

**ASSEMBLY BILL**

**No. 2448**

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**Introduced by Assembly Member Dickerson**

February 21, 2002

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An act to amend Sections 10700 and 10733.5 of the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 2448, as introduced, Dickerson. Health care.

Existing law, the Health Insurance Plan of California, establishes a comprehensive scheme for providing health insurance coverage to employees of small employer groups and the dependents of those employees. Existing law defines the term “small employer” for those purposes to include a person and specified entities that are actively engaged in business and that employ on at least 50% of their working days during the preceding calendar quarter, or preceding calendar year, 2, but not more than 50, eligible employees.

This bill would provide that a person or entity that employs up to 200 employees under those conditions is a small employer for purposes of eligibility for the Health Insurance Plan of California. The bill would make related changes.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

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

- 1 SECTION 1. Section 10700 of the Insurance Code is
- 2 amended to read:
- 3 10700. As used in this chapter:

1 (a) “Agent or broker” means a person or entity licensed under  
2 Chapter 5 (commencing with Section 1621) of Part 2 of Division  
3 1.

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

15 (c) “Board” means the Major Risk Medical Insurance Board.

16 (d) “Carrier” means any disability insurance company or any  
17 other entity that writes, issues, or administers health benefit plans  
18 that cover the employees of small employers, regardless of the  
19 situs of the contract or master policyholder. For the purposes of  
20 Articles 3 (commencing with Section 10719) and 4 (commencing  
21 with Section 10730), “carrier” also includes health care service  
22 plans.

23 (e) “Dependent” means the spouse or child of an eligible  
24 employee, subject to applicable terms of the health benefit plan  
25 covering the employee, and includes dependents of guaranteed  
26 association members if the association elects to include  
27 dependents under its health coverage at the same time it determines  
28 its membership composition pursuant to subdivision (z).

29 (f) “Eligible employee” means either of the following:

30 (1) Any permanent employee who is actively engaged on a  
31 full-time basis in the conduct of the business of the small employer  
32 with a normal workweek of at least 30 hours, in the small  
33 employer’s regular place of business, who has met any statutorily  
34 authorized applicable waiting period requirements. The term  
35 includes sole proprietors or partners of a partnership, if they are  
36 actively engaged on a full-time basis in the small employer’s  
37 business, and they are included as employees under a health  
38 benefit plan of a small employer, but does not include employees  
39 who work on a part-time, temporary, or substitute basis. It includes  
40 any eligible employee as defined in this paragraph who obtains



1 coverage through a guaranteed association. Employees of  
2 employers purchasing through a guaranteed association shall be  
3 deemed to be eligible employees if they would otherwise meet the  
4 definition except for the number of persons employed by the  
5 employer. A permanent employee who works at least 20 hours but  
6 not more than 29 hours is deemed to be an eligible employee if all  
7 four of the following apply:

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

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

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

14 (D) The employee must have worked at least 20 hours per  
15 normal workweek for at least 50 percent of the weeks in the  
16 previous calendar quarter. The insurer may request any necessary  
17 information to document the hours and time period in question,  
18 including, but not limited to, payroll records and employee wage  
19 and tax filings.

20 (2) Any member of a guaranteed association as defined in  
21 subdivision (z).

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

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

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

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

32 (i) “Fund” means the California Small Group Reinsurance  
33 Fund.

34 (j) “Health benefit plan” means a policy or contract written or  
35 administered by a carrier that arranges or provides health care  
36 benefits for the covered eligible employees of a small employer  
37 and their dependents. The term does not include accident only,  
38 credit, disability income, coverage of Medicare services pursuant  
39 to contracts with the United States government, Medicare  
40 supplement, long-term care insurance, dental, vision, coverage



1 issued as a supplement to liability insurance, automobile medical  
2 payment insurance, or insurance under which benefits are payable  
3 with or without regard to fault and that is statutorily required to be  
4 contained in any liability insurance policy or equivalent  
5 self-insurance.

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

8 (l) “Late enrollee” means an eligible employee or dependent  
9 who has declined health coverage under a health benefit plan  
10 offered by a small employer at the time of the initial enrollment  
11 period provided under the terms of the health benefit plan, and who  
12 subsequently requests enrollment in a health benefit plan of that  
13 small employer, provided that the initial enrollment period shall be  
14 a period of at least 30 days. It also means any member of an  
15 association that is a guaranteed association as well as any other  
16 person eligible to purchase through the guaranteed association  
17 when that person has failed to purchase coverage during the initial  
18 enrollment period provided under the terms of the guaranteed  
19 association’s health benefit plan and who subsequently requests  
20 enrollment in the plan, provided that the initial enrollment period  
21 shall be a period of at least 30 days. However, an eligible  
22 employee, another person eligible for coverage through a  
23 guaranteed association pursuant to subdivision (z), or dependent  
24 shall not be considered a late enrollee if any of the following is  
25 applicable:

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

27 (A) He or she was covered under another employer health  
28 benefit plan or no share-of-cost Medi-Cal coverage at the time the  
29 individual was eligible to enroll.

30 (B) He or she certified at the time of the initial enrollment that  
31 coverage under another employer health benefit plan or no  
32 share-of-cost Medi-Cal coverage was the reason for declining  
33 enrollment provided that, if the individual was covered under  
34 another employer health plan, the individual was given the  
35 opportunity to make the certification required by this subdivision  
36 and was notified that failure to do so could result in later treatment  
37 as a late enrollee.

38 (C) He or she has lost or will lose coverage under another  
39 employer health benefit plan as a result of termination of  
40 employment of the individual or of a person through whom the



1 individual was covered as a dependent, change in employment  
2 status of the individual, or of a person through whom the  
3 individual was covered as a dependent, the termination of the other  
4 plan's coverage, cessation of an employer's contribution toward  
5 an employee or dependent's coverage, death of the person through  
6 whom the individual was covered as a dependent, legal separation,  
7 divorce, or loss of no share-of-cost Medi-Cal coverage.

8 (D) He or she requests enrollment within 30 days after  
9 termination of coverage or employer contribution toward  
10 coverage provided under another employer health benefit plan.

11 (2) The individual is employed by an employer who offers  
12 multiple health benefit plans and the individual elects a different  
13 plan during an open enrollment period.

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

16 (4) (A) In the case of an eligible employee as defined in  
17 paragraph (1) of subdivision (f), the carrier cannot produce a  
18 written statement from the employer stating that the individual or  
19 the person through whom an individual was eligible to be covered  
20 as a dependent, prior to declining coverage, was provided with,  
21 and signed acknowledgment of, an explicit written notice in  
22 boldface type specifying that failure to elect coverage during the  
23 initial enrollment period permits the carrier to impose, at the time  
24 of the individual's later decision to elect coverage, an exclusion  
25 from coverage for a period of 12 months as well as a six-month  
26 preexisting condition exclusion unless the individual meets the  
27 criteria specified in paragraph (1), (2), or (3).

28 (B) In the case of an eligible employee who is a guaranteed  
29 association member, the plan cannot produce a written statement  
30 from the guaranteed association stating that the association sent a  
31 written notice in boldface type to all potentially eligible  
32 association members at their last known address prior to the initial  
33 enrollment period informing members that failure to elect  
34 coverage during the initial enrollment period permits the plan to  
35 impose, at the time of the member's later decision to elect  
36 coverage, an exclusion from coverage for a period of 12 months  
37 as well as a six-month preexisting condition exclusion unless the  
38 member can demonstrate that he or she meets the requirements of  
39 subparagraphs (A), (C), and (D) of paragraph (1) or paragraph (2)  
40 or (3).



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

11 (5) The individual is an employee or dependent who meets the  
12 criteria described in paragraph (1) and was under a COBRA  
13 continuation provision and the coverage under that provision has  
14 been exhausted. For purposes of this section, the definition of  
15 “COBRA” set forth in subdivision (e) of Section 1373.62 shall  
16 apply.

17 (6) The individual is a dependent of an enrolled eligible  
18 employee who has lost or will lose his or her no share-of-cost  
19 Medi-Cal coverage and requests enrollment within 30 days after  
20 notification of this loss of coverage.

21 (7) The individual is an eligible employee who previously  
22 declined coverage under an employer health benefit plan and who  
23 has subsequently acquired a dependent who would be eligible for  
24 coverage as a dependent of the employee through marriage, birth,  
25 adoption, or placement for adoption, and who enrolls for coverage  
26 under that employer health benefit plan on his or her behalf, and  
27 on behalf of his or her dependent within 30 days following the date  
28 of marriage, birth, adoption, or placement for adoption, in which  
29 case the effective date of coverage shall be the first day of the  
30 month following the date the completed request for enrollment is  
31 received in the case of marriage, or the date of birth, or the date of  
32 adoption or placement for adoption, whichever applies. Notice of  
33 the special enrollment rights contained in this paragraph shall be  
34 provided by the employer to an employee at or before the time the  
35 employee is offered an opportunity to enroll in plan coverage.

36 (8) The individual is an eligible employee who has declined  
37 coverage for himself or herself or his or her dependents during a  
38 previous enrollment period because his or her dependents were  
39 covered by another employer health benefit plan at the time of the  
40 previous enrollment period. That individual may enroll himself or



1 herself or his or her dependents for plan coverage during a special  
2 open enrollment opportunity if his or her dependents have lost or  
3 will lose coverage under that other employer health benefit plan.  
4 The special open enrollment opportunity shall be requested by the  
5 employee not more than 30 days after the date that the other health  
6 coverage is exhausted or terminated. Upon enrollment, coverage  
7 shall be effective not later than the first day of the first calendar  
8 month beginning after the date the request for enrollment is  
9 received. Notice of the special enrollment rights contained in this  
10 paragraph shall be provided by the employer to an employee at or  
11 before the time the employee is offered an opportunity to enroll in  
12 plan coverage.

13 (m) “New business” means a health benefit plan issued to a  
14 small employer that is not the carrier’s in force business.

15 (n) “Participating carrier” means a carrier that has entered into  
16 a contract with the program to provide health benefits coverage  
17 under this part.

18 (o) “Plan of operation” means the plan of operation of the  
19 fund, including articles, bylaws and operating rules adopted by the  
20 fund pursuant to Article 3 (commencing with Section 10719).

21 (p) “Program” means the Health Insurance Plan of California.

22 (q) “Preexisting condition provision” means a policy  
23 provision that excludes coverage for charges or expenses incurred  
24 during a specified period following the insured’s effective date of  
25 coverage, as to a condition for which medical advice, diagnosis,  
26 care, or treatment was recommended or received during a  
27 specified period immediately preceding the effective date of  
28 coverage.

29 (r) “Creditable coverage” means:

30 (1) Any individual or group policy, contract, or program, that  
31 is written or administered by a disability insurer, health care  
32 service plan, fraternal benefits society, self-insured employer plan,  
33 or any other entity, in this state or elsewhere, and that arranges or  
34 provides medical, hospital, and surgical coverage not designed to  
35 supplement other private or governmental plans. The term  
36 includes continuation or conversion coverage but does not include  
37 accident only, credit, coverage for onsite medical clinics,  
38 disability income, Medicare supplement, long-term care, dental,  
39 vision, coverage issued as a supplement to liability insurance,  
40 insurance arising out of a workers’ compensation or similar law,



1 automobile medical payment insurance, or insurance under which  
2 benefits are payable with or without regard to fault and that is  
3 statutorily required to be contained in any liability insurance  
4 policy or equivalent self-insurance.

5 (2) The federal Medicare program pursuant to Title XVIII of  
6 the Social Security Act.

7 (3) The medicaid program pursuant to Title XIX of the Social  
8 Security Act.

9 (4) Any other publicly sponsored program, provided in this  
10 state or elsewhere, of medical, hospital, and surgical care.

11 (5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071)  
12 (Civilian Health and Medical Program of the Uniformed Services  
13 (CHAMPUS)).

14 (6) A medical care program of the Indian Health Service or of  
15 a tribal organization.

16 (7) A state health benefits risk pool.

17 (8) A health plan offered under 5 U.S.C.A. Chapter 89  
18 (commencing with Section 8901) (Federal Employees Health  
19 Benefits Program (FEHBP)).

20 (9) A public health plan as defined in federal regulations  
21 authorized by Section 2701(c)(1)(I) of the Public Health Service  
22 Act, as amended by Public Law 104-191, the Health Insurance  
23 Portability and Accountability Act of 1996.

24 (10) A health benefit plan under Section 5(e) of the Peace  
25 Corps Act (22 U.S.C.A. Sec. 2504(e)).

26 (11) Any other creditable coverage as defined by subdivision  
27 (c) of Section 2701 of Title XXVII of the federal Public Health  
28 Services Act (42 U.S.C. Sec. 300gg(c)).

29 (s) "Rating period" means the period for which premium rates  
30 established by a carrier are in effect and shall be no less than six  
31 months.

32 (t) "Risk adjusted employee risk rate" means the rate  
33 determined for an eligible employee of a small employer in a  
34 particular risk category after applying the risk adjustment factor.

35 (u) "Risk adjustment factor" means the percent adjustment to  
36 be applied equally to each standard employee risk rate for a  
37 particular small employer, based upon any expected deviations  
38 from standard claims. This factor may not be more than 120  
39 percent or less than 80 percent until July 1, 1996. Effective July 1,



1 1996, this factor may not be more than 110 percent or less than 90  
2 percent.

3 (v) “Risk category” means the following characteristics of an  
4 eligible employee: age, geographic region, and family size of the  
5 employee, plus the benefit plan design selected by the small  
6 employer.

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

9 Under 30

10 30–39

11 40–49

12 50–54

13 55–59

14 60–64

15 65 and over

16 However, for the 65 and over age category, separate premium  
17 rates may be specified depending upon whether coverage under  
18 the health benefit plan will be primary or secondary to benefits  
19 provided by the federal Medicare program pursuant to Title XVIII  
20 of the federal Social Security Act.

21 (2) Small employer carriers shall base rates to small employers  
22 using no more than the following family size categories:

23 (A) Single.

24 (B) Married couple.

25 (C) One adult and child or children.

26 (D) Married couple and child or children.

27 (3) (A) In determining rates for small employers, a carrier that  
28 operates statewide shall use no more than nine geographic regions  
29 in the state, have no region smaller than an area in which the first  
30 three digits of all its ZIP Codes are in common within a county and  
31 shall divide no county into more than two regions. Carriers shall  
32 be deemed to be operating statewide if their coverage area includes  
33 90 percent or more of the state’s population. Geographic regions  
34 established pursuant to this section shall, as a group, cover the  
35 entire state, and the area encompassed in a geographic region shall  
36 be separate and distinct from areas encompassed in other  
37 geographic regions. Geographic regions may be noncontiguous.

38 (B) In determining rates for small employers, a carrier that does  
39 not operate statewide shall use no more than the number of  
40 geographic regions in the state than is determined by the following



1 formula: the population, as determined in the last federal census,  
2 of all counties which are included in their entirety in a carrier's  
3 service area divided by the total population of the state, as  
4 determined in the last federal census, multiplied by nine. The  
5 resulting number shall be rounded to the nearest whole integer. No  
6 region may be smaller than an area in which the first three digits  
7 of all its ZIP Codes are in common within a county and no county  
8 may be divided into more than two regions. The area encompassed  
9 in a geographic region shall be separate and distinct from areas  
10 encompassed in other geographic regions. Geographic regions  
11 may be noncontiguous. No carrier shall have less than one  
12 geographic area.

13 (w) "Small employer" means either of the following:

14 (1) Any person, proprietary or nonprofit firm, corporation,  
15 partnership, public agency, or association that is actively engaged  
16 in business or service that, on at least 50 percent of its working days  
17 during the preceding calendar quarter, or preceding calendar year,  
18 employed at least two, but not more than ~~50~~ 200, eligible  
19 employees, the majority of whom were employed within this state,  
20 that was not formed primarily for purposes of buying health  
21 insurance and in which a bona fide employer-employee  
22 relationship exists. In determining whether to apply the calendar  
23 quarter or calendar year test, the insurer shall use the test that  
24 ensures eligibility if only one test would establish eligibility.  
25 However, for purposes of subdivisions (b) and (h) of Section  
26 10705, the definition shall include employers with at least three  
27 eligible employees until July 1, 1997, and two eligible employees  
28 thereafter. In determining the number of eligible employees,  
29 companies that are affiliated companies and that are eligible to file  
30 a combined income tax return for purposes of state taxation shall  
31 be considered one employer. Subsequent to the issuance of a health  
32 benefit plan to a small employer pursuant to this chapter, and for  
33 the purpose of determining eligibility, the size of a small employer  
34 shall be determined annually. Except as otherwise specifically  
35 provided, provisions of this chapter that apply to a small employer  
36 shall continue to apply until the health benefit plan anniversary  
37 following the date the employer no longer meets the requirements  
38 of this definition. It includes any small employer as defined in this  
39 paragraph who purchases coverage through a guaranteed



1 association, and any employer purchasing coverage for employees  
2 through a guaranteed association.

3 (2) Any guaranteed association, as defined in subdivision (y),  
4 that purchases health coverage for members of the association.

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

8 (y) “Guaranteed association” means a nonprofit organization  
9 comprised of a group of individuals or employers who associate  
10 based solely on participation in a specified profession or industry,  
11 accepting for membership any individual or employer meeting its  
12 membership criteria which (1) includes one or more small  
13 employers as defined in paragraph (1) of subdivision (w), (2) does  
14 not condition membership directly or indirectly on the health or  
15 claims history of any person, (3) uses membership dues solely for  
16 and in consideration of the membership and membership benefits,  
17 except that the amount of the dues shall not depend on whether the  
18 member applies for or purchases insurance offered by the  
19 association, (4) is organized and maintained in good faith for  
20 purposes unrelated to insurance, (5) has been in active existence  
21 on January 1, 1992, and for at least five years prior to that date, (6)  
22 has been offering health insurance to its members for at least five  
23 years prior to January 1, 1992, (7) has a constitution and bylaws,  
24 or other analogous governing documents that provide for election  
25 of the governing board of the association by its members, (8) offers  
26 any benefit plan design that is purchased to all individual members  
27 and employer members in this state, (9) includes any member  
28 choosing to enroll in the benefit plan design offered to the  
29 association provided that the member has agreed to make the  
30 required premium payments, and (10) covers at least 1,000  
31 persons with the carrier with which it contracts. The requirement  
32 of 1,000 persons may be met if component chapters of a statewide  
33 association contracting separately with the same carrier cover at  
34 least 1,000 persons in the aggregate.

35 This subdivision applies regardless of whether a master policy  
36 by an admitted insurer is delivered directly to the association or a  
37 trust formed for or sponsored by an association to administer  
38 benefits for association members.

39 For purposes of this subdivision, an association formed by a  
40 merger of two or more associations after January 1, 1992, and



1 otherwise meeting the criteria of this subdivision shall be deemed  
2 to have been in active existence on January 1, 1992, if its  
3 predecessor organizations had been in active existence on January  
4 1, 1992, and for at least five years prior to that date and otherwise  
5 met the criteria of this subdivision.

6 (z) “Members of a guaranteed association” means any  
7 individual or employer meeting the association’s membership  
8 criteria if that person is a member of the association and chooses  
9 to purchase health coverage through the association. At the  
10 association’s discretion, it may also include employees of  
11 association members, association staff, retired members, retired  
12 employees of members, and surviving spouses and dependents of  
13 deceased members. However, if an association chooses to include  
14 those persons as members of the guaranteed association, the  
15 association must so elect in advance of purchasing coverage from  
16 a plan. Health plans may require an association to adhere to the  
17 membership composition it selects for up to 12 months.

18 (aa) “Affiliation period” means a period that, under the terms  
19 of the health benefit plan, must expire before health care services  
20 under the plan become effective.

21 SEC. 2. Section 10733.5 of the Insurance Code is amended to  
22 read:

23 10733.5. Notwithstanding any other provision of law, an  
24 employer purchasing coverage through the program shall not be  
25 ~~determined to be no longer~~ eligible to participate in the program  
26 ~~solely because if~~ the employer employs more than ~~50~~ eligible  
27 ~~employees, provided the employer employs no more than 100~~ 200  
28 eligible employees.

