SENATE HEALTH
COMMITTEE ANALYSIS
Senator Ed Hernandez, O.D., Chair

BILL NO:	**AB 1083**	**A**
AUTHOR:	**Monning**	**B**
AMENDED:	**June 27, 2011**	
HEARING DATE:	**June 29, 2011**	**1**
CONSULTANT:		**0**
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SUBJECT

Small group health insurance coverage

SUMMARY

Effective January 1, 2014, makes a number of changes to state laws governing the sale of small group insurance products to conform state law to provisions in the federal Patient Protection and Affordable Care Act (PPACA), pertaining to definitions of "small employer" and "employee," pre-existing condition exclusions, waiting periods, and other provisions. Makes other changes to laws governing the offering and sale of small group insurance products that become effective January 1, 2012, pertaining to self-employed individuals, duration of premium rates, notification of availability of coverage, and notice of material modifications by carriers.

CHANGES TO EXISTING LAW

General provisions

Existing federal law:

Establishes the PPACA (Public Law 111-148), which imposes various requirements, some of which take effect on January 1, 2014, on states, carriers, employers, and individuals regarding health care coverage, including coverage in the small group health insurance market.

Defines "grandfathered plan" as any group or individual health insurance product that was in effect on March 23, 2010.

Existing state law:

Provides for the regulation of health plans by the Department of Managed Health Care (DMHC) under the Knox-Keene Health Care Service Plan Act of 1975, and for the

Continued---

regulation of health insurers by the California Department of Insurance (CDI) under provisions of the Insurance Code (collectively referred to as regulators).

Establishes and specifies the duties and authority of the Exchange within state government in a manner that is consistent with PPACA.

Requires as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to fairly and affirmatively offer, market and sell all products made available in the Exchange to individuals and small employers purchasing coverage outside of the Exchange.

Requires health plans to fairly and affirmatively offer, market, and sell health coverage to small employers. This is known as "guaranteed issue."

Requires health plans to offer, market, and sell all of the health plan's contracts that are sold to small employers, to any small employers in each service area in which the plan provides health care services. This is known as an "all products" requirement.

PROVISIONS CONFORMING TO PPACA

Definition of "small employer"

Existing federal law:

Defines "small employer" as an employer who employed an average of at least 1, but not more than 100 employees on business days during the preceding calendar year.

Allows states the option to, prior to January 1, 2016, define "small employer" as an employer who employed an average of at least 1, but not more than 50 employees.

Existing state law:

Defines a small employer as 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 two, but no more than 50, eligible employees, the majority of whom were employed within this state

This bill:

Maintains the existing state definition of small employer (2 to 50 eligible employees) until January 1, 2014, and implements the federal option to define small employer as 1 to 50 from January 1, 2014, until December 31, 2015.

Implements the federal definition of small employer as having at least 1, but no more than 100 eligible employees, as specified, on or after January 1, 2016.

Adds to the definition, on or after January 1, 2014, a self-employed individual who obtains at least 50 percent of annual income from self-employment as demonstrated through personal income tax filings for the current or prior year.

Replaces an obsolete reference to an employer purchasing program that is no longer in existence with a reference to the Exchange.

Requires employer contribution requirements to be consistent with PPACA.

Definition of "eligible employee"
Existing federal law:
Defines the term "full-time employee" to mean, with respect to any month, an employee who is employed on average at least 30 hours of service per week.

Existing state law:
Defines an eligible employee as 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 at least 30 hours, at the employer's place of business, who has met any statutory waiting periods.

Deems permanent employees who work at least 20 hours but not more than 29 hours eligible, if certain conditions apply.

This bill:
Effective January 1, 2012, expands the definition of eligible employee by calculating the hours in a normal work week as an average of, rather than a minimum of, 30 hours per week over the course of a month.

Effective January 1, 2012, prohibits carriers from establishing rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, based on any other health status-related factor as determined by the regulators.

Pre-existing condition exclusions
Existing federal law:
Prohibits, effective January 1, 2014, any carrier offering group or individual health insurance coverage that imposes any pre-existing condition exclusions.

Prohibits a carrier, except for grandfathered plans, from imposing any pre-existing condition provision upon any child less than 19 years of age.

Existing state law:
Permits plans to exclude a "pre-existing condition" for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a pre-existing condition, defined as 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.

Prohibits a plan contract for individual or group coverage, other than grandfathered plans, from imposing any pre-existing condition provision upon any child less than 19 years of age.

This bill:
Prohibits, effective January 1, 2014, carriers from limiting or excluding coverage for any individual based on a pre-existing condition, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

Waiting periods

Existing federal law:

Effective January 1, 2014, prohibits all insurance products from requiring a waiting periods for individual or group coverage longer than 90 days.

Existing state law:

Allows carriers who use pre-existing condition exclusions in their products to impose up to a six month pre-existing condition waiting period related to medical conditions.

Allows carriers who do not use pre-existing condition exclusions in their products to impose a waiting period of up to 60 days.

This bill:

Effective January 1, 2014, prohibits a carrier from imposing a waiting period based on a pre-existing condition, health status, or any other factor, as specified.

Effective January 1, 2014, allows a carrier to impose a waiting period of up to 90 days as a condition of enrollment, if applied equally to all full-time employees and if consistent with PPACA and any subsequent federal rules, regulations or guidance.

Beginning January 1, 2013, requires a carrier providing aggregate or specific stop-loss coverage, or any other assumption of risk with reference to a health benefit plan, to ensure that the plan meets all the waiting period provisions in state law pertaining to small group insurance policies.

Late enrollees

Existing state law:

Allows carriers to exclude late enrollees from group coverage for more than 12 months from the date of the application.

This bill:

Repeals authority for carriers to exclude late enrollees from coverage for more than 12 months from the date of the application on January 1, 2014, and instead permits carriers to exclude late enrollees from coverage for up to 90 days from the date of the late enrollee's application.

Prohibits premiums from being charged to the late enrollee until the exclusion period has ended.

Health status

Existing federal law:

Effective in January 1, 2014, prohibits all health insurance products, except grandfathered plans and self-insured plans, from discriminating based on health status, including medical history, domestic violence, claims experience, and genetic information.

Existing state law:

Prohibits a policy or contract that covers two or more employees from establishing 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; and,
h) Disability.

Allows carriers to use a risk adjustment factor of +/- 10 percent from the standard employee rate in determining an individual employee's premium rate, as specified.

This bill:
Effective January 1, 2012, adds to the list of health status-related factors in existing law a prohibition based on any other health status-related factor as determined by the regulator.

Effective January 1, 2014, prohibits the use of a risk adjustment factor in the determination of an individual employee's premium within a group.

Essential health benefits
Existing federal law:
Establishes a list of categories of "essential health benefits package" which individual and small group insurance products must provide beginning in 2014.

Existing state law:
Requires DMHC-regulated health plans to provide all medically necessary basic health care services, as defined. Permits DMHC to define the scope of the services and to exempt plans from the requirement for good cause. No similar provision is applicable to health insurers regulated by CDI.

Defines disability insurance to include insurance appertaining to injury, disablement, or death resulting to the insured from accidents or sickness.

Defines, for statutes effective on or after January 1, 2002, the term "health insurance" to mean an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits, as specified.

Defines, for statutes effective on or after January 1, 2008, the term "specialized health insurance policy" to mean a policy of health insurance for covered benefits in a single specialized area of health care, including dental-only, vision-only, and behavioral health-only policies.

This bill:
Changes the definition of health benefit plan to include essential health benefits on or after January 1, 2014, as defined consistent with PPACA.

Defines, for statutes effective on or after January 1, 2014, the term "health insurance" to mean individual or group disability insurance policies, except for grandfathered policies that provides essential health benefits as defined in PPACA, as specified.

PROVISIONS NOT CONFORMING TO PPACA

Premium rates

Existing federal law:

Effective January 1, 2014, permits carriers to vary premiums in the individual and small group markets only based on a geographic rating area, age of policyholder, tobacco use, and whether the policy is for an individual or family.

Prohibits premiums from varying by more than three to one for adults.

Prohibits premiums from varying by more than 1.5 to one for smokers.

Allows for the provision of wellness incentives by employers to vary premiums up to 30 percent. May be increased up to 50 percent up approval by the Secretary of the federal Health and Human Services Agency.

Existing state law:

Establishes the following risk categories for rating purposes: age, geographic region, and family composition, plus the health benefit plan selected by the small employer. Specifies age categories, family size categories, and nine geographic regions.

Prohibits rates from being adjusted annually more than 10 percent, up or down, from the filed premium rates based on an employer's industry, geographic location, occupation, or claims experience. This is called the risk adjustment factor.

This bill:

Eliminates the ability of carriers to impose a risk adjustment factor to premium rates effective January 1, 2014.

Allows premium rate variation based upon age of no more than three to one for adults effective January 1, 2014.

Does not allow for provisions of wellness incentives.

Does not provide for smokers' premiums to vary.

OTHER PROVISIONS NOT ADDRESSED IN PPACA

Self-employed individuals

This bill:

Effective January 1, 2014, permits certain self-employed individuals to, to the extent permitted under federal law, at his or her discretion, enroll in the Exchange as an individual rather than a small employer. Eligible self-employed individuals are defined as those with at least 50 percent of annual income from self-employment, and whose modified adjusted gross income is under 400 percent of the federal poverty level.

Rating periods
Existing state law:
Prohibits carriers, during the term of a group plan contract or policy, from changing the rate of the premium, copayment, coinsurance, or deductible during specified time periods.

Defines a rating period as the period for which premium rates established by a plan are in effect and requires them to be in effect no less than six months.

This bill:
Defines a rating period as the period for which premium rates established by a plan are in effect and requires them to be in effect no less than twelve months (instead of six).

Notifications
Existing state law:
Prohibits health plans and insurers from changing premium rates or coverage policies without prior written notification of the change to the contract holder or policyholder.

This bill:
Modifies the requirements for carriers to notify the small employer about rate increases, and instead, on or after January 1, 2013, requires carriers to notify the small employer that the actual rates are required to be the same for all small employers.

Requires solicitors to notify the small employer of the availability of tax credits for certain employers, and beginning January 1, 2014, of the availability of coverage and tax credits through the Exchange.

Carrier filing requirements
Existing state law:
Requires carriers to file a notice of material modification with their respective regulators at least 20 business days prior to renewing or amending a plan contract, as specified.

This bill:
Requires carriers to file a notice of material modification with their respective regulators at least 60 calendar days (rather than 20 business days) prior to renewing or amending a plan contract, as specified.

FISCAL IMPACT

According to the Assembly Appropriations Committee analysis, minor and absorbable state costs as a result of this bill. The numerous provisions in this bill, including some that go beyond federal law, largely affect the small-group private insurance markets and have negligible cost implications for the state. In the normal course of DMHC and CDI's existing regulatory duties, regulators would respond to complaints and provide oversight to ensure that carriers were complying with state laws governing how health insurance must be offered and sold. There may be minor up-front costs to departments to respond to the health care coverage and insurance market changes, but these would happen under existing federal law.

BACKGROUND AND DISCUSSION

According to the author, approximately 3.4 million Californians enjoy the protections brought about by California's landmark small employer group health insurance rating and underwriting rules which have applied to employer groups with 2 to 50 workers since 1993. These rules require carriers to offer health plan contracts and insurance policies to small employer purchasers on a guaranteed issue basis (i.e. accepting a group applying for coverage regardless of the health status or claims experience of group members). They also require carriers to offer renewal contracts, limit the rating factors carriers can employ in pricing small group products, require carriers to guarantee issue all small employer products to all small group purchasers, and limit the ways in which carriers can exclude coverage for existing health care conditions.

The author states that the federal health reform law, PPACA, includes several significant reforms to the health insurance market, including numerous provisions that interact with California's small group laws. According to the author, implementation of PPACA small group reforms in California has the potential to bring millions of people into the small group market. This bill is intended to revise California law to conform to the federal law in order to bring more uninsured into coverage. The author also states that there are some provisions in AB 1083 that go beyond PPACA, such as requiring carrier rates to be in effect for no less than 12, rather than 6 months, and requires carriers to notify small employers of the availability of coverage through the Exchange.

California's small group health insurance market

In 1992, under AB 1672 (Margolin and Hansen), Chapter 1128, Statutes of 1992, California enacted a number of reforms to the small group market, making health insurance more accessible to small employers through guaranteed issue and renewability provisions, regulating pre-existing conditions limitations, underwriting protections, and disclosure requirements. Before AB 1672, a carrier would examine an employer's health history and could either increase the premiums significantly or decline the entire group.

California's small group market has been shaped by guaranteed issue and other protections established in small group reform in 1992. In this market, carriers may impose participation requirements (i.e. 70 percent of eligible employees must enroll) and contribution requirements (i.e. employer must pay at least pay half of the premium). As a result, enrollees in small group coverage typically pay a fraction of their premium.

A 2011 California HealthCare Foundation report indicates that 3.4 million, or 9 percent, of Californians have health coverage through small group insurance products. Roughly 67 percent of small group products are regulated by DMHC, compared to 33 percent regulated by CDI. In addition, there are 2.2 million people who purchase insurance for themselves in the individual market. Of those 2.2 million, 32 percent are self-employed and another 26 percent work for small employers. Another 3 million people who are uninsured have a head of family who works for a small employer or is self-employed.

Small group reforms in PPACA

On March 23, 2010, President Obama signed the PPACA. This federal law makes several significant changes to the group and individual insurance markets. In general, PPACA requires individuals, beginning in 2014, to maintain health insurance coverage,

with some exceptions. Employers are not explicitly required to provide health benefits, although certain employers with more than 50 employees may be required to pay a penalty if they either (1) do not provide insurance, under certain circumstances, or (2) the insurance they provide does not meet specified requirements. PPACA also eliminates the pricing of premiums based on health status, limits the range of premiums based on age, adds the self-employed to those eligible for guaranteed issue of coverage, includes wellness incentives in the coverage available to small businesses and expands the rules to employers with one to 100 employees.

Related bills

SB 51 (Alquist) would require health plans and insurers to meet federal annual and lifetime limits and medical loss ratio (MLR) requirements in specified provisions of the federal health care reform law, as specified. Would also authorize the Director of DMHC and the Insurance Commissioner to issue guidance, as specified, and promulgate regulations to implement requirements relating to MLRs, as specified. *Set for hearing on July 5, 2011 in the Assembly Health Committee.*

AB 52 (Feuer and Huffman) requires, effective January 1, 2012, health plans and insurers to apply for prior approval of proposed rate increases, under specified conditions, and imposes on CDI and DMHC specific rate regulation criteria, timelines, and hearing requirements. *Set for hearing on June 29, 2011 in the Senate Health Committee.*

Prior legislation

SB 890 (Alquist) of 2010 would have, among other things, required health plans and insurers to meet federal annual and lifetime limits and the MLR requirements in PPACA. *Vetoed by the Governor.*

SB 900 (Alquist)*, *Chapter 659, Statutes of 2010, established the California Health Benefit Exchange as an independent public entity within state government, required the Exchange to be governed by a board composed of the Secretary of California Health and Human Services, or his or her designee, and four other members appointed by the Governor and the Legislature, who meet specified criteria.

SB 1163 (Leno), Chapter 661, Statutes of 2010 requires health plans and insurers to file with DMHC and CDI specified rate information for at least 60 days prior to implementing any rate change. Requires rate filings to be actuarially sound. Increases, from 30 days to 60 days, the amount of time that a carrier must provide written notice before a change in premium rates or coverage becomes effective. Requires health plans and insurers that decline to offer coverage or that deny enrollment for a large group applying for coverage, or that offer small group coverage at a rate that is higher than the standard employee risk rate, to provide the applicant with reason for the decision.

AB 1602 (John A. Pérez)*, *Chapter 655, Statutes of 2010, specified the powers and duties of the Exchange relative to determining eligibility for enrollment in the Exchange and arranging for coverage under qualified health plans, required the Exchange to provide health plan products in all five of the federal benefit levels (platinum, gold, silver, bronze and catastrophic), required health plans participating in the Exchange to sell at least one product in all five benefit levels in the Exchange, required health plans participating in the Exchange to sell their Exchange products outside of the Exchange,

and required health plans that do not participate in the Exchange to sell at least one standardized product designated by the Exchange in each of the four levels of coverage, if the Exchange elects to standardize products.

AB 2042 (Feuer) of 2010 would have prohibited carriers from altering rates, as specified, or any benefits more than once per calendar year, for individual plan contracts and policies that are issued, amended, or renewed on or after January 1, 2011, with certain exceptions including allowing a plan or contract to lower premiums if it does not otherwise alter cost sharing or any benefits and if the reduction in premium is consistent with other provisions of state and federal law. *Vetoed.*

AB 2244 (Feuer)*, *Chapter 656, Statutes of 2010, requires guaranteed issue for children in 2011 and adults in 2014. Establishes standard individual market rating factors (age, geographic region, family composition and health benefit plan design). Limits premium variation for children's coverage until 2014 by requiring health plans and health insurers to use "rate bands" that limit premium variation to no more than a specified percentage of a standard rate for a child in each particular rating category and benefit plan for children who are in an open enrollment period.

AB 2578 (Jones and Feuer) of 2010 would have required health plans and insurers to file a complete rate application with DMHC and CDI for a rate increase that will become effective on or after January 1, 2012. Would have prohibited a health plan or insurer's premium rate (defined to include premiums, co-payments, coinsurance obligations, deductibles, and other charges) from being approved or remaining in effect that is excessive, inadequate, unfairly discriminatory, as specified. *Failed passage off the Senate Floor.*

SB 316 (Alquist) of 2009 would have, among other things, broadened an existing MLR disclosure requirement that currently applies to individuals and groups of 25 or fewer individuals, to instead apply to individuals and groups of 50 or fewer individuals. An earlier version of the bill contained similar MLR requirements to SB 51. *Failed passage out of Assembly Health Committee.*

AB 812 (De La Torre) of 2009 would have required health plans and health insurers to report to their respective regulators the MLR of each health care plan product or health insurance policy. *Failed passage out of Assembly Appropriations Committee.*

AB 1218 (Jones) of 2009 was substantively similar to AB 2578 (Jones and Feuer) of 2010. *Failed passage out of the Assembly Health Committee.*

SB 1440 (Kuehl) of 2008 was an identical measure to SB 316 as introduced. *Vetoed by the Governor.*

AB 1554 (Jones) of 2007 was substantively similar to AB 2578 (Jones and Feuer) of 2010 and AB 1219 (Jones) of 2009. *Failed passage out of Senate Health Committee.*

***ABX1 1 (Nunez)* of 2007** among its provisions, would have, on and after July 1, 2010, required full-service health plans and health insurers to expend no less than 85 percent of the after-tax revenues they receive from dues, fees, premiums, or other periodic

payments, on health care benefits. The bill would have allowed plans and insurers to average their administrative costs across all of the plans and insurance policies they offer, with the exception of Medicare supplement plans and policies and certain other limited benefit policies, and would have allowed DMHC and CDI to exclude any new contracts or policies from this limit for the first two years they are offered in California. "Health care benefits" would have been broadly defined to include the costs of programs or activities which improve the provision of health care services and improve health care outcomes, as well as disease management services, medical advice, and pay-for-performance payments. *Failed passage out of Senate Health Committee.*

***AB 8 (Nunez)* of 2007** contained similar provisions to ABX1 1 with regard to the amount health plans and health insurers would have been required to expend on health care benefits. *Vetoed by the Governor.*

SB 1591 (Kuehl) of 2006 would have prohibited health insurers from spending on administrative costs in any fiscal year an excessive amount of aggregate dues, fees, or other periodic payments received by the insurer. Provides, for purposes of the bill, that administrative costs include all costs identified in current regulations applying to health plans. Would have required CDI to develop regulations to implement the bill by January 1, 2008, and provided that the bill is to take effect on July 1, 2008. *These provisions were amended out of the bill.*

SB 425 (Ortiz) of 2006 would have required carriers to obtain prior approval for a rate increase, defined in a similar manner to rates under AB 1218 of 2009. *Failed passage out of Senate Health Committee.*

SB 26 (Figueroa) of 2004 would have required carriers to obtain prior approval of rate increases from DMHC and CDI, as specified, and would have potentially required significant refunds of premiums previously collected. *Failed passage out of the Senate Insurance Committee.*

AB 1672 (Margolin and Hansen), Chapter 1128, Statutes of 1992, enacted a number of reforms to the small group market, including guaranteed issue, renewability provisions, regulating pre-existing conditions limitations, underwriting protections, and disclosure requirements.

Arguments in support

Health Access California, co-sponsor of AB 1083, writes in support and states that this bill will make health insurance more available to 5.3 million small business owners, their employees and self-employed Californians. The Small Business Majority (SBM), the other co-sponsor of the bill, concurs and points out that California's small businesses have suffered from skyrocketing health insurance costs. SBM believes that it is critical to pass this legislation to strengthen safeguards in California as the bill eliminates the practice of determining rates based on health status, reins in rates based on age by limiting premiums that an older person must pay to a maximum of three times the amount a younger person pays, and guarantees coverage for the self-employed.

The Latino Health Alliance supports this bill because it conforms and phases-in new insurance market rules for small businesses, particularly so that small employers don't get additional premium spikes based on the health of their workforce.

CALPIRG argues that, by expanding guaranteed issue to self-employed individuals and sole proprietors, this bill gives individuals more mobility and spurs economic growth by allowing them to start new business ventures without the risk of losing coverage. CALPIRG also points out that the newly-included businesses, which are generally not sufficiently large to negotiate the good health insurance deals enjoyed by the largest businesses, will benefit from the protections in the small group market, including eligibility for the Exchange.

The California Medical Association agrees with the proponents that it is important to strengthen safeguards in California that are consistent with PPACA, and to make insurance more available to small business owners, their employees, and self-employed Californians.

Arguments in opposition
The California Association of Health Plans (CAHP) opposes this bill unless it is amended to carefully and precisely conform to federal law to avoid regulatory confusion, stating that California should use great caution in passing state laws intended to implement federal reform while so many questions about the details of the federal law are pending regulatory action by federal agencies. CAHP also argues that this bill is ambitious and notes that several provisions are not contained or differ from the federal law.

The Association of California Life and Health Insurance Companies (ACLHIC) concurs with CAHP, stating that it would be prudent to take a bit more time to await guidance from federal regulators before moving forward with implementing any changes to the small group market.

PRIOR ACTIONS

Assembly Health:	13- 6
Assembly Appropriations:	11- 6
Assembly Floor:	50- 27

COMMENTS

1. Recent amendments. Amendments taken recently by the author make the following changes:

a. **Effective date of existing law.** Changes the effective date of the some of the bill's changes from January 1, 2014 to December 31, 2013.
b. **Use of risk adjustment factors.** Clarify that there will be no risk adjustment factor used in the determination of rates effective January 1, 2014.
c. **References to PPACA.** Adds "to the extent permitted under (or consistent with) PPACA and any rules, regulations or guidance issued consistent with that law" throughout bill

d. **Definition of small group.** Changes the effective date of group size going up to 100, from January 1, 2017 to January 1, 2016, to be consistent with PPACA.
e. **Agent and broker provisions.** Deletes anti-steering provisions originally proposed and restores existing law.
f. **Waiting periods.** Clarifies that a waiting period of up to 90 days is permitted as a condition of employment if applied equally to all fulltime employees and if consistent with PPACA and any subsequent rules, regulations, and guidance.
g. **Disability insurance.** Defines "health insurance" in Insurance Code Section 106 to mean individual or group disability insurance policy that provides essential health benefits as defined consistent with Section 1302 of PPACA, but not grandfathered coverage.
h. **Other technical and clarifying changes,** such as correcting federal code references used in the bill and making parallel changes between the Insurance and Health & Safety Code provisions.

2. Effect of the bill. The bill largely conforms state law related to small group health insurance to federal requirements established in PPACA, except for the following provisions:

a. **Self-employed.** Federal and state law is silent on whether the self-employed individuals qualify as an individual or as an employer (for group coverage) in the context of the Exchange. AB 1083 would provide a choice to those self-employed individuals whose modified adjusted gross income is below 400 percent FPL and who receives at least 50 percent of their annual income from self-employment.
b. **Rating periods.** Current state law requires small group premium rates to be in effect no less than six months. AB 1083 would extend the rating period from six to twelve months. This is not addressed in federal law, but recent amendments specify that the rating period provision would be implemented to the extent permitted under federal laws and regulations.
c. **Notification requirements on carriers and solicitors.** This bill requires carriers to notify small employers that the actual rates are required to be the same for all small employers, and requires solicitors to notify the small employer of the availability of tax credits for certain employers, and beginning January 1, 2014, of the availability of coverage and tax credits through the Exchange.
d. **Carrier filing requirements.** AB 1083 requires carriers to file notices of material modification with their respective regulators at least 60 calendar days (rather than 20 business days) prior to renewing or amending a plan contract, to conform with rate review filing requirements established in SB 1163 (Leno), Chapter 661, Statutes of 2010.

3. Should the state implement the federal option to define small employers as 1 to 50? PPACA defines small employers as those with 1 to 100 employees beginning in 2014, but allows states the option to define small employers 1 to 50 employees between 2014 and 2016. AB 1083 defines small employers as 1 to 50 between 2014 and 2016, a change from 2 to 50 in existing law, and defines small employers as 1 to 100 after 2016. By phasing in the definition of 1 to 100 consistent with federal law, the author and sponsors believe that it would make the adjustment easier on the market.

4. Premium rating based on tobacco use or wellness incentives not allowed. PPACA also allows premium rating differences based on tobacco use or financial wellness incentives. The effect of the bill would prohibit premium rates to vary for smokers and for those who may qualify for plan or employer based wellness incentives.

5. Suggested technical amendments to provide references to federal law and subsequently issued federal rules, regulations or guidance:

(a) On page 9, line 10, after "month." insert:

"This subdivision shall be implemented to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law."

(b) On page 20, line 36, after "month." insert:

"This paragraph shall be implemented to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law."

(c) On page 62, line 10, after "month." insert:

"This subdivision shall be implemented to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law."

(d) On page 78, line 28, after "month." insert:

"This paragraph shall be implemented to the extent permitted under the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any rules, regulations, or guidance issued consistent with that law."

POSITIONS

Support:
Health Access California (co-sponsor)
Small Business Majority (co-sponsor)
California Medical Association
California Optometric Association
California Retired Teachers Association
CALPIRG
Congress of California Seniors
Latino Health Alliance

Oppose:
Association of California Life and Health Insurance Companies
California Association of Health Plans

-- END --