§ 1357.503. Small employer health benefit plans; Enrollment periods; Prohibited activities; Participation requirements; Small employer eligibility; Limitations on individual eligibility rules; Single risk pool; Applicability [Operative January 1, 2030]

(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 exer-

cise 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.

HISTORY:

Added Stats 2021 ch 736 § 2.3 (SB 718), effective January 1, 2022, operative January 1, 2026. Amended Stats 2024 ch 374 § 2 (AB 2072), effective January 1, 2025, operative January 1, 2030.

§ 1357.503.035. Purchase of small employer health coverage by asso- ciation meeting definition of guaranteed association

(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.

HISTORY:

Added Stats 2012 ch 852 § 3 (AB 1083), effective January 1, 2013.