

AMENDED IN ASSEMBLY JUNE 18, 2001

AMENDED IN SENATE APRIL 16, 2001

SENATE BILL

No. 454

**Introduced by Committee on Insurance (Senators Speier
(Chair), Escutia, Figueroa, Johnson, Oller, Scott, and Soto)**

February 22, 2001

An act to amend Sections 106 and 10198.6 of the Insurance Code, relating to disability insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 454, as amended, Committee on Insurance. Disability insurance: health insurance definition.

Existing law defines disability insurance to include insurance appertaining to injury, disablement, or death resulting from accidents or sickness.

This bill would define the term "health insurance" as a disability insurance policy that provides coverage for hospital, medical, or surgical benefits but does not include certain kinds of insurance. ~~The bill would also define the term "specialized health insurance" as a disability insurance policy that provides coverage for hospital, medical, or surgical benefits under specified kinds of insurance and would specify that new coverage benefits mandated by a statute that is effective on or after January 1, 2002, shall apply to a specialized health insurance policy despite the statute exempting these policies from its provisions, if the new mandated coverage benefit is included under the general terms and conditions of the specialized health insurance policy.~~ The bill would also make a related change.

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 106 of the Insurance Code is amended
2 to read:

3 106. (a) Disability insurance includes insurance appertaining
4 to injury, disablement or death resulting to the insured from
5 accidents, and appertaining to disablements resulting to the
6 insured from sickness.

7 (b) In statutes that become effective on or after January 1, 2002,
8 the term “health insurance” for purposes of this code means an
9 individual or group disability insurance policy that provides
10 coverage for hospital, medical, or surgical benefits. The term
11 “health insurance” does not include any of the following kinds of
12 insurance:

13 (1) Accidental death and accidental death and dismemberment.

14 ~~(2) Automobile medical payments insurance.~~

15 (2) *Hospital indemnity, accident only, and specified disease*
16 *insurance that pays benefits on a cash basis, either through a*
17 *lump-sum or periodic payment method, without regard to a claim*
18 *for reimbursement for services performed by a health care*
19 *provider or institution.*

20 (3) Credit disability, as defined in subdivision (2) of Section
21 779.2.

22 (4) Coverage of Medicare services pursuant to contracts with
23 the United States government.

24 (5) Dental or vision coverage issued as a supplement to liability
25 insurance.

26 (6) Disability income, as defined in subdivision (i) of Section
27 799.01.

28 (7) Insurance under which benefits are payable with or without
29 regard to fault and that is statutorily required to be contained in any
30 liability insurance policy or equivalent self-insurance.

31 (8) Insurance arising out of a workers’ compensation or similar
32 law.

33 (9) Long-term care.

34 ~~(c) In statutes that become effective on or after January 1, 2002,~~
35 ~~the term “specialized health insurance” for purposes of this code~~



1 ~~means an individual or group disability insurance policy that~~
2 ~~provides coverage for hospital, medical, or surgical benefits~~
3 ~~pursuant to subdivision (b) under the following kinds of insurance:~~

- 4 ~~(1) Dental only.~~
- 5 ~~(2) Vision only.~~
- 6 ~~(3) Medicare supplement.~~
- 7 ~~(4) CHAMPUS supplement.~~
- 8 ~~(5) Accident only.~~
- 9 ~~(6) Specified disease.~~
- 10 ~~(7) Hospital confinement indemnity.~~

11 ~~(d) For statutes that become effective on or after January 1,~~
12 ~~2002, and that mandate new coverage benefits in individual or~~
13 ~~group health insurance policies, as defined in subdivision (b), but~~
14 ~~exempt specialized health insurance policies, as defined in~~
15 ~~subdivision (c), the exemption shall not apply if the new, mandated~~
16 ~~coverage benefit is included under the general terms and~~
17 ~~conditions of the specialized health insurance policy.~~

18 SEC. 2. Section 10198.6 of the Insurance Code is amended to
19 read:

20 10198.6. For purposes of this article:

21 (a) “Health benefit plan” means any group or individual policy
22 or contract that provides medical, hospital, or surgical benefits.
23 The term does not include accident only, credit, disability income,
24 coverage of Medicare services pursuant to contracts with the
25 United States government, Medicare supplement, long-term care
26 insurance, dental, vision, coverage issued as a supplement to
27 liability insurance, insurance arising out of a workers’
28 compensation or similar law, automobile medical payment
29 insurance, or insurance under which benefits are payable with or
30 without regard to fault and that is statutorily required to be
31 contained in any liability insurance policy or equivalent
32 self-insurance.

33 (b) “Late enrollee” means an eligible employee or dependent
34 who has declined health coverage under a health benefit plan
35 offered through employment or sponsored by an employer at the
36 time of the initial enrollment period provided under the terms of
37 the health benefit plan, and who subsequently requests enrollment
38 in a health benefit plan of that employer; provided that the initial
39 enrollment period shall be a period of at least 30 days. However,



1 an eligible employee or dependent shall not be considered a late
2 enrollee if any of the following is applicable:

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

4 (A) The individual was covered under another employer health
5 benefit plan or no share-of-cost Medi-Cal coverage at the time the
6 individual was eligible to enroll.

7 (B) The individual certified, at the time of the initial enrollment
8 that coverage under another employer health benefit plan or no
9 share-of-cost Medi-Cal coverage was the reason for declining
10 enrollment provided that, if the individual was covered under
11 another employer health benefit plan, the individual was given the
12 opportunity to make the certification required by this subdivision
13 and was notified that failure to do so could result in later treatment
14 as a late enrollee.

15 (C) The individual has lost or will lose coverage under another
16 employer health benefit plan as a result of termination of
17 employment of the individual or of a person through whom the
18 individual was covered as a dependent, change in employment
19 status of the individual or of a person through whom the individual
20 was covered as a dependent, termination of the other plan's
21 coverage, cessation of an employer's contribution toward an
22 employee or dependent's coverage, death of a person through
23 whom the individual was covered as a dependent, legal separation,
24 divorce, or loss of no share-of-cost Medi-Cal coverage.

25 (D) The individual requests enrollment within 30 days after
26 termination of coverage, or cessation of employer contribution
27 toward coverage provided under another employer health benefit
28 plan.

29 (2) The individual is employed by an employer that offers
30 multiple health benefit plans and the individual elects a different
31 plan during an open enrollment period.

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

34 (4) The carrier cannot produce a written statement from the
35 employer stating that, prior to declining coverage, the individual
36 or the person through whom the individual was eligible to be
37 covered as a dependent was provided with, and signed
38 acknowledgment of, explicit written notice in boldface type
39 specifying that failure to elect coverage during the initial
40 enrollment period permits the carrier to impose, at the time of the



1 individual’s later decision to elect coverage, an exclusion from
2 coverage for a period of 12 months as well as a six-month
3 preexisting condition exclusion, unless the individual meets the
4 criteria specified in paragraph (1), (2), or (3).

5 (5) The individual is an employee or dependent who meets the
6 criteria described in paragraph (1) and was under a COBRA
7 continuation provision and the coverage under that provision has
8 been exhausted. For purposes of this section, the definition of
9 “COBRA” set forth in subdivision (e) of Section 10116.5 shall
10 apply.

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

15 (c) “Preexisting condition provision” means a policy
16 provision that excludes coverage for charges or expenses incurred
17 during a specified period following the insured’s effective date of
18 coverage, as to a condition for which medical advice, diagnosis,
19 care, or treatment was recommended or received during a
20 specified period immediately preceding the effective date of
21 coverage.

22 (d) “Creditable coverage” means:

23 (1) Any individual or group policy, contract or program, that is
24 written or administered by a disability insurance company, health
25 care service plan, fraternal benefits society, self-insured employer
26 plan, or any other entity, in this state or elsewhere, and that
27 arranges or provides medical, hospital, and surgical coverage not
28 designed to supplement other private or governmental plans. The
29 term includes continuation or conversion coverage but does not
30 include accident only, credit, coverage for onsite medical clinics,
31 disability income, Medicare supplement, long-term care
32 insurance, dental, vision, coverage issued as a supplement to
33 liability insurance, insurance arising out of a workers’
34 compensation or similar law, automobile medical payment
35 insurance, or insurance under which benefits are payable with or
36 without regard to fault and that is statutorily required to be
37 contained in any liability insurance policy or equivalent
38 self-insurance.

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



- 1 (3) The medicaid program pursuant to Title XIX of the Social
2 Security Act.
- 3 (4) Any other publicly sponsored program, provided in this
4 state or elsewhere, of medical, hospital and surgical care.
- 5 (5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071)
6 (Civilian Health and Medical Program of the Uniformed Services
7 (CHAMPUS)).
- 8 (6) A medical care program of the Indian Health Service or of
9 a tribal organization.
- 10 (7) A state health benefits risk pool.
- 11 (8) A health plan offered under 5 U.S.C.A. Chapter 89
12 (commencing with Section 8901) (Federal Employees Health
13 Benefits Program (FEHBP)).
- 14 (9) A public health plan as defined in federal regulations
15 authorized by Section 2701(c)(1)(I) of the Public Health Service
16 Act, as amended by Public Law 104-191, the Health Insurance
17 Portability and Accountability Act of 1996.
- 18 (10) A health benefit plan under Section 5(e) of the Peace
19 Corps Act (22 U.S.C.A. Sec. 2504(e)).
- 20 (11) Any other creditable coverage as defined by subsection (c)
21 of Section 2701 of Title XXVII of the federal Public Health
22 Services Act (42 U.S.C. Sec. 300gg(c)).
- 23 (e) “Affiliation period” means a period that, under the terms
24 of the health benefit plan, must expire before health care services
25 under the plan become effective.
- 26 (f) “Waivered condition” means a contract provision that
27 excludes coverage for charges or expenses incurred during a
28 specified period of time for one or more specific, identified,
29 medical conditions.

