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INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880. - 12865.] *(Division 2 enacted by Stats. 1935, Ch. 145.)*

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

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

ARTICLE 1. Definitions [10753. - 10753.01.] *(Article 1 added by Stats. 2012, Ch. 852, Sec. 14.)*

10753. (a) “Agent or broker” means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) “Benefit plan design” means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) “Carrier” means a health insurer or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder.

(d) “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.

(e) “Dependent” means the spouse or registered domestic partner, or child, of an eligible employee, subject to applicable terms of the health benefit plan 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 (s).

(f) “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, in the small employer’s regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer’s business, and they are included as employees under a health benefit plan of a small employer, but does not include 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 shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. A permanent employee who works at least 20 hours but not more than 29 hours is deemed to be an eligible employee if all four of the following apply:

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

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

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

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The insurer 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 (s).

(g) “Enrollee” means an eligible employee or dependent who receives health coverage through the program from a participating carrier.

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

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(i) “Financially impaired” means, for the purposes of this chapter, a carrier that, on or after the effective date of this chapter, is not insolvent and is either:

(1) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations.

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(j) “Health benefit plan” means a policy of health insurance, as defined in Section 106, 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, or coverage that provides excepted benefits, as described in Sections 2722 and 2791 of the federal Public Health Service Act, subject to Section 10701.

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

(l) “Late enrollee” means an eligible employee or dependent who has declined health coverage under 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 10753.05 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 10753.05. 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 health benefit plan consistent with the periods provided pursuant to Section 10753.05 and who subsequently requests enrollment in the plan, except where the employee or dependent qualifies for a special enrollment period provided pursuant to Section 10753.05.

(m) "New business" means a health benefit plan issued to a small employer that is not the carrier's in force business.

(n) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured'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.

(o) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program, that is written or administered by a health 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 federal 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) 10 U.S.C. Chapter 55 (commencing with Section 1071) (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 5 U.S.C. Chapter 89 (commencing with Section 8901) (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 subdivision (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(c)).

(p) "Rating period" means the period for which premium rates established by a carrier are in effect and shall be no less than 12 months from the date of issuance or renewal of the health benefit plan.

(q) (1) "Small employer" means either 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 benefit plans, 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 benefit plans, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, a carrier 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 benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this chapter, provisions of this chapter 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, and any employer purchasing coverage for employees through a guaranteed association. This subparagraph shall be implemented to the extent consistent with PPACA, except that the minimum requirement of one employee shall be implemented only to the extent required by PPACA.

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

(2) For plan years commencing on or after January 1, 2014, the definition of an employer, for purposes of determining whether an employer with one employee shall include sole proprietors, certain owners of “S” corporations, or other individuals, shall be consistent with Section 1304 of PPACA. 42 USC 18024 GPO.gov

(r) “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 which (1) includes one or more small employers as defined in subparagraph (A) of paragraph (1) of subdivision (q), (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 by 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 been offering health insurance to its members 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 benefit plan design that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the benefit plan design 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 carrier 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 master policy by an admitted insurer is delivered directly to the 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.

(s) “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 may also 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 those persons as members of the guaranteed association, the association must so elect in advance of purchasing coverage from a plan. Health plans may require an association to adhere to the membership composition it selects for up to 12 months.

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

(u) “Nongrandfathered health benefit plan” means a health benefit plan that is not a grandfathered health plan.

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

(w) “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.

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

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

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

10753.01. (a) For purposes of this chapter, "health benefit plan" does not include policies or certificates of specified disease or hospital confinement indemnity provided that the carrier offering those policies or certificates complies with the following:

(1) The carrier files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in paragraph (2).

(2) The certification required in paragraph (1) shall contain the following:

(A) A statement from the carrier certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for coverage that provides essential health benefits as defined by the state pursuant to Section 1302 of PPACA, and (ii) the disclosure forms as described in Section 10603 contains the following statement prominently on the first page: "This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

(B) A summary description of each policy or certificate described in this section, including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender, or other factors, charged for the policies and certificates issued or delivered in this state.

(3) In the case of a policy or certificate that is described in this section and that is offered for the first time in this state with respect to plan years on or after January 1, 2014, the carrier files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

(b) As used in this section, "policies or certificates of specified disease" and "policies or certificates of hospital confinement indemnity" mean policies or certificates of insurance sold to an insured to supplement other health insurance coverage as specified in this section. An insurer issuing a "policy or certificate of specified disease" or a "policy or certificate of hospital confinement indemnity" shall require that the person to be insured is covered by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

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

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

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

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

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

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

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

10753.02.1. Any person or entity subject to the requirements of this chapter shall comply with the standards set

forth in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

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

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

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

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

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

10753.05. (a) No group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10753.17.

(b) (1) On and after October 1, 2013, each carrier shall fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are sold to, offered through, or sponsored by, small employers or associations that include small employers for plan years on or after January 1, 2014, to all small employers in each geographic region in which the carrier makes coverage available or provides benefits.

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

(3) A carrier shall provide enrollment periods consistent with PPACA and set forth in Section 155.725 of Title 45 of the Code of Federal Regulations. A carrier shall provide special enrollment periods consistent with the special enrollment periods required in the individual nongrandfathered market in the state, as set forth in Section 10965.3, except for the triggering events identified in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of Federal Regulations with respect to health benefit plans offered through the Exchange.

(4) Nothing in this section shall be construed to require an association, or a trust established and maintained by an association to receive a master insurance policy issued by an admitted insurer and to administer the benefits thereof solely for association members, to offer, market or sell a benefit plan design to those who are not members of the association. However, if the association markets, offers or sells a benefit plan design to those who are not members of the association it is subject to the requirements of this section. This shall apply to an association that otherwise meets the requirements of paragraph (8) formed by merger of two or more associations after January 1, 1992, if the predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and met the requirements of paragraph (5).

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

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

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

(8) For purposes of paragraphs (4) and (6), an association is a nonprofit organization comprised of a group of

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

(c) On and after October 1, 2013, each carrier shall make available to each small employer all health benefit plans that the carrier offers or sells to small employers or to associations that include small employers for plan years on or after January 1, 2014. Notwithstanding subdivision (d) of Section 10753, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10753, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section 10753, is provided in connection with a guaranteed association.

(g) No carrier shall reject an application from a small employer for a health benefit plan provided:

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

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

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

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

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

(i) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer or the small employer's employees. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

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

(A) Health status.

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

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

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

(l) (1) With respect to the obligation to provide coverage newly issued under subdivision (c), to the extent permitted by PPACA, the carrier may cease enrolling new small employer groups and new eligible employees as defined by paragraph (2) of subdivision (f) of Section 10753 if it certifies to the commissioner that the number of eligible employees and dependents, of the employers newly enrolled or insured during the current calendar year by the carrier equals or exceeds: (A) in the case of a carrier that administers any self-funded health benefits arrangement in California, 10 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured in California by that carrier as of December 31 of the preceding year, or (B) in the case of a carrier that does not administer any self-funded health benefit arrangements in California, 8 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured by the carrier in California as of December 31 of the preceding year.

(2) Certification shall be deemed approved if not disapproved within 45 days after submission to the commissioner. If that certification is approved, the small employer carrier shall not offer coverage to any small employers under any health benefit plans during the remainder of the current year. If the certification is not approved, the carrier shall continue to issue coverage as required by subdivision (c) and be subject to administrative penalties as established in Section 10753.18.

(m) (1) Except as provided in paragraph (2), this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, in which case carriers subject to this section shall instead be governed by Section 10705 to the extent permitted by federal law, and all references in this chapter to this section shall instead refer to Section 10705, except for purposes of paragraph (2).

(2) Paragraph (3) of subdivision (b) of this section shall remain operative as it relates to health benefit plans offered through the Exchange.

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

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

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

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

10753.06. Every carrier shall file with the commissioner the reasonable participation requirements and employer contribution requirements that are to be included in its health benefit plans. Participation requirements shall be applied uniformly among all small employer groups, except that a carrier may vary application of minimum employer participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A carrier shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (e) of Section 10753 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a carrier to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage eligible under subdivision (s) of Section 10753

but not electing any health coverage through the association shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a carrier's reasonable participation standards.

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

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

(b) (1) Except as required under paragraph (2), when a small employer submits a premium payment, based on the quoted rates, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of a month, coverage shall become effective no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(2) A carrier shall apply coverage effective dates for health benefit plans subject to this chapter consistent with the coverage effective dates applicable to nongrandfathered individual health benefit plans set forth in Section 10965.3.

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

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

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

10753.08. (a) A health benefit plan shall not impose a preexisting condition provision upon any individual.

(b) A health benefit plan may apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents and if consistent with PPACA. A waiting period shall not be based on a preexisting condition of an employee or dependent, the health status of an employee or dependent, or any other factor listed in subdivision (j) of Section 10753. During the waiting period, the health benefit plan is not required to provide coverage and no premium shall be charged to the policyholder or insureds.

(c) In determining whether a waiting period applies to any person, a carrier shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A carrier shall also credit any time an eligible employee must wait before enrolling in the plan, including any employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

(d) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-3(e)).

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

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

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

10753.11. To the extent permitted by PPACA, no carrier shall be required by the provisions of this chapter:

(a) To offer coverage to, or accept applications from, a small employer as defined in subparagraph (A) of paragraph (1) of subdivision (q) of Section 10753, where the small employer is not physically located in a carrier's approved service areas.

(b) To offer coverage to or accept applications from a small employer as defined in subparagraph (B) of paragraph (1) of subdivision (q) of Section 10753 where the small employer is seeking coverage for eligible employees who do not work or reside in a carrier's approved service areas.

(c) To include in a health benefit plan an otherwise eligible employee or dependent, when the eligible employee or dependent does not work or reside within a carrier's approved service area, except as provided in Section 10753.02.1.

(d) To offer coverage to, or accept applications from, a small employer for a benefits plan design within an area if the commissioner has found that the carrier will not have the capacity within the area in its network of providers to deliver service adequately to the eligible employees and dependents of that employee because of its obligations to existing group contractholders and enrollees and that the action is not unreasonable or clearly inconsistent with the intent of this chapter.

A carrier that cannot offer coverage to small employers in a specific service area because it is lacking sufficient capacity may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the carrier notifies the commissioner that it has regained capacity to deliver services to small employers, and certifies to the commissioner that from the date of the notice it will enroll all small groups requesting coverage from the carrier until the carrier has met the requirements of subdivision (h) of Section 10753.05.

(e) To offer coverage to a small employer, or an eligible employee as defined in paragraph (2) of subdivision (f) of Section 10753, who within 12 months of application for coverage terminated from a health benefit plan offered by the carrier.

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

10753.12. (a) A carrier shall not be required to offer coverage or accept applications for benefit plan designs pursuant to this chapter where the commissioner determines that the acceptance of an application or applications would place the carrier in a financially impaired condition.

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

(c) A carrier that has not offered coverage or accepted applications pursuant to this chapter shall not offer coverage or accept applications for any individual or group health benefit plan until the commissioner has determined that the carrier has ceased to be financially impaired.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Age, pursuant to the age bands established by the United States Secretary of Health and Human Services 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 based on the individual's birthday and shall not vary by more than three to one for adults.

(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, Del Norte, Siskiyou, Modoc, Lassen, Shasta, Trinity, Humboldt, Tehama, Plumas, Nevada, Sierra, Mendocino, Lake, Butte, Glenn, Sutter, Yuba, Colusa, Amador, Calaveras, and Tuolumne.

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

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

(iv) Region 4 shall consist of the 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 Santa Cruz, Monterey, and San Benito.

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

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

(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 Mono, Inyo, and Imperial.

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

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

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

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

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

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

(B) No later than June 1, 2017, the department, in collaboration with the Exchange and the Department of Managed Health Care, shall review the geographic rating regions specified in this paragraph and the impacts of those regions on the health care coverage market in California, and make a report to the appropriate policy committees of the Legislature.

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

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

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

(d) This section shall become inoperative if Section 2701 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg), as added by Section 1201 of PPACA, is repealed, in which case rates for health benefit plans subject to this section shall instead be subject to Section 10714, to the extent permitted by federal law, and all references to this section shall be deemed to be references to Section 10714.

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

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

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

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

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

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

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

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

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

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

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

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

(2) Either:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) (1) Whenever it appears to the commissioner that irreparable loss and injury has occurred or may occur to an insured, employer, employee, or other member of the public because a carrier, production agent, or other person or entity engaged in the business of insurance has violated this chapter, the commissioner may, before hearing, but after notice and opportunity to submit relevant information, issue and cause to be served upon the entity such order or orders as shall be reasonably necessary to correct, eliminate, or remedy the alleged violations of this

chapter, including, but not limited to, an order requiring the entity to forthwith cease and desist from engaging further in the violations which are causing or may cause such irreparable injury.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of this chapter.

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