment of late enrollees to open enrollment periods provided under Section 1357.503 as authorized under Section 2702 of the federal Public Health Service Act.

(Added by Stats. 2012, Ch. 852, Sec. 3. (AB 1083) Effective January 1, 2013.)

1357.508. A small employer health care service plan contract shall provide to subscribers and enrollees at least all of the essential health benefits as defined by the state pursuant to Section 1302 of PPACA.

(Added by Stats. 2012, Ch. 852, Sec. 3. (AB 1083) Effective January 1, 2013.)

1357.509. (a) To the extent permitted by PPACA, a plan shall not be required to offer a health care service plan contract or accept applications for the contract pursuant to this article in the case of any of the following:

(1) To a small employer, if the eligible employees and dependents who are to be covered by the plan contract do not live, work, or reside within a plan's approved service areas.

(2) (A) Within a specific service area or portion of a service area, if a plan reasonably anticipates and demonstrates to the satisfaction of the director all of the following:

(i) It will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the eligible employee and dependents of the employee because of its obligations to existing enrollees.

(ii) It is applying this subparagraph 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 plan that cannot offer a health care service plan contract to small employers because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area pursuant to subparagraph (A) may not offer a contract in the area in which the plan is not offering coverage to small employers 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 plan notifies the director that it has the ability to deliver services to small employer groups, and certifies to the director that from the date of the notice it will enroll all small employer groups requesting coverage in that area from the plan.

(C) Subparagraph (B) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

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

(b) (1) A health care service plan may decline to offer a health care service plan contract to a small employer if the plan demonstrates to the satisfaction of the director both of the following:

(A) It does not have the financial reserves necessary to underwrite additional coverage. In determining whether this subparagraph has been satisfied, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(B) It 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.

(2) A plan that denies coverage to a small employer under paragraph (1) shall not offer coverage in the group market before the later of the following dates:

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

(B) The date the plan demonstrates to the satisfaction of the director that the plan has sufficient financial reserves necessary to underwrite additional coverage.

(3) Paragraph (2) shall not limit the plan's ability to renew coverage already in force or relieve the plan of the responsibility to renew that coverage as described in Section 1365.

(4) Coverage offered within a service area after the period specified in paragraph (2) shall be subject to the requirements of this section.

(c) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired, to the extent permitted by PPACA.

(Amended by Stats. 2013, 1st Ex. Sess., Ch. 2, Sec. 6. (SB 2 1x) Effective September 30, 2013.)

1357.510. The director may require a plan to discontinue the offering of contracts or acceptance of applications from any small employer or group upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

(Added by Stats. 2012, Ch. 852, Sec. 3. (AB 1083) Effective January 1, 2013.)

1357.512. (a) The premium rate for a small employer health care service plan contract 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 contract 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 Insurance, 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 under this subparagraph is inoperative June 1, 2021, pursuant to Section 10231.5 of the Government Code.

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

(b) The rate for a health care service plan contract 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 plan contract.

(Amended by Stats. 2021, Ch. 764, Sec. 3. (SB 326) Effective January 1, 2022.)

1357.514. In connection with the offering for sale of a small employer health care service plan contract subject to this article, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The provisions concerning the plan's right to change premium rates and the factors other than provision of services experience that affect changes in premium rates. The plan shall disclose that claims experience cannot be used.

(b) Provisions relating to the guaranteed issue and renewal of 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 small employer health care service plan contract written, issued, or administered by the plan at the time of application for a new health care service plan contract, or at the time of renewal of a health care service plan contract, consistent with the requirements of PPACA.

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

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

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

(1) Prepare a brochure that summarizes all of its plan contracts offered to small employers and to make this summary available to any small employer and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, and a telephone number that can be called for more detailed benefit information. Plans are

required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.

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

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

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

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

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

(A) Advise the small employer of the plan's obligation to sell to any small employer any small employer health care service plan contract, consistent with PPACA, and provide the small employer, upon request, with the actual rates that would be charged to that employer for a given contract.

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

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

(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 (g) containing the benefit plan design or designs being recommended by the agent or broker.

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

(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the small employer with the benefit summary required in paragraph (1) of subdivision (g) and the premium for that particular employer.

(B) Notify the small employer that, upon request, the solicitor or solicitor firm will provide the small employer with an evidence of coverage brochure for each contract the plan offers.

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

(Amended by Stats. 2014, Ch. 195, Sec. 5. (SB 1034) Effective January 1, 2015.)

1357.515. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article which will be in force on the operative date of this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with Section 1357.512. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(b) At least 20 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with Section 1357.512. Plans that will be offering to a small employer plan contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

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

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

(Added by Stats. 2012, Ch. 852, Sec. 3. (AB 1083) Effective January 1, 2013.)

1357.516. (a) Health care service plans 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. Health care service plans 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 health care service plan shall permit all qualified associations to assume one or more of these functions when the health care service plan determines the qualified association demonstrates 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 health care service plan or through a third-party administrator on a commission basis or an agent or solicitor workforce on a commission basis. Each health care service plan 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 health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service plan shall report to the department its schedule of discounts for each administrative service.

In no instance may a health care service plan 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 director to enforce this chapter, the director may declare a contract between a health care service plan and a qualified association for administrative services pursuant to this section null and void if the director 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 only to association members any plan contract.

(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 Section 1357.52.

(Added by Stats. 2012, Ch. 852, Sec. 3. (AB 1083) Effective January 1, 2013.)