

AMENDED IN ASSEMBLY MAY 13, 2009

AMENDED IN ASSEMBLY MAY 5, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 1541

Introduced by Committee on Health (Jones (Chair), Ammiano, Block, Carter, De La Torre, De Leon, Hall, Hayashi, Hernandez, Bonnie Lowenthal, Nava, V. Manuel Perez, and Salas)

March 4, 2009

An act to amend Sections 1357 and 1357.50 of the Health and Safety Code, and to amend Sections 10198.6 and 10700 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1541, as amended, Committee on Health. Health care coverage.

Existing law, the federal Children's Health Insurance Program Reauthorization Act of 2009, requires a group health plan to permit an eligible person to enroll for coverage under the plan if the person's coverage under Medicaid or under a state child health plan was terminated, as specified, and the person applies for coverage under the group health plan not later than 60 days after that termination.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes plans and insurers to exclude late enrollees from group health care coverage for a specified period of time. Existing law defines a "late enrollee" as an eligible employee or dependent who has declined health

coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in that plan. Existing law provides that a late enrollee does not include an individual, or his or her dependent, who has lost or will lose Healthy Families Program coverage, as specified, or no share-of-cost Medi-Cal coverage and who requests enrollment within 30 days after termination of coverage.

This bill would define late enrollee to exclude an individual, or dependent, who has lost or will lose Healthy Families Program coverage, as specified, or no share-of-cost Medi-Cal coverage and who requests enrollment within 60 days after termination of coverage.

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would 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. It is the intent of the Legislature to enact
2 legislation that would implement *a provision of* the federal
3 Children's Health Insurance Program Reauthorization Act of 2009
4 (Public Law 111-3).

5 SEC. 2. Section 1357 of the Health and Safety Code is amended
6 to read:

7 1357. As used in this article:

8 (a) "Dependent" means the spouse or child of an eligible
9 employee, subject to applicable terms of the health care plan
10 contract covering the employee, and includes dependents of
11 guaranteed association members if the association elects to include
12 dependents under its health coverage at the same time it determines
13 its membership composition pursuant to subdivision (o).

14 (b) "Eligible employee" means either of the following:

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

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

21 (B) The employer offers the employees health coverage under
22 a health benefit plan.

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

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

31 (2) Any member of a guaranteed association as defined in
32 subdivision (o).

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

35 (d) "Late enrollee" means an eligible employee or dependent
36 who has declined enrollment in a health benefit plan offered by a
37 small employer at the time of the initial enrollment period provided
38 under the terms of the health benefit plan and who subsequently
39 requests enrollment in a health benefit plan of that small employer,
40 provided that the initial enrollment period shall be a period of at

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

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

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

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

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

36 (D) He or she requests enrollment within 30 days after
37 termination of coverage or employer contribution toward coverage
38 provided under another employer health benefit plan, or requests
39 enrollment within 60 days after termination of no share-of-cost
40 Medi-Cal coverage or Healthy Families Program coverage.

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

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

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

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

30 (C) In the case of an employer or person who is not a member
31 of an association, was eligible to purchase coverage through a
32 guaranteed association, and did not do so, and would not be eligible
33 to purchase guaranteed coverage unless purchased through a
34 guaranteed association, the employer or person can demonstrate
35 that he or she meets the requirements of subparagraphs (A), (C),
36 and (D) of paragraph (1), or meets the requirements of paragraph
37 (2) or (3), or that he or she recently had a change in status that
38 would make him or her eligible and that application for enrollment
39 was made within 30 days of the change.

1 (5) The individual is an employee or dependent who meets the
2 criteria described in paragraph (1) and was under a COBRA
3 continuation provision and the coverage under that provision has
4 been exhausted. For purposes of this section, the definition of
5 “COBRA” set forth in subdivision (e) of Section 1373.621 shall
6 apply.

7 (6) The individual is a dependent of an enrolled eligible
8 employee who has lost or will lose his or her coverage under the
9 Healthy Families Program as a result of exceeding the program’s
10 income or age limits or no share-of-cost Medi-Cal coverage and
11 requests enrollment within 60 days after notification of this loss
12 of coverage.

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

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

1 received. Notice of the special enrollment rights contained in this
2 paragraph shall be provided by the employer to an employee at or
3 before the time the employee is offered an opportunity to enroll
4 in plan coverage.

5 (e) "New business" means a health care service plan contract
6 issued to a small employer that is not the plan's in force business.

7 (f) "Preexisting condition provision" means a contract provision
8 that excludes coverage for charges or expenses incurred during a
9 specified period following the employee's effective date of
10 coverage, as to a condition for which medical advice, diagnosis,
11 care, or treatment was recommended or received during a specified
12 period immediately preceding the effective date of coverage.

13 (g) "Creditable coverage" means:

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

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

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

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

35 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
36 (Civilian Health and Medical Program of the Uniformed Services
37 (CHAMPUS)).

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

40 (7) A state health benefits risk pool.

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

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

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

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

13 (h) “Rating period” means the period for which premium rates
14 established by a plan are in effect and shall be no less than six
15 months.

16 (i) “Risk adjusted employee risk rate” means the rate determined
17 for an eligible employee of a small employer in a particular risk
18 category after applying the risk adjustment factor.

19 (j) “Risk adjustment factor” means the percentage adjustment
20 to be applied equally to each standard employee risk rate for a
21 particular small employer, based upon any expected deviations
22 from standard cost of services. This factor may not be more than
23 120 percent or less than 80 percent until July 1, 1996. Effective
24 July 1, 1996, this factor may not be more than 110 percent or less
25 than 90 percent.

26 (k) “Risk category” means the following characteristics of an
27 eligible employee: age, geographic region, and family composition
28 of the employee, plus the health benefit plan selected by the small
29 employer.

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

32 Under 30

33 30–39

34 40–49

35 50–54

36 55–59

37 60–64

38 65 and over

39 However, for the 65 and over age category, separate premium
40 rates may be specified depending upon whether coverage under

1 the plan contract will be primary or secondary to benefits provided
2 by the federal Medicare program pursuant to Title XVIII of the
3 federal Social Security Act.

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

7 (A) Single.

8 (B) Married couple.

9 (C) One adult and child or children.

10 (D) Married couple and child or children.

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

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

37 (ii) If the formula in clause (i) results in a plan that operates in
38 more than one county having only one geographic region, then the
39 formula in clause (i) shall not apply and the plan may have two

1 geographic regions, provided that no county is divided into more
2 than one region.

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

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

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

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

38 (m) "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 (n) "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 any individual or employer meeting its
5 membership criteria, and that (1) includes one or more small
6 employers as defined in paragraph (1) of subdivision (l), (2) does
7 not condition membership directly or indirectly on the health or
8 claims history of any 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 to 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 included health insurance as a membership benefit for at
16 least 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 any plan contract that is purchased to all individual
20 members and employer members in this state, (9) includes any
21 member choosing to enroll in the plan contracts offered to the
22 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 health care service plan with which it contracts. The
25 requirement of 1,000 persons may be met if component chapters
26 of a statewide association contracting separately with the same
27 carrier cover at least 1,000 persons in the aggregate.

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

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

38 (o) "Members of a guaranteed association" means any individual
39 or employer meeting the association's membership criteria if that
40 person is a member of the association and chooses to purchase

1 health coverage through the association. At the association's
2 discretion, it also may include employees of association members,
3 association staff, retired members, retired employees of members,
4 and surviving spouses and dependents of deceased members.
5 However, if an association chooses to include these persons as
6 members of the guaranteed association, the association shall make
7 that election in advance of purchasing a plan contract. Health care
8 service plans may require an association to adhere to the
9 membership composition it selects for up to 12 months.

10 (p) "Affiliation period" means a period that, under the terms of
11 the health care service plan contract, must expire before health
12 care services under the contract become effective.

13 SEC. 3. Section 1357.50 of the Health and Safety Code is
14 amended to read:

15 1357.50. For purposes of this article:

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

28 (b) "Late enrollee" means an eligible employee or dependent
29 who has declined health coverage under a health benefit plan
30 offered through employment or sponsored by an employer at the
31 time of the initial enrollment period provided under the terms of
32 the health benefit plan, and who subsequently requests enrollment
33 in a health benefit plan of that employer, provided that the initial
34 enrollment period shall be a period of at least 30 days. However,
35 an eligible employee or dependent shall not be considered a late
36 enrollee if any of the following is applicable:

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

38 (A) The individual was covered under another employer health
39 benefit plan, the Healthy Families Program, or no share-of-cost
40 Medi-Cal coverage at the time the individual was eligible to enroll.

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

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

21 (D) The individual requests enrollment within 30 days after
22 termination of coverage, or cessation of employer contribution
23 toward coverage provided under another employer health benefit
24 plan, or requests enrollment within 60 days after termination of
25 no share-of-cost Medi-Cal coverage or Healthy Families Program
26 coverage.

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

30 (3) A court has ordered that coverage be provided for a spouse
31 or minor child under a covered employee's health benefit plan.
32 The health benefit plan shall enroll a dependent child within 30
33 days after receipt of a court order or request from the district
34 attorney, either parent or the person having custody of the child
35 as defined in Section 3751.5 of the Family Code, the employer,
36 or the group administrator. In the case of children who are eligible
37 for medicaid, the State Department of Health Services may also
38 make the request.

39 (4) The plan cannot produce a written statement from the
40 employer stating that, prior to declining coverage, the individual

1 or the person through whom the individual was eligible to be
2 covered as a dependent was provided with, and signed
3 acknowledgment of, explicit written notice in boldface type
4 specifying that failure to elect coverage during the initial
5 enrollment period permits the plan to impose, at the time of the
6 individual's later decision to elect coverage, an exclusion from
7 coverage for a period of 12 months as well as a six-month
8 preexisting condition exclusion, unless the individual meets the
9 criteria specified in paragraph (1), (2), or (3).

10 (5) The individual is an employee or dependent who meets the
11 criteria described in paragraph (1) and was under a COBRA
12 continuation provision, and the coverage under that provision has
13 been exhausted. For purposes of this section, the definition of
14 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
15 apply.

16 (6) The individual is a dependent of an enrolled eligible
17 employee who has lost or will lose his or her coverage under the
18 Healthy Families Program as a result of exceeding the program's
19 income or age limits or no share-of-cost Medi-Cal coverage and
20 requests enrollment within 60 days of notification of this loss of
21 coverage.

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

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

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

14 (c) "Preexisting condition provision" means a contract provision
 15 that excludes coverage for charges or expenses incurred during a
 16 specified period following the enrollee's effective date of coverage,
 17 as to a condition for which medical advice, diagnosis, care, or
 18 treatment was recommended or received during a specified period
 19 immediately preceding the effective date of coverage.

20 (d) "Creditable coverage" means:

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

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

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

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

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

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

(7) A state health benefits risk pool.

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

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

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

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

(e) “Waivered condition” means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

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

SEC. 4. Section 10198.6 of the Insurance Code is amended to read:

10198.6. For purposes of this article:

(a) “Health benefit plan” means any group or individual policy or contract that provides medical, hospital, or surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault

1 and that is statutorily required to be contained in any liability
2 insurance policy or equivalent self-insurance.

3 (b) "Late enrollee" means an eligible employee or dependent
4 who has declined health coverage under a health benefit plan
5 offered through employment or sponsored by an employer at the
6 time of the initial enrollment period provided under the terms of
7 the health benefit plan, and who subsequently requests enrollment
8 in a health benefit plan of that employer; provided that the initial
9 enrollment period shall be a period of at least 30 days. However,
10 an eligible employee or dependent shall not be considered a late
11 enrollee if any of the following is applicable:

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

13 (A) The individual was covered under another employer health
14 benefit plan, the Healthy Families Program, or no share-of-cost
15 Medi-Cal coverage at the time the individual was eligible to enroll.

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

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

36 (D) The individual requests enrollment within 30 days after
37 termination of coverage, or cessation of employer contribution
38 toward coverage provided under another employer health benefit
39 plan, or requests enrollment within 60 days after termination of

1 no share-of-cost Medi-Cal coverage or Healthy Families Program
2 coverage.

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

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

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

19 (5) The individual is an employee or dependent who meets the
20 criteria described in paragraph (1) and was under a COBRA
21 continuation provision and the coverage under that provision has
22 been exhausted. For purposes of this section, the definition of
23 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
24 apply.

25 (6) The individual is a dependent of an enrolled eligible
26 employee who has lost or will lose his or her coverage under the
27 Healthy Families Program as a result of exceeding the program's
28 income or age limits or no share-of-cost Medi-Cal coverage and
29 requests enrollment within 60 days of notification of this loss of
30 coverage.

31 (c) "Preexisting condition provision" means a policy provision
32 that excludes coverage for charges or expenses incurred during a
33 specified period following the insured's effective date of coverage,
34 as to a condition for which medical advice, diagnosis, care, or
35 treatment was recommended or received during a specified period
36 immediately preceding the effective date of coverage.

37 (d) "Creditable coverage" means:

38 (1) Any individual or group policy, contract or program, that is
39 written or administered by a disability insurance company, health
40 care service plan, fraternal benefits society, self-insured employer

1 plan, or any other entity, in this state or elsewhere, and that
2 arranges or provides medical, hospital, and surgical coverage not
3 designed to supplement other private or governmental plans. The
4 term includes continuation or conversion coverage but does not
5 include accident only, credit, coverage for onsite medical clinics,
6 disability income, Medicare supplement, long-term care insurance,
7 dental, vision, coverage issued as a supplement to liability
8 insurance, insurance arising out of a workers' compensation or
9 similar law, automobile medical payment insurance, or insurance
10 under which benefits are payable with or without regard to fault
11 and that is statutorily required to be contained in any liability
12 insurance policy or equivalent self-insurance.

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

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

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

19 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
20 (Civilian Health and Medical Program of the Uniformed Services
21 (CHAMPUS)).

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

24 (7) A state health benefits risk pool.

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

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

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

34 (11) Any other creditable coverage as defined by subsection (c)
35 of Section 2701 of Title XXVII of the federal Public Health
36 Services Act (42 U.S.C. Sec. 300gg(c)).

37 (e) "Affiliation period" means a period that, under the terms of
38 the health benefit plan, must expire before health care services
39 under the plan become effective.

1 (f) “Waivered condition” means a contract provision that
2 excludes coverage for charges or expenses incurred during a
3 specified period of time for one or more specific, identified,
4 medical conditions.

5 SEC. 5. Section 10700 of the Insurance Code is amended to
6 read:

7 10700. As used in this chapter:

8 (a) “Agent or broker” means a person or entity licensed under
9 Chapter 5 (commencing with Section 1621) of Part 2 of Division
10 1.

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

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

23 (d) “Carrier” means any disability insurance company or any
24 other entity that writes, issues, or administers health benefit plans
25 that cover the employees of small employers, regardless of the
26 situs of the contract or master policyholder. For the purposes of
27 Articles 3 (commencing with Section 10719) and 4 (commencing
28 with Section 10730), “carrier” also includes health care service
29 plans.

30 (e) “Dependent” means the spouse or child of an eligible
31 employee, subject to applicable terms of the health benefit plan
32 covering the employee, and includes dependents of guaranteed
33 association members if the association elects to include dependents
34 under its health coverage at the same time it determines its
35 membership composition pursuant to subdivision (z).

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

37 (1) Any permanent employee who is actively engaged on a
38 full-time basis in the conduct of the business of the small employer
39 with a normal workweek of at least 30 hours, in the small
40 employer’s regular place of business, who has met any statutorily

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

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

17 (B) The employer offers the employee health coverage under a
18 health benefit plan.

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

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

27 (2) Any member of a guaranteed association as defined in
28 subdivision (z).

29 (g) "Enrollee" means an eligible employee or dependent who
30 receives health coverage through the program from a participating
31 carrier.

32 (h) "Financially impaired" means, for the purposes of this
33 chapter, a carrier that, on or after the effective date of this chapter,
34 is not insolvent and is either:

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

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

39 (i) "Fund" means the California Small Group Reinsurance Fund.

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

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

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

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

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

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment provided that, if the individual

1 was covered under another employer health plan, the individual
2 was given the opportunity to make the certification required by
3 this subdivision and was notified that failure to do so could result
4 in later treatment as a late enrollee.

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

17 (D) He or she requests enrollment within 30 days after
18 termination of coverage or employer contribution toward coverage
19 provided under another employer health benefit plan, or requests
20 enrollment within 60 days after termination of no share-of-cost
21 Medi-Cal coverage or Healthy Families Program coverage.

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

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

27 (4) (A) In the case of an eligible employee as defined in
28 paragraph (1) of subdivision (f), the carrier cannot produce a
29 written statement from the employer stating that the individual or
30 the person through whom an individual was eligible to be covered
31 as a dependent, prior to declining coverage, was provided with,
32 and signed acknowledgment of, an explicit written notice in
33 boldface type specifying that failure to elect coverage during the
34 initial enrollment period permits the carrier to impose, at the time
35 of the individual's later decision to elect coverage, an exclusion
36 from coverage for a period of 12 months as well as a six-month
37 preexisting condition exclusion unless the individual meets the
38 criteria specified in paragraph (1), (2), or (3).

39 (B) In the case of an eligible employee who is a guaranteed
40 association member, the plan cannot produce a written statement

1 from the guaranteed association stating that the association sent a
2 written notice in boldface type to all potentially eligible association
3 members at their last known address prior to the initial enrollment
4 period informing members that failure to elect coverage during
5 the initial enrollment period permits the plan to impose, at the time
6 of the member's later decision to elect coverage, an exclusion from
7 coverage for a period of 12 months as well as a six-month
8 preexisting condition exclusion unless the member can demonstrate
9 that he or she meets the requirements of subparagraphs (A), (C),
10 and (D) of paragraph (1) or meets the requirements of paragraph
11 (2) or (3).

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

22 (5) The individual is an employee or dependent who meets the
23 criteria described in paragraph (1) and was under a COBRA
24 continuation provision and the coverage under that provision has
25 been exhausted. For purposes of this section, the definition of
26 "COBRA" set forth in subdivision (e) of Section 1373.62 shall
27 apply.

28 (6) The individual is a dependent of an enrolled eligible
29 employee who has lost or will lose his or her coverage under the
30 Healthy Families Program as a result of exceeding the program's
31 income or age limits or no share-of-cost Medi-Cal coverage and
32 requests enrollment within 60 days after notification of this loss
33 of coverage.

34 (7) The individual is an eligible employee who previously
35 declined coverage under an employer health benefit plan and who
36 has subsequently acquired a dependent who would be eligible for
37 coverage as a dependent of the employee through marriage, birth,
38 adoption, or placement for adoption, and who enrolls for coverage
39 under that employer health benefit plan on his or her behalf, and
40 on behalf of his or her dependent within 30 days following the

1 date of marriage, birth, adoption, or placement for adoption, in
2 which case the effective date of coverage shall be the first day of
3 the month following the date the completed request for enrollment
4 is received in the case of marriage, or the date of birth, or the date
5 of adoption or placement for adoption, whichever applies. Notice
6 of the special enrollment rights contained in this paragraph shall
7 be provided by the employer to an employee at or before the time
8 the employee is offered an opportunity to enroll in plan coverage.

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

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

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

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

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

35 (q) “Preexisting condition provision” means a policy provision
36 that excludes coverage for charges or expenses incurred during a
37 specified period following the insured’s effective date of coverage,
38 as to a condition for which medical advice, diagnosis, care, or
39 treatment was recommended or received during a specified period
40 immediately preceding the effective date of coverage.

1 (r) “Creditable coverage” means:

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

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

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

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

23 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
24 (Civilian Health and Medical Program of the Uniformed Services
25 (CHAMPUS)).

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

28 (7) A state health benefits risk pool.

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

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

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

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

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

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

7 (u) "Risk adjustment factor" means the percent adjustment to
8 be applied equally to each standard employee risk rate for a
9 particular small employer, based upon any expected deviations
10 from standard claims. This factor may not be more than 120 percent
11 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
12 this factor may not be more than 110 percent or less than 90
13 percent.

14 (v) "Risk category" means the following characteristics of an
15 eligible employee: age, geographic region, and family size of the
16 employee, plus the benefit plan design selected by the small
17 employer.

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

20 Under 30

21 30-39

22 40-49

23 50-54

24 55-59

25 60-64

26 65 and over

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

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

34 (A) Single.

35 (B) Married couple.

36 (C) One adult and child or children.

37 (D) Married couple and child or children.

38 (3) (A) In determining rates for small employers, a carrier that
39 operates statewide shall use no more than nine geographic regions
40 in the state, have no region smaller than an area in which the first

1 three digits of all its ZIP Codes are in common within a county
2 and shall divide no county into more than two regions. Carriers
3 shall be deemed to be operating statewide if their coverage area
4 includes 90 percent or more of the state's population. Geographic
5 regions established pursuant to this section shall, as a group, cover
6 the entire state, and the area encompassed in a geographic region
7 shall be separate and distinct from areas encompassed in other
8 geographic regions. Geographic regions may be noncontiguous.

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

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

25 (1) Any person, proprietary or nonprofit firm, corporation,
26 partnership, public agency, or association that is actively engaged
27 in business or service that, on at least 50 percent of its working
28 days during the preceding calendar quarter, or preceding calendar
29 year, employed at least two, but not more than 50, eligible
30 employees, the majority of whom were employed within this state,
31 that was not formed primarily for purposes of buying health
32 insurance and in which a bona fide employer-employee relationship
33 exists. In determining whether to apply the calendar quarter or
34 calendar year test, the insurer shall use the test that ensures
35 eligibility if only one test would establish eligibility. However,
36 for purposes of subdivisions (b) and (h) of Section 10705, the
37 definition shall include employers with at least three eligible
38 employees until July 1, 1997, and two eligible employees
39 thereafter. In determining the number of eligible employees,
40 companies that are affiliated companies and that are eligible to file

1 a combined income tax return for purposes of state taxation shall
2 be considered one employer. Subsequent to the issuance of a health
3 benefit plan to a small employer pursuant to this chapter, and for
4 the purpose of determining eligibility, the size of a small employer
5 shall be determined annually. Except as otherwise specifically
6 provided, provisions of this chapter that apply to a small employer
7 shall continue to apply until the health benefit plan anniversary
8 following the date the employer no longer meets the requirements
9 of this definition. It includes any small employer as defined in this
10 paragraph who purchases coverage through a guaranteed
11 association, and any employer purchasing coverage for employees
12 through a guaranteed association.

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

15 (x) "Standard employee risk rate" means the rate applicable to
16 an eligible employee in a particular risk category in a small
17 employer group.

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

1 with the carrier with which it contracts. The requirement of 1,000
2 persons may be met if component chapters of a statewide
3 association contracting separately with the same carrier cover at
4 least 1,000 persons in the aggregate.

5 This subdivision applies regardless of whether a master policy
6 by an admitted insurer is delivered directly to the association or a
7 trust formed for or sponsored by an association to administer
8 benefits for association members.

9 For purposes of this subdivision, an association formed by a
10 merger of two or more associations after January 1, 1992, and
11 otherwise meeting the criteria of this subdivision shall be deemed
12 to have been in active existence on January 1, 1992, if its
13 predecessor organizations had been in active existence on January
14 1, 1992, and for at least five years prior to that date and otherwise
15 met the criteria of this subdivision.

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

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

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

- 1 the meaning of Section 6 of Article XIII B of the California
- 2 Constitution.

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