

AMENDED IN ASSEMBLY APRIL 9, 2007

AMENDED IN ASSEMBLY MARCH 26, 2007

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 799

Introduced by Assembly Member Smyth
(Coauthor: Senator Runner)

February 22, 2007

An act to amend Section 1357.02 of the Health and Safety Code, and to amend Section 10700 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 799, as amended, Smyth. Health care coverage: small employers.

Existing law provides for the regulation of health care service plans by the Department of Managed Health Care, and for the regulation of health insurers by the Insurance Commissioner. Existing law imposes various requirements on health care service plans and health insurers with respect to small employer coverage and specifies that those requirements do not apply to certain forms of coverage, as specified.

This bill would additionally provide that those requirements do not apply to ~~a policy, a rider, or a contract, as specified, offered to a small employer in conjunction with a health benefit plan or health care services, as specified, in order to promote wellness and healthy lifestyles~~ *program of services and incentives offered to a small employer, separate and apart from a contract or policy for health care services or benefits, as specified, designed to promote wellness and healthy lifestyles.*

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 1357.02 of the Health and Safety Code
2 is amended to read:

3 1357.02. (a) A health care service plan providing or arranging
4 for the provision of basic health care services to small employers
5 shall be subject to this article if either of the following conditions
6 are met:

7 (1) A portion of the premium is paid by a small employer, or
8 a covered individual is reimbursed, whether through wage
9 adjustments or otherwise, by a small employer for a portion of the
10 premium.

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

14 (b) This article shall not apply to health plan contracts for
15 coverage of Medicare services pursuant to contracts with the United
16 States government, Medicare supplement, Medi-Cal contracts with
17 the State Department of Health Services, long-term care coverage,
18 specialized health plan contracts, ~~or a contract offered to a small~~
19 ~~employer in conjunction with a health benefit plan or basic health~~
20 ~~care services in order to promote wellness and healthy lifestyles.~~
21 ~~or a program of services and incentives offered to a small employer~~
22 ~~separate and apart from a plan contract for basic health care~~
23 ~~services that is designed to promote wellness and healthy lifestyles.~~

24 SEC. 2. Section 10700 of the Insurance Code is amended to
25 read:

26 10700. As used in this chapter:

27 (a) “Agent or broker” means a person or entity licensed under
28 Chapter 5 (commencing with Section 1621) of Part 2 of Division
29 1.

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

1 which has significant incentives for the covered individuals to use
2 the system.

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

4 (d) “Carrier” means a disability insurance company or any other
5 entity that writes, issues, or administers health benefit plans that
6 cover the employees of small employers, regardless of the situs of
7 the contract or master policyholder. For the purposes of Articles
8 3 (commencing with Section 10719) and 4 (commencing with
9 Section 10730), “carrier” also includes health care service plans.

10 (e) “Dependent” means the spouse or child of an eligible
11 employee, subject to applicable terms of the health benefit plan
12 covering the employee, and includes dependents of guaranteed
13 association members if the association elects to include dependents
14 under its health coverage at the same time it determines its
15 membership composition pursuant to subdivision (z).

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

17 (1) A permanent employee who is actively engaged on a
18 full-time basis in the conduct of the business of the small employer
19 with a normal workweek of at least 30 hours, in the small
20 employer’s regular place of business, who has met any statutorily
21 authorized applicable waiting period requirements. The term
22 includes sole proprietors or partners of a partnership, if they are
23 actively engaged on a full-time basis in the small employer’s
24 business, and they are included as employees under a health benefit
25 plan of a small employer, but does not include employees who
26 work on a part-time, temporary, or substitute basis. It includes an
27 eligible employee as defined in this paragraph who obtains
28 coverage through a guaranteed association. Employees of
29 employers purchasing through a guaranteed association shall be
30 deemed to be eligible employees if they would otherwise meet the
31 definition except for the number of persons employed by the
32 employer. A permanent employee who works at least 20 hours but
33 not more than 29 hours is deemed to be an eligible employee if all
34 four of the following apply:

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

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

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

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

7 (2) A member of a guaranteed association as defined in
8 subdivision (z).

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

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

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

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

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

20 (j) “Health benefit plan” means a policy or contract written or
21 administered by a carrier that arranges or provides health care
22 benefits for the covered eligible employees of a small employer
23 and their dependents. The term does not include accident only,
24 credit, disability income, coverage of Medicare services pursuant
25 to contracts with the United States government, Medicare
26 supplement, long-term care insurance, dental, vision, coverage
27 issued as a supplement to liability insurance, automobile medical
28 payment insurance, insurance under which benefits are payable
29 with or without regard to fault and that is statutorily required to
30 be contained in a liability insurance policy or equivalent
31 self-insurance, ~~or a policy or rider offered to a small employer in
32 conjunction with a health benefit plan in order to promote wellness
33 and healthy lifestyles. or a program of services and incentives
34 offered to a small employer separate and apart from a policy or
35 contract of health care benefits that is designed to promote wellness
36 and healthy lifestyles.~~

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

39 (l) “Late enrollee” means an eligible employee or dependent
40 who has declined health coverage under a health benefit plan

1 offered by a small employer at the time of the initial enrollment
2 period provided under the terms of the health benefit plan, and
3 who subsequently requests enrollment in a health benefit plan of
4 that small employer, provided that the initial enrollment period
5 shall be a period of at least 30 days. It also means a member of an
6 association that is a guaranteed association as well as any other
7 person eligible to purchase through the guaranteed association
8 when that person has failed to purchase coverage during the initial
9 enrollment period provided under the terms of the guaranteed
10 association's health benefit plan and who subsequently requests
11 enrollment in the plan, provided that the initial enrollment period
12 shall be a period of at least 30 days. However, an eligible
13 employee, another person eligible for coverage through a
14 guaranteed association pursuant to subdivision (z), or an eligible
15 dependent shall not be considered a late enrollee if any of the
16 following is applicable:

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

18 (A) He or she was covered under another employer health
19 benefit plan, the Healthy Families Program, or no share-of-cost
20 Medi-Cal coverage at the time the individual was eligible to enroll.

21 (B) He or she certified at the time of the initial enrollment that
22 coverage under another employer health benefit plan, the Healthy
23 Families Program, or no share-of-cost Medi-Cal coverage was the
24 reason for declining enrollment provided that, if the individual
25 was covered under another employer health plan, the individual
26 was given the opportunity to make the certification required by
27 this subdivision and was notified that failure to do so could result
28 in later treatment as a late enrollee.

29 (C) He or she has lost or will lose coverage under another
30 employer health benefit plan as a result of termination of
31 employment of the individual or of a person through whom the
32 individual was covered as a dependent, change in employment
33 status of the individual, or of a person through whom the individual
34 was covered as a dependent, the termination of the other plan's
35 coverage, cessation of an employer's contribution toward an
36 employee or dependent's coverage, death of the person through
37 whom the individual was covered as a dependent, legal separation,
38 divorce, loss of coverage under the Healthy Families Program as
39 a result of exceeding the program's income or age limits, or loss
40 of no share-of-cost Medi-Cal coverage.

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

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

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

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

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

34 (C) In the case of an employer or person who is not a member
35 of an association, was eligible to purchase coverage through a
36 guaranteed association, and did not do so, and would not be eligible
37 to purchase guaranteed coverage unless purchased through a
38 guaranteed association, the employer or person can demonstrate
39 that he or she meets the requirements of subparagraphs (A), (C),
40 and (D) of paragraph (1), or meets the requirements of paragraph

1 (2) or (3), or that he or she recently had a change in status that
2 would make him or her eligible and that application for coverage
3 was made within 30 days of the change.

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

10 (6) The individual is a dependent of an enrolled eligible
11 employee who has lost or will lose his or her coverage under the
12 Healthy Families Program as a result of exceeding the program’s
13 income or age limits or no share-of-cost Medi-Cal coverage and
14 requests enrollment within 30 days after notification of this loss
15 of coverage.

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

31 (8) The individual is an eligible employee who has declined
32 coverage for himself or herself or his or her dependents during a
33 previous enrollment period because his or her dependents were
34 covered by another employer health benefit plan at the time of the
35 previous enrollment period. That individual may enroll himself or
36 herself or his or her dependents for plan coverage during a special
37 open enrollment opportunity if his or her dependents have lost or
38 will lose coverage under that other employer health benefit plan.
39 The special open enrollment opportunity shall be requested by the
40 employee not more than 30 days after the date that the other health

1 coverage is exhausted or terminated. Upon enrollment, coverage
2 shall be effective not later than the first day of the first calendar
3 month beginning after the date the request for enrollment is
4 received. Notice of the special enrollment rights contained in this
5 paragraph shall be provided by the employer to an employee at or
6 before the time the employee is offered an opportunity to enroll
7 in plan coverage.

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

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

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

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

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

23 (r) “Creditable coverage” means:

24 (1) An individual or group policy, contract, or program, that is
25 written or administered by a disability insurer, health care service
26 plan, fraternal benefits society, self-insured employer plan, or any
27 other entity, in this state or elsewhere, and that arranges or provides
28 medical, hospital, and surgical coverage not designed to supplement
29 other private or governmental plans. The term includes continuation
30 or conversion coverage but does not include accident only, credit,
31 coverage for onsite medical clinics, disability income, Medicare
32 supplement, long-term care, dental, vision, coverage issued as a
33 supplement to liability insurance, insurance arising out of a
34 workers’ 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 a 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 state
4 or elsewhere, of medical, hospital, and surgical care.
- 5 (5) 10 U.S.C. 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. 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 Corps
19 Act (22 U.S.C. Sec. 2504(e)).
- 20 (11) Any other creditable coverage as defined by subdivision
21 (c) of Section 2701 of Title XXVII of the federal Public Health
22 Services Act (42 U.S.C. Sec. 300gg(c)).
- 23 (s) "Rating period" means the period for which premium rates
24 established by a carrier are in effect and shall be no less than six
25 months.
- 26 (t) "Risk adjusted employee risk rate" means the rate determined
27 for an eligible employee of a small employer in a particular risk
28 category after applying the risk adjustment factor.
- 29 (u) "Risk adjustment factor" means the percent adjustment to
30 be applied equally to each standard employee risk rate for a
31 particular small employer, based upon any expected deviations
32 from standard claims. This factor may not be more than 120 percent
33 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
34 this factor may not be more than 110 percent or less than 90
35 percent.
- 36 (v) "Risk category" means the following characteristics of an
37 eligible employee: age, geographic region, and family size of the
38 employee, plus the benefit plan design selected by the small
39 employer.

- 1 (1) No more than the following age categories may be used in
- 2 determining premium rates:
- 3 Under 30
- 4 30–39
- 5 40–49
- 6 50–54
- 7 55–59
- 8 60–64
- 9 65 and over

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

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

- 17 (A) Single.
- 18 (B) Married couple.
- 19 (C) One adult and child or children.
- 20 (D) Married couple and child or children.

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

32 (B) In determining rates for small employers, a carrier that does
33 not operate statewide shall use no more than the number of
34 geographic regions in the state than is determined by the following
35 formula: the population, as determined in the last federal census,
36 of all counties that are included in their entirety in a carrier’s
37 service area divided by the total population of the state, as
38 determined in the last federal census, multiplied by nine. The
39 resulting number shall be rounded to the nearest whole integer.
40 No region may be smaller than an area in which the first three

1 digits of all its ZIP Codes are in common within a county and no
2 county may be divided into more than two regions. The area
3 encompassed in a geographic region shall be separate and distinct
4 from areas encompassed in other geographic regions. Geographic
5 regions may be noncontiguous. No carrier shall have less than one
6 geographic area.

7 (w) “Small employer” means either of the following:

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

36 (2) A guaranteed association, as defined in subdivision (y), that
37 purchases health coverage for members of the association.

38 (x) “Standard employee risk rate” means the rate applicable to
39 an eligible employee in a particular risk category in a small
40 employer group.

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

28 This subdivision applies regardless of whether a master policy
29 by an admitted insurer is delivered directly to the association or a
30 trust formed for or sponsored by an association to administer
31 benefits for association members.

32 For purposes of this subdivision, an association formed by a
33 merger of two or more associations after January 1, 1992, and
34 otherwise meeting the criteria of this subdivision shall be deemed
35 to have been in active existence on January 1, 1992, if its
36 predecessor organizations had been in active existence on January
37 1, 1992, and for at least five years prior to that date and otherwise
38 met the criteria of this subdivision.

39 (z) “Members of a guaranteed association” means an individual
40 or employer meeting the association’s membership criteria if that

1 person is a member of the association and chooses to purchase
2 health coverage through the association. At the association's
3 discretion, it may also include employees of association members,
4 association staff, retired members, retired employees of members,
5 and surviving spouses and dependents of deceased members.
6 However, if an association chooses to include those persons as
7 members of the guaranteed association, the association must so
8 elect in advance of purchasing coverage from a plan. Health plans
9 may require an association to adhere to the membership
10 composition it selects for up to 12 months.

11 (aa) "Affiliation period" means a period that, under the terms
12 of the health benefit plan, must expire before health care services
13 under the plan become effective.

O