Assembly Bill No. 424

CHAPTER 799

An act to amend Sections 12670, 12671, and 12678 of, and to add Section 12692.5 to, the Insurance Code, relating to health insurance.

[Approved by Governor September 22, 2002. Filed with Secretary of State September 22, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

AB 424, Thomson. Health insurance: conversion coverage.

Existing law imposes requirements relating to the obligation of a health insurance issuer to provide coverage through a converted policy to certain individuals after they become ineligible for coverage through a group plan. Under existing law, these requirements pertain to a group health insurance policy issued, amended, or renewed on or after January 1, 1983.

This bill would specify that certain existing requirements to provide coverage through a converted policy do not apply to a group policy that is issued, amended, or renewed on or after September 1, 2003. The bill would provide that its provisions would become operative on September 1, 2003, only if this bill and AB 1401 are both enacted on or before January 1, 2003.

The people of the State of California do enact as follows:

SECTION 1. Section 12670 of the Insurance Code is amended to read:

12670. It is the intent of the Legislature to ensure that persons covered by a group policy, who become ineligible for that coverage have access to benefits pursuant to this part by requiring employers, employee organizations, and other entities that provide that coverage to their employees or members to also make available conversion policies for those persons and to ensure that insurers as herein defined offer conversion policies. The conversion policy shall be the most popular preferred provider organization product offered to residents of this state under the provisions of the federal Health Insurance Portability and Accountability Act of 1996. In addition, it is the intent of the Legislature to encourage the continuation of group health coverage by requiring the entities herein defined to make available continuation benefits for widows, widowers, divorced spouses, and dependents who were covered by the group policy on the date of termination of coverage.

SEC. 2. Section 12671 of the Insurance Code is amended to read:

12671. As used in this part:

(a) ''Group policy'' means a group health insurance policy providing medical, hospital, surgical, major medical, or comprehensive medical coverage issued by an insurer, a group contract issued by a hospital service corporation or medical, hospital, surgical, major medical, or comprehensive medical coverage otherwise provided by a policyholder to its employees or members, except for self-insurance programs provided by employers that are not exempt from ERISA, as specified in subdivision (i). For the purposes of this part, a group policy not having an established annual renewal date shall be considered renewed on each anniversary of its effective date.

(b) ''Conversion coverage'' means health insurance benefits providing hospital, surgical, major medical, or comprehensive medical coverage issued to an individual under a converted policy.

(c) ''Converted policy'' means a policy or contract providing conversion coverage issued by an insurance company or by a hospital service corporation, or individual hospital, surgical, major medical, or comprehensive medical coverage otherwise provided by a policyholder to its employees or members.

(d) ''Insurer'' means the entity issuing a group policy, an individual or converted policy, a hospital service contract or an employer or employee organization otherwise providing medical, hospital, surgical, major medical, or comprehensive medical coverage to its employees or members.

(e) ''Insurance'' refers to health insurance, major medical, or comprehensive coverage paid by premium or contribution under a group policy, a hospital service contract, or as otherwise provided by a policyholder to its employees or members other than by self-insuring except in the case of a plan that is exempt from ERISA, but does include an employer plan that is exempt from ERISA as specified in subdivision (i). ''Insurance'' does not include any of the following:

(1) Coverage provided solely as an accrued liability or by reason of a disability extension.

(2) Medicare supplement insurance.

(3) Vision-only insurance.

(4) Dental-only insurance.

(5) CHAMPUS supplement insurance.

(6) Hospital indemnity insurance.

(7) Accident-only insurance.

(8) Short-term limited duration health insurance. ''Short-term limited duration health insurance'' means individual health insurance coverage that is offered by a licensed insurance company, intended to be

used as transitional or interim coverage to remain in effect for not more than 185 days, that cannot be renewed or otherwise continued for more than one additional period of not more than 185 days, and that is not intended or marketed as health insurance coverage, a health care service plan, or a health maintenance organization subject to guaranteed issuance or guaranteed renewal pursuant to relevant state or federal law.

(9) Specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(f) ''Policyholder'' means the holder of a group policy issued by an insurer, a holder of a group contract issued by a hospital service corporation or an employer, employee association or other entity otherwise providing medical, hospital, surgical, major medical, or comprehensive medical coverage on a group basis to its employees or members.

(g) ''Premium'' means contribution or other consideration paid or payable for coverage under a group policy or converted policy.

(h) ''Medicare'' means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(i) ''Employer plan that is exempt from ERISA'' means any employer plan that, pursuant to the provisions of Section 1003 of Title 29 of the United States Code, is not covered by or that is exempt from the provisions of Subchapter I (commencing with Section 1001) of Chapter 18 of Title 29 of the United States Code, except that, in the case of a governmental plan, it only includes a self-insured governmental plan as defined in subdivision (h).

(j) ''Self-insured governmental plan'' means a self-insured plan established or maintained for its employees by any public entity, as defined in Section 811.2 of the Government Code, which is a governmental plan as defined in subdivision (32) of Section 1002 of Title 29 of the United States Code.

SEC. 3. Section 12678 of the Insurance Code is amended to read:

12678. The insurer shall not be required to issue a converted policy covering any person if any of the following exists:

(a) The person is covered for similar benefits by another individual policy.

(b) The person is covered or is eligible to be covered for similar benefits by another group policy.

(c) The person is covered or is eligible to be covered for similar benefits under any arrangement of coverage for persons in a group whether insured or uninsured.

SEC. 4. Section 12692.5 is added to the Insurance Code, to read:

12692.5. Notwithstanding any other provision of this part, Sections 12672, 12673, 12674, 12675, 12676, 12677, 12678, 12679, 12680, 12681, 12682, 12683, 12684, 12685, 12686, 12687, 12688, 12689, 12690, 12691, and 12692 shall not apply to a group policy that is issued, amended, or renewed on or after September 1, 2003.

SEC. 5. This act shall become operative on September 1, 2003, only if this act and Assembly Bill 1401 of the 2001–02 Regular Session are both enacted on or before January 1, 2003.

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