

AMENDED IN ASSEMBLY APRIL 9, 2007

CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 1607

Introduced by Assembly Member Tran
(Coauthors: Assembly Members *Adams, Anderson, Benoit, DeVore,*
***Jeffries, Maze, Silva, Smyth, Strickland, and Villines*)**

February 23, 2007

An act to amend ~~Section 1357~~ *Sections 1357 and 1357.08* 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 1607, as amended, Tran. Guaranteed associations.

Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for regulation of health insurers by the Department of Insurance. A willful violation of provisions governing health care service plans is a crime.

Existing law imposes certain requirements on health care service plans and health insurers to enable small employers to access health care coverage. Existing law defines "small employer" for these purposes to include a guaranteed association that purchases health care coverage for its members. Existing law defines "guaranteed association" to mean a nonprofit organization of individuals or employers that meets certain requirements, including having been in active existence and having included health coverage as a membership benefit for at least 5 years prior to January 1, 1992, and covering at least 1,000 persons in that regard.

This bill would delete the requirements for a guaranteed association to have been in active existence and to have included health care coverage as a membership benefit for at least 5 years prior to January 1, 1992. The bill would also reduce the required number of persons covered by health coverage provided through the guaranteed association from 1,000 to 100. ~~Because the bill would thereby modify the requirements applicable to health care service plans, it would change the definition of a crime and impose a state-mandated local program.~~

Existing law requires a health care service plan contract offered to a small employer to provide at least all of the same basic health care services otherwise required for health care service plan contracts.

This bill would authorize a health care service plan to also offer to a small employer a health savings account option with a high deductible plan.

Because the bill would thereby modify the requirements applicable to health care service plans, it would change the definition of a crime and impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

- 1 SECTION 1. Section 1357 of the Health and Safety Code is
- 2 amended to read:
- 3 1357. As used in this article:
- 4 (a) "Dependent" means the spouse or child of an eligible
- 5 employee, subject to applicable terms of the health care plan
- 6 contract covering the employee, and includes dependents of
- 7 guaranteed association members if the association elects to include
- 8 dependents under its health coverage at the same time it determines
- 9 its membership composition pursuant to subdivision (o).
- 10 (b) "Eligible employee" means either of the following:
- 11 (1) Any permanent employee who is actively engaged on a
- 12 full-time basis in the conduct of the business of the small employer
- 13 with a normal workweek of at least 30 hours, at the small

1 employer's regular places of business, who has met any statutorily
2 authorized applicable waiting period requirements. The term
3 includes sole proprietors or partners of a partnership, if they are
4 actively engaged on a full-time basis in the small employer's
5 business and included as employees under a health care plan
6 contract of a small employer, but does not include employees who
7 work on a part-time, temporary, or substitute basis. It includes any
8 eligible employee, as defined in this paragraph, who obtains
9 coverage through a guaranteed association. Employees of
10 employers purchasing through a guaranteed association shall be
11 deemed to be eligible employees if they would otherwise meet the
12 definition except for the number of persons employed by the
13 employer. Permanent employees who work at least 20 hours but
14 not more than 29 hours are deemed to be eligible employees if all
15 four of the following apply:

16 (A) They otherwise meet the definition of an eligible employee
17 except for the number of hours worked.

18 (B) The employer offers the employees health coverage under
19 a health benefit plan.

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

22 (D) The employee must have worked at least 20 hours per
23 normal workweek for at least 50 percent of the weeks in the
24 previous calendar quarter. The health care service plan may request
25 any necessary information to document the hours and time period
26 in question, including, but not limited to, payroll records and
27 employee wage and tax filings.

28 (2) Any member of a guaranteed association as defined in
29 subdivision (o).

30 (c) "In force business" means an existing health benefit plan
31 contract issued by the plan to a small employer.

32 (d) "Late enrollee" means an eligible employee or dependent
33 who has declined enrollment in a health benefit plan offered by a
34 small employer at the time of the initial enrollment period provided
35 under the terms of the health benefit plan and who subsequently
36 requests enrollment in a health benefit plan of that small employer,
37 provided that the initial enrollment period shall be a period of at
38 least 30 days. It also means any member of an association that is
39 a guaranteed association as well as any other person eligible to
40 purchase through the guaranteed association when that person has

1 failed to purchase coverage during the initial enrollment period
2 provided under the terms of the guaranteed association’s plan
3 contract and who subsequently requests enrollment in the plan,
4 provided that the initial enrollment period shall be a period of at
5 least 30 days. However, an eligible employee, any other person
6 eligible for coverage through a guaranteed association pursuant to
7 subdivision (o), or an eligible dependent shall not be considered
8 a late enrollee if any of the following is applicable:

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

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

13 (B) He or she certified at the time of the initial enrollment that
14 coverage under another employer health benefit plan, the Healthy
15 Families Program, or no share-of-cost Medi-Cal coverage was the
16 reason for declining enrollment, provided that, if the individual
17 was covered under another employer health plan, the individual
18 was given the opportunity to make the certification required by
19 this subdivision and was notified that failure to do so could result
20 in later treatment as a late enrollee.

21 (C) He or she has lost or will lose coverage under another
22 employer health benefit plan as a result of termination of
23 employment of the individual or of a person through whom the
24 individual was covered as a dependent, change in employment
25 status of the individual or of a person through whom the individual
26 was covered as a dependent, termination of the other plan’s
27 coverage, cessation of an employer’s contribution toward an
28 employee or dependent’s coverage, death of the person through
29 whom the individual was covered as a dependent, legal separation,
30 divorce, loss of coverage under the Healthy Families Program as
31 a result of exceeding the program’s income or age limits, or loss
32 of no share-of-cost Medi-Cal coverage.

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

36 (2) The employer offers multiple health benefit plans and the
37 employee elects a different plan during an open enrollment period.

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

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

13 (B) In the case of an association member who did not purchase
14 coverage through a guaranteed association, the plan cannot produce
15 a written statement from the association stating that the association
16 sent a written notice in boldface type to all potentially eligible
17 association members at their last known address prior to the initial
18 enrollment period informing members that failure to elect coverage
19 during the initial enrollment period permits the plan to impose, at
20 the time of the member's later decision to elect coverage, an
21 exclusion from coverage for a period of 12 months as well as a
22 six-month preexisting condition exclusion unless the member can
23 demonstrate that he or she meets the requirements of subparagraphs
24 (A), (C), and (D) of paragraph (1) or meets the requirements of
25 paragraph (2) or (3).

26 (C) In the case of an employer or person who is not a member
27 of an association, was eligible to purchase coverage through a
28 guaranteed association, and did not do so, and would not be eligible
29 to purchase guaranteed coverage unless purchased through a
30 guaranteed association, the employer or person 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), or that he or she recently had a change in status that
34 would make him or her eligible and that application for enrollment
35 was made within 30 days of the change.

36 (5) The individual is an employee or dependent who meets the
37 criteria described in paragraph (1) and was under a COBRA
38 continuation provision and the coverage under that provision has
39 been exhausted. For purposes of this section, the definition of

1 “COBRA” set forth in subdivision (e) of Section 1373.621 shall
2 apply.

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

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

24 (8) The individual is an eligible employee who has declined
25 coverage for himself or herself or his or her dependents during a
26 previous enrollment period because his or her dependents were
27 covered by another employer health benefit plan at the time of the
28 previous enrollment period. That individual may enroll himself or
29 herself or his or her dependents for plan coverage during a special
30 open enrollment opportunity if his or her dependents have lost or
31 will lose coverage under that other employer health benefit plan.
32 The special open enrollment opportunity shall be requested by the
33 employee not more than 30 days after the date that the other health
34 coverage is exhausted or terminated. Upon enrollment, coverage
35 shall be effective not later than the first day of the first calendar
36 month beginning after the date the request for enrollment is
37 received. Notice of the special enrollment rights contained in this
38 paragraph shall be provided by the employer to an employee at or
39 before the time the employee is offered an opportunity to enroll
40 in plan coverage.

1 (e) “New business” means a health care service plan contract
2 issued to a small employer that is not the plan’s in force business.

3 (f) “Preexisting condition provision” means a contract provision
4 that excludes coverage for charges or expenses incurred during a
5 specified period following the employee’s effective date of
6 coverage, as to a condition for which medical advice, diagnosis,
7 care, or treatment was recommended or received during a specified
8 period immediately preceding the effective date of coverage.

9 (g) “Creditable coverage” means:

10 (1) Any individual or group policy, contract, or program that is
11 written or administered by a disability insurer, health care service
12 plan, fraternal benefits society, self-insured employer plan, or any
13 other entity, in this state or elsewhere, and that arranges or provides
14 medical, hospital, and surgical coverage not designed to supplement
15 other private or governmental plans. The term includes continuation
16 or conversion coverage but does not include accident only, credit,
17 coverage for onsite medical clinics, disability income, Medicare
18 supplement, long-term care, dental, vision, coverage issued as a
19 supplement to liability insurance, insurance arising out of a
20 workers’ compensation or similar law, automobile medical payment
21 insurance, or insurance under which benefits are payable with or
22 without regard to fault and that is statutorily required to be
23 contained in any liability insurance policy or equivalent
24 self-insurance.

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

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

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

31 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
32 (Civilian Health and Medical Program of the Uniformed Services
33 (CHAMPUS)).

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

36 (7) A state health benefits risk pool.

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

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

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

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

10 (h) "Rating period" means the period for which premium rates
11 established by a plan are in effect and shall be no less than six
12 months.

13 (i) "Risk adjusted employee risk rate" means the rate determined
14 for an eligible employee of a small employer in a particular risk
15 category after applying the risk adjustment factor.

16 (j) "Risk adjustment factor" means the percentage adjustment
17 to be applied equally to each standard employee risk rate for a
18 particular small employer, based upon any expected deviations
19 from standard cost of services. This factor may not be more than
20 120 percent or less than 80 percent until July 1, 1996. Effective
21 July 1, 1996, this factor may not be more than 110 percent or less
22 than 90 percent.

23 (k) "Risk category" means the following characteristics of an
24 eligible employee: age, geographic region, and family composition
25 of the employee, plus the health benefit plan selected by the small
26 employer.

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

- 29 Under 30
- 30 30-39
- 31 40-49
- 32 50-54
- 33 55-59
- 34 60-64
- 35 65 and over

36 However, for the 65 and over age category, separate premium
37 rates may be specified depending upon whether coverage under
38 the plan contract will be primary or secondary to benefits provided
39 by the federal Medicare program pursuant to Title XVIII of the
40 federal Social Security Act.

1 (2) Small employer health care service plans shall base rates to
2 small employers using no more than the following family size
3 categories:

- 4 (A) Single.
- 5 (B) Married couple.
- 6 (C) One adult and child or children.
- 7 (D) Married couple and child or children.

8 (3) (A) In determining rates for small employers, a plan that
9 operates statewide shall use no more than nine geographic regions
10 in the state, have no region smaller than an area in which the first
11 three digits of all its ZIP Codes are in common within a county,
12 and divide no county into more than two regions. Plans shall be
13 deemed to be operating statewide if their coverage area includes
14 90 percent or more of the state's population. Geographic regions
15 established pursuant to this section shall, as a group, cover the
16 entire state, and the area encompassed in a geographic region shall
17 be separate and distinct from areas encompassed in other
18 geographic regions. Geographic regions may be noncontiguous.

19 (B) (i) In determining rates for small employers, a plan that
20 does not operate statewide shall use no more than the number of
21 geographic regions in the state that is determined by the following
22 formula: the population, as determined in the last federal census,
23 of all counties that are included in their entirety in a plan's service
24 area divided by the total population of the state, as determined in
25 the last federal census, multiplied by nine. The resulting number
26 shall be rounded to the nearest whole integer. No region may be
27 smaller than an area in which the first three digits of all its ZIP
28 Codes are in common within a county and no county may be
29 divided into more than two regions. The area encompassed in a
30 geographic region shall be separate and distinct from areas
31 encompassed in other geographic regions. Geographic regions
32 may be noncontiguous. No plan shall have less than one geographic
33 area.

34 (ii) If the formula in clause (i) results in a plan that operates in
35 more than one county having only one geographic region, then the
36 formula in clause (i) shall not apply and the plan may have two
37 geographic regions, provided that no county is divided into more
38 than one region.

1 Nothing in this section shall be construed to require a plan to
2 establish a new service area or to offer health coverage on a
3 statewide basis, outside of the plan's existing service area.

4 (l) "Small employer" means either of the following:

5 (1) Any person, firm, proprietary or nonprofit corporation,
6 partnership, public agency, or association that is actively engaged
7 in business or service, that, on at least 50 percent of its working
8 days during the preceding calendar quarter or preceding calendar
9 year, employed at least two, but no more than 50, eligible
10 employees, the majority of whom were employed within this state,
11 that was not formed primarily for purposes of buying health care
12 service plan contracts, and in which a bona fide employer-employee
13 relationship exists. In determining whether to apply the calendar
14 quarter or calendar year test, a health care service plan shall use
15 the test that ensures eligibility if only one test would establish
16 eligibility. However, for purposes of subdivisions (a), (b), and (c)
17 of Section 1357.03, the definition shall include employers with at
18 least three eligible employees until July 1, 1997, and two eligible
19 employees thereafter. In determining the number of eligible
20 employees, companies that are affiliated companies and that are
21 eligible to file a combined tax return for purposes of state taxation
22 shall be considered one employer. Subsequent to the issuance of
23 a health care service plan contract to a small employer pursuant
24 to this article, and for the purpose of determining eligibility, the
25 size of a small employer shall be determined annually. Except as
26 otherwise specifically provided in this article, provisions of this
27 article that apply to a small employer shall continue to apply until
28 the plan contract anniversary following the date the employer no
29 longer meets the requirements of this definition. It includes any
30 small employer as defined in this paragraph who purchases
31 coverage through a guaranteed association, and any employer
32 purchasing coverage for employees through a guaranteed
33 association.

34 (2) Any guaranteed association, as defined in subdivision (n),
35 that purchases health coverage for members of the association.

36 (m) "Standard employee risk rate" means the rate applicable to
37 an eligible employee in a particular risk category in a small
38 employer group.

39 (n) "Guaranteed association" means a nonprofit organization
40 comprised of a group of individuals or employers who associate

1 based solely on participation in a specified profession or industry,
2 accepting for membership any individual or employer meeting its
3 membership criteria, and that (1) includes one or more small
4 employers as defined in paragraph (1) of subdivision (l), (2) does
5 not condition membership directly or indirectly on the health or
6 claims history of any person, (3) uses membership dues solely for
7 and in consideration of the membership and membership benefits,
8 except that the amount of the dues shall not depend on whether
9 the member applies for or purchases insurance offered to the
10 association, (4) is organized and maintained in good faith for
11 purposes unrelated to insurance, (5) has a constitution and bylaws,
12 or other analogous governing documents that provide for election
13 of the governing board of the association by its members, (6) offers
14 any plan contract that is purchased to all individual members and
15 employer members in this state, (7) includes any member choosing
16 to enroll in the plan contracts offered to the association provided
17 that the member has agreed to make the required premium
18 payments, and (8) covers at least 100 persons with the health care
19 service plan with which it contracts. The requirement of 100
20 persons may be met if component chapters of a statewide
21 association contracting separately with the same carrier cover at
22 least 100 persons in the aggregate.

23 This subdivision applies regardless of whether a contract issued
24 by a plan is with an association or a trust formed for, or sponsored
25 by, an association to administer benefits for association members.

26 (o) “Members of a guaranteed association” means any individual
27 or employer meeting the association’s membership criteria if that
28 person is a member of the association and chooses to purchase
29 health coverage through the association. At the association’s
30 discretion, it also may include employees of association members,
31 association staff, retired members, retired employees of members,
32 and surviving spouses and dependents of deceased members.
33 However, if an association chooses to include these persons as
34 members of the guaranteed association, the association shall make
35 that election in advance of purchasing a plan contract. Health care
36 service plans may require an association to adhere to the
37 membership composition it selects for up to 12 months.

38 (p) “Affiliation period” means a period that, under the terms of
39 the health care service plan contract, must expire before health
40 care services under the contract become effective.

1 SEC. 2. Section 1357.08 of the Health and Safety Code is
2 amended to read:

3 1357.08. ~~All~~(a) Except as otherwise provided in subdivision
4 (b), all health care service plan contracts offered to a small
5 employer shall provide to subscribers and enrollees at least all of
6 the basic health care services included in subdivision (b) of Section
7 1345, and in Section 1300.67 of the California Code of
8 Regulations.

9 (b) A health care service plan may offer to a small employer a
10 health savings account option with a high deductible plan.

11 ~~SEC. 2.~~

12 SEC. 3. Section 10700 of the Insurance Code is amended to
13 read:

14 10700. As used in this chapter:

15 (a) “Agent or broker” means a person or entity licensed under
16 Chapter 5 (commencing with Section 1621) of Part 2 of Division
17 1.

18 (b) “Benefit plan design” means a specific health coverage
19 product issued by a carrier to small employers, to trustees of
20 associations that include small employers, or to individuals if the
21 coverage is offered through employment or sponsored by an
22 employer. It includes services covered and the levels of copayment
23 and deductibles, and it may include the professional providers who
24 are to provide those services and the sites where those services are
25 to be provided. A benefit plan design may also be an integrated
26 system for the financing and delivery of quality health care services
27 which has significant incentives for the covered individuals to use
28 the system.

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

30 (d) “Carrier” means any disability insurance company or any
31 other entity that writes, issues, or administers health benefit plans
32 that cover the employees of small employers, regardless of the
33 situs of the contract or master policyholder. For the purposes of
34 Articles 3 (commencing with Section 10719) and 4 (commencing
35 with Section 10730), “carrier” also includes health care service
36 plans.

37 (e) “Dependent” means the spouse or child of an eligible
38 employee, subject to applicable terms of the health benefit plan
39 covering the employee, and includes dependents of guaranteed
40 association members if the association elects to include dependents

1 under its health coverage at the same time it determines its
2 membership composition pursuant to subdivision (z).

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

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

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

24 (B) The employer offers the employee health coverage under a
25 health benefit plan.

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

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

34 (2) Any member of a guaranteed association as defined in
35 subdivision (z).

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

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

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

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

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

9 (j) “Health benefit plan” means a policy or contract written or
10 administered by a carrier that arranges or provides health care
11 benefits for the covered eligible employees of a small employer
12 and their dependents. The term does not include accident only,
13 credit, disability income, coverage of Medicare services pursuant
14 to contracts with the United States government, Medicare
15 supplement, long-term care insurance, dental, vision, coverage
16 issued as a supplement to liability insurance, automobile medical
17 payment insurance, or insurance under which benefits are payable
18 with or without regard to fault and that is statutorily required to
19 be contained in any liability insurance policy or equivalent
20 self-insurance.

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

23 (l) “Late enrollee” means an eligible employee or dependent
24 who has declined health coverage under a health benefit plan
25 offered by a small employer at the time of the initial enrollment
26 period provided under the terms of the health benefit plan, and
27 who subsequently requests enrollment in a health benefit plan of
28 that small employer, provided that the initial enrollment period
29 shall be a period of at least 30 days. It also means any member of
30 an association that is a guaranteed association as well as any other
31 person eligible to purchase through the guaranteed association
32 when that person has failed to purchase coverage during the initial
33 enrollment period provided under the terms of the guaranteed
34 association’s health benefit plan and who subsequently requests
35 enrollment in the plan, provided that the initial enrollment period
36 shall be a period of at least 30 days. However, an eligible
37 employee, another person eligible for coverage through a
38 guaranteed association pursuant to subdivision (z), or an eligible
39 dependent shall not be considered a late enrollee if any of the
40 following is applicable:

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

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

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

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

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

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

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

33 (4) (A) In the case of an eligible employee as defined in
34 paragraph (1) of subdivision (f), the carrier cannot produce a
35 written statement from the employer stating that the individual or
36 the person through whom an individual was eligible to be covered
37 as a dependent, prior to declining coverage, was provided with,
38 and signed acknowledgment of, an explicit written notice in
39 boldface type specifying that failure to elect coverage during the
40 initial enrollment period permits the carrier to impose, at the time

1 of the individual's later decision to elect coverage, an exclusion
2 from 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 (B) In the case of an eligible employee who is a guaranteed
6 association member, the plan cannot produce a written statement
7 from the guaranteed association stating that the association sent a
8 written notice in boldface type to all potentially eligible association
9 members at their last known address prior to the initial enrollment
10 period informing members that failure to elect coverage during
11 the initial enrollment period permits the plan to impose, at the time
12 of the member's later decision to elect coverage, an exclusion from
13 coverage for a period of 12 months as well as a six-month
14 preexisting condition exclusion unless the member can demonstrate
15 that he or she meets the requirements of subparagraphs (A), (C),
16 and (D) of paragraph (1) or meets the requirements of paragraph
17 (2) or (3).

18 (C) In the case of an employer or person who is not a member
19 of an association, was eligible to purchase coverage through a
20 guaranteed association, and did not do so, and would not be eligible
21 to purchase guaranteed coverage unless purchased through a
22 guaranteed association, the employer or person can demonstrate
23 that he or she meets the requirements of subparagraphs (A), (C),
24 and (D) of paragraph (1), or meets the requirements of paragraph
25 (2) or (3), or that he or she recently had a change in status that
26 would make him or her eligible and that application for coverage
27 was made within 30 days of the change.

28 (5) The individual is an employee or dependent who meets the
29 criteria described in paragraph (1) and was under a COBRA
30 continuation provision and the coverage under that provision has
31 been exhausted. For purposes of this section, the definition of
32 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
33 apply.

34 (6) The individual is a dependent of an enrolled eligible
35 employee who has lost or will lose his or her coverage under the
36 Healthy Families Program as a result of exceeding the program's
37 income or age limits or no share-of-cost Medi-Cal coverage and
38 requests enrollment within 30 days after notification of this loss
39 of coverage.

1 (7) The individual is an eligible employee who previously
2 declined coverage under an employer health benefit plan and who
3 has subsequently acquired a dependent who would be eligible for
4 coverage as a dependent of the employee through marriage, birth,
5 adoption, or placement for adoption, and who enrolls for coverage
6 under that employer health benefit plan on his or her behalf, and
7 on behalf of his or her dependent within 30 days following the
8 date of marriage, birth, adoption, or placement for adoption, in
9 which case the effective date of coverage shall be the first day of
10 the month following the date the completed request for enrollment
11 is received in the case of marriage, or the date of birth, or the date
12 of adoption or placement for adoption, whichever applies. Notice
13 of the special enrollment rights contained in this paragraph shall
14 be provided by the employer to an employee at or before the time
15 the employee is offered an opportunity to enroll in plan coverage.

16 (8) The individual is an eligible employee who has declined
17 coverage for himself or herself or his or her dependents during a
18 previous enrollment period because his or her dependents were
19 covered by another employer health benefit plan at the time of the
20 previous enrollment period. That individual may enroll himself or
21 herself or his or her dependents for plan coverage during a special
22 open enrollment opportunity if his or her dependents have lost or
23 will lose coverage under that other employer health benefit plan.
24 The special open enrollment opportunity shall be requested by the
25 employee not more than 30 days after the date that the other health
26 coverage is exhausted or terminated. Upon enrollment, coverage
27 shall be effective not later than the first day of the first calendar
28 month beginning after the date the request for enrollment is
29 received. Notice of the special enrollment rights contained in this
30 paragraph shall be provided by the employer to an employee at or
31 before the time the employee is offered an opportunity to enroll
32 in plan coverage.

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

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

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

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

2 (q) “Preexisting condition provision” means a policy provision
3 that excludes coverage for charges or expenses incurred during a
4 specified period following the insured’s effective date of coverage,
5 as to a condition for which medical advice, diagnosis, care, or
6 treatment was recommended or received during a specified period
7 immediately preceding the effective date of coverage.

8 (r) “Creditable coverage” means:

9 (1) Any individual or group policy, contract, or program, that
10 is written or administered by a disability insurer, health care service
11 plan, fraternal benefits society, self-insured employer plan, or any
12 other entity, in this state or elsewhere, and that arranges or provides
13 medical, hospital, and surgical coverage not designed to supplement
14 other private or governmental plans. The term includes continuation
15 or conversion coverage but does not include accident only, credit,
16 coverage for onsite medical clinics, disability income, Medicare
17 supplement, long-term care, dental, vision, coverage issued as a
18 supplement to liability insurance, insurance arising out of a
19 workers’ compensation or similar law, automobile medical payment
20 insurance, or insurance under which benefits are payable with or
21 without regard to fault and that is statutorily required to be
22 contained in any liability insurance policy or equivalent
23 self-insurance.

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

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

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

30 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
31 (Civilian Health and Medical Program of the Uniformed Services
32 (CHAMPUS)).

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

35 (7) A state health benefits risk pool.

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

39 (9) A public health plan as defined in federal regulations
40 authorized by Section 2701(c)(1)(I) of the Public Health Service

1 Act, as amended by Public Law 104-191, the Health Insurance
2 Portability and Accountability Act of 1996.

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

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

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

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

14 (u) "Risk adjustment factor" means the percent adjustment to
15 be applied equally to each standard employee risk rate for a
16 particular small employer, based upon any expected deviations
17 from standard claims. This factor may not be more than 120 percent
18 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
19 this factor may not be more than 110 percent or less than 90
20 percent.

21 (v) "Risk category" means the following characteristics of an
22 eligible employee: age, geographic region, and family size of the
23 employee, plus the benefit plan design selected by the small
24 employer.

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

- 27 Under 30
- 28 30-39
- 29 40-49
- 30 50-54
- 31 55-59
- 32 60-64
- 33 65 and over

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

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

- 1 (A) Single.
- 2 (B) Married couple.
- 3 (C) One adult and child or children.
- 4 (D) Married couple and child or children.

5 (3) (A) In determining rates for small employers, a carrier that
 6 operates statewide shall use no more than nine geographic regions
 7 in the state, have no region smaller than an area in which the first
 8 three digits of all its ZIP Codes are in common within a county
 9 and shall divide no county into more than two regions. Carriers
 10 shall be deemed to be operating statewide if their coverage area
 11 includes 90 percent or more of the state’s population. Geographic
 12 regions established pursuant to this section shall, as a group, cover
 13 the entire state, and the area encompassed in a geographic region
 14 shall be separate and distinct from areas encompassed in other
 15 geographic regions. Geographic regions may be noncontiguous.

16 (B) In determining rates for small employers, a carrier that does
 17 not operate statewide shall use no more than the number of
 18 geographic regions in the state than is determined by the following
 19 formula: the population, as determined in the last federal census,
 20 of all counties which are included in their entirety in a carrier’s
 21 service area divided by the total population of the state, as
 22 determined in the last federal census, multiplied by nine. The
 23 resulting number shall be rounded to the nearest whole integer.
 24 No region may be smaller than an area in which the first three
 25 digits of all its ZIP Codes are in common within a county and no
 26 county may be divided into more than two regions. The area
 27 encompassed in a geographic region shall be separate and distinct
 28 from areas encompassed in other geographic regions. Geographic
 29 regions may be noncontiguous. No carrier shall have less than one
 30 geographic area.

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

32 (1) Any person, proprietary or nonprofit firm, corporation,
 33 partnership, public agency, or association that is actively engaged
 34 in business or service that, on at least 50 percent of its working
 35 days during the preceding calendar quarter, or preceding calendar
 36 year, employed at least two, but not more than 50, eligible
 37 employees, the majority of whom were employed within this state,
 38 that was not formed primarily for purposes of buying health
 39 insurance and in which a bona fide employer-employee relationship
 40 exists. In determining whether to apply the calendar quarter or

1 calendar year test, the insurer shall use the test that ensures
2 eligibility if only one test would establish eligibility. However,
3 for purposes of subdivisions (b) and (h) of Section 10705, the
4 definition shall include employers with at least three eligible
5 employees until July 1, 1997, and two eligible employees
6 thereafter. In determining the number of eligible employees,
7 companies that are affiliated companies and that are eligible to file
8 a combined income tax return for purposes of state taxation shall
9 be considered one employer. Subsequent to the issuance of a health
10 benefit plan to a small employer pursuant to this chapter, and for
11 the purpose of determining eligibility, the size of a small employer
12 shall be determined annually. Except as otherwise specifically
13 provided, provisions of this chapter that apply to a small employer
14 shall continue to apply until the health benefit plan anniversary
15 following the date the employer no longer meets the requirements
16 of this definition. It includes any small employer as defined in this
17 paragraph who purchases coverage through a guaranteed
18 association, and any employer purchasing coverage for employees
19 through a guaranteed association.

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

22 (x) "Standard employee risk rate" means the rate applicable to
23 an eligible employee in a particular risk category in a small
24 employer group.

25 (y) "Guaranteed association" means a nonprofit organization
26 comprised of a group of individuals or employers who associate
27 based solely on participation in a specified profession or industry,
28 accepting for membership any individual or employer meeting its
29 membership criteria, and that (1) includes one or more small
30 employers as defined in paragraph (1) of subdivision (w), (2) does
31 not condition membership directly or indirectly on the health or
32 claims history of any person, (3) uses membership dues solely for
33 and in consideration of the membership and membership benefits,
34 except that the amount of the dues shall not depend on whether
35 the member applies for or purchases insurance offered by the
36 association, (4) is organized and maintained in good faith for
37 purposes unrelated to insurance, (5) has a constitution and bylaws,
38 or other analogous governing documents that provide for election
39 of the governing board of the association by its members, (6) offers
40 any benefit plan design that is purchased to all individual members

1 and employer members in this state, (7) includes any member
 2 choosing to enroll in the benefit plan design offered to the
 3 association provided that the member has agreed to make the
 4 required premium payments, and (8) covers at least 100 persons
 5 with the carrier with which it contracts. The requirement of 100
 6 persons may be met if component chapters of a statewide
 7 association contracting separately with the same carrier cover at
 8 least 100 persons in the aggregate.

9 This subdivision applies regardless of whether a master policy
 10 by an admitted insurer is delivered directly to the association or a
 11 trust formed for or sponsored by an association to administer
 12 benefits for association members.

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

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

28 ~~SEC. 3.~~

29 *SEC. 4.* No reimbursement is required by this act pursuant to
 30 Section 6 of Article XIII B of the California Constitution because
 31 the only costs that may be incurred by a local agency or school
 32 district will be incurred because this act creates a new crime or
 33 infraction, eliminates a crime or infraction, or changes the penalty
 34 for a crime or infraction, within the meaning of Section 17556 of
 35 the Government Code, or changes the definition of a crime within
 36 the meaning of Section 6 of Article XIII B of the California
 37 Constitution.