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 3.17. Grandfathered Small Employer Plans [1357.600 - 1357.618] *(Article 3.17 added by Stats. 2012, Ch. 852, Sec. 6.)*

1357.600. As used in this article, the following definitions shall apply:

(a) “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 (n).

(b) “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 (n).

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

(d) “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 and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association’s plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (n), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

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

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

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

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

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

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

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

(4) (A) In the case of an eligible employee, as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from eligibility for coverage until the next open enrollment period, unless the individual meets the criteria specified in paragraph (1), (2), or (3). This exclusion from eligibility for coverage shall not be considered a waiting period in violation of Section 1357.51 or 1357.607.

(B) In the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from eligibility for coverage until the next open enrollment period, unless the individual meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3). This exclusion from eligibility for coverage shall not be considered a waiting period in violation of Section 1357.51 or 1357.607.

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

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

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

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

days following the date of marriage, birth, adoption, or placement for adoption, in which case the effective date of coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan, including a plan offered through the California Health Benefit Exchange, at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(e) “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. A health care service plan shall not 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.

(f) “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)).

(g) “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 health care service plan contract.

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

(i) “Risk adjustment factor” means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 110 percent or less than 90 percent.

(j) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

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

Under 30

30–39

40–49

50–54

55–59

60–64

65 and over.

However, for the 65 years of age and over category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

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

(A) Single.

(B) Married couple or registered domestic partners.

(C) One adult and child or children.

(D) Married couple or registered domestic partners and child or children.

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

(B) (i) In determining rates for small employers, a plan that does not operate statewide shall use no more than the number of geographic regions in the state that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan’s service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. A region shall not be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. A plan shall not have less than one geographic area.

(ii) If the formula in clause (i) results in a plan that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the plan may have two geographic regions, provided that no county is divided into more than one region.

This section does not require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan’s existing service area.

(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, 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. 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 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 subparagraph 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 (m), 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.

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

(m) “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.

(n) “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.

(o) “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.

(p) “Grandfathered small employer health care service plan contract” means a small employer health care service plan contract that constitutes a grandfathered health plan.

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

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

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

(t) “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.

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

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

(w) “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.

(Amended by Stats. 2018, Ch. 700, Sec. 4. (SB 1375) Effective January 1, 2019.)

1357.601. This article shall apply only to grandfathered small group health care service plan contracts and only with respect to plan years commencing on or after January 1, 2014.

(Added by Stats. 2012, Ch. 852, Sec. 6. (AB 1083) Effective January 1, 2013.)

1357.602. (a) A health care service plan providing or arranging for the provision of basic health care services to small employers shall be subject to this article if either of the following conditions are 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. 6. (AB 1083) Effective January 1, 2013.)

1357.603. 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. 6. (AB 1083) Effective January 1, 2013.)

1357.604. (a) (1) A plan shall fairly and affirmatively renew a grandfathered health plan contract with a small employer.

(2) Each plan shall make available to each small employer all nongrandfathered 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 consistent with Article 3.1 (commencing with Section 1357).

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

(b) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in renewing its grandfathered health care service 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 subdivision (a) of Section 1357.600 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 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 (n) of Section 1357.600, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan’s reasonable participation standards.

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

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

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

(d) 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 or small employer's employees.

(e) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in subdivision (k) of Section 1357.600 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.

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

(Added by Stats. 2012, Ch. 852, Sec. 6. (AB 1083) Effective January 1, 2013.)

1357.606. (a) For plan contracts expiring after July 1, 1994, 60 days prior to July 1, 1994, an association that meets the definition of a guaranteed association, as set forth in Section 1357.600, except for the requirement that 1,000 persons be covered, shall be entitled to renew grandfathered small employer health care service plan contracts 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 1357.600, (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. 6. (AB 1083) Effective January 1, 2013.)

1357.607. 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. 8. (SB 1034) Effective January 1, 2015.)

1357.608. Nothing in this article shall be construed as prohibiting a health care service plan from restricting enrollment of late enrollees to open enrollment periods consistent with federal law.

(Added by Stats. 2012, Ch. 852, Sec. 6. (AB 1083) Effective January 1, 2013.)

1357.609. All grandfathered small employer health care service plan contracts shall provide to subscribers and enrollees at least all of the basic health care services included in subdivision (b) of Section 1345, and in Section 1300.67 of the California Code of Regulations.

(Added by Stats. 2012, Ch. 852, Sec. 6. (AB 1083) Effective January 1, 2013.)

1357.610. (a) No plan shall be required by the provisions of this article:

(1) To offer coverage under a small employer's health care service plan contract to an otherwise eligible employee or dependent, when the eligible employee or dependent does not work or reside within the plan's approved service area, except as provided in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code.

(2) To offer coverage under a small employer's health care service plan contract to an eligible employee, as defined in paragraph (2) of subdivision (b) of Section 1357.600, who within 12 months of application for coverage terminated from a small employer health care service plan contract offered by the plan.

(b) 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.

(Added by Stats. 2012, Ch. 852, Sec. 6. (AB 1083) Effective January 1, 2013.)

1357.611. (a) The director may require a plan to discontinue the renewal of grandfathered small employer health care service plan contracts or the offering or acceptance of applications from any 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.

(b) 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.

(Added by Stats. 2012, Ch. 852, Sec. 6. (AB 1083) Effective January 1, 2013.)

1357.612. Premiums for grandfathered contracts renewed by plans on or after January 1, 2014, shall be subject to the following requirements:

(a) (1) The premium for in force business shall be determined for an eligible employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rates may not be more than 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 no less than 12 months.

(b) (1) For any small employer, a plan 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 subdivision (a). 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 plan may reserve the right to redetermine the composite rates if the enrollment under the contract 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 plan reserves the right to redetermine the rates and the enrollment changes more than the specified percentage, the plan shall redetermine the composite rates if the redetermined rates would result in a lower premium for the small employer. A plan 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. 6. (AB 1083) Effective January 1, 2013.)

1357.613. Plans shall apply standard employee risk rates consistently with respect to all small employers.

(Added by Stats. 2012, Ch. 852, Sec. 6. (AB 1083) Effective January 1, 2013.)

1357.614. In connection with the renewal of a grandfathered small employer health care service plan contract, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

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

(b) 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.

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

(d) Provisions relating to the effect of any waiting or affiliation provision.

(e) Provisions relating to the small employer's right to apply for any nongrandfathered 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.

(f) The availability, upon request, of a listing of all the plan's nongrandfathered small employer health care service plan contracts and benefit plan designs offered, both inside and outside the California Health Benefit Exchange, including the rates for each contract.

(g) At the time it renews a grandfathered small employer health care service plan contract, each plan shall provide the small employer with a statement of all of its nongrandfathered 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.

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

(1) Prepare a brochure that summarizes all of its small employer health care service plan contracts and to make this summary available to any small employer and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, and 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 which the plan contracts to solicit enrollments or subscriptions.

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

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

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

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

(Amended by Stats. 2014, Ch. 195, Sec. 9. (SB 1034) Effective January 1, 2015.)

1357.615. (a) At least 20 business days prior to renewing or amending a small employer health care service plan contract subject to 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 subdivision (i) of Section 1357.600 and Section 1357.612. The certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. 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) Prior to making any changes in the risk categories, risk adjustment factors or standard employee risk rates filed with the director pursuant to subdivision (a), the plan shall file as an amendment a statement setting forth the changes and certifying that the plan is in compliance with subdivision (i) of Section 1357.600 and Section 1357.612. A plan may commence utilizing the changed risk categories set forth in the certified statement on the 31st day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the reasons therefor. If only the standard employee risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence utilizing the changed standard employee risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.

(c) Periodic changes to the standard employee risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a) or (b).

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

(e) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular small employer.

(f) 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. 6. (AB 1083) Effective January 1, 2013.)

1357.616. (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 apply these uniform discounts to the health care service plan's risk adjusted employee risk rates after the health plan has determined the qualified association's risk adjusted employee risk rates pursuant to Section 1357.612. 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. 6. (AB 1083) Effective January 1, 2013.)

1357.618. (a) The department may adopt emergency regulations implementing this article 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.

(Added by Stats. 2012, Ch. 852, Sec. 6. (AB 1083) Effective January 1, 2013.)