

AMENDED IN SENATE JUNE 11, 2009

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 *or notification of the loss of coverage, as specified*.

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

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

3 (b) “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, at the small
7 employer’s regular places 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 included as employees under a health care plan
12 contract 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. Permanent employees who work at least 20 hours but
20 not more than 29 hours are deemed to be eligible employees if all
21 four of the following apply:

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

24 (B) The employer offers the employees health coverage under
25 a 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 health care service plan may request
31 any necessary information to document the hours and time period
32 in question, including, but not limited to, payroll records and
33 employee wage and tax filings.

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

36 (c) “In force business” means an existing health benefit plan
37 contract issued by the plan to a small employer.

38 (d) “Late enrollee” means an eligible employee or dependent
39 who has declined enrollment in a health benefit plan offered by a
40 small employer at the time of the initial enrollment period provided

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

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

16 (A) He or she was covered under another employer health
17 benefit plan, the Healthy Families Program, *the Access for Infants*
18 *and Mothers (AIM) Program*, or no share-of-cost Medi-Cal
19 coverage at the time the individual was eligible to enroll.

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

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

1 (D) He or she requests enrollment within 30 days after
2 termination of coverage or employer contribution toward coverage
3 provided under another employer health benefit plan, or requests
4 enrollment within 60 days after termination of no share-of-cost
5 Medi-Cal coverage, *AIM Program coverage*, or Healthy Families
6 Program coverage.

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

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

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

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

36 (C) In the case of an employer or person who is not a member
37 of an association, was eligible to purchase coverage through a
38 guaranteed association, and did not do so, and would not be eligible
39 to purchase guaranteed coverage unless purchased through a
40 guaranteed association, the employer or person can demonstrate

1 that he or she meets the requirements of subparagraphs (A), (C),
2 and (D) of paragraph (1), or meets the requirements of paragraph
3 (2) or (3), or that he or she recently had a change in status that
4 would make him or her eligible and that application for enrollment
5 was made within 30 days of the change.

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

12 (6) The individual is a dependent of an enrolled eligible
13 employee who has lost or will lose his or her coverage under the
14 Healthy Families Program as a result of exceeding the program’s
15 income or age limits, *coverage under the AIM Program*, or no
16 share-of-cost Medi-Cal coverage and requests enrollment within
17 60 days after ~~notification of this loss of termination of that~~
18 coverage.

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

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

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

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

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

19 (g) "Creditable coverage" means:

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

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

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

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

1 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
2 (Civilian Health and Medical Program of the Uniformed Services
3 (CHAMPUS)).

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

6 (7) A state health benefits risk pool.

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

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

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

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

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

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

25 (j) "Risk adjustment factor" means the percentage adjustment
26 to be applied equally to each standard employee risk rate for a
27 particular small employer, based upon any expected deviations
28 from standard cost of services. This factor may not be more than
29 120 percent or less than 80 percent until July 1, 1996. Effective
30 July 1, 1996, this factor may not be more than 110 percent or less
31 than 90 percent.

32 (k) "Risk category" means the following characteristics of an
33 eligible employee: age, geographic region, and family composition
34 of the employee, plus the health benefit plan selected by the small
35 employer.

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

38 Under 30

39 30-39

40 40-49

- 1 50–54
- 2 55–59
- 3 60–64
- 4 65 and over

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

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

- 13 (A) Single.
- 14 (B) Married couple.
- 15 (C) One adult and child or children.
- 16 (D) Married couple and child or children.

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

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

1 may be noncontiguous. No plan shall have less than one geographic
2 area.

3 (ii) If the formula in clause (i) results in a plan that operates in
4 more than one county having only one geographic region, then the
5 formula in clause (i) shall not apply and the plan may have two
6 geographic regions, provided that no county is divided into more
7 than one region.

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

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

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

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

3 (m) "Standard employee risk rate" means the rate applicable to
4 an eligible employee in a particular risk category in a small
5 employer group.

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

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

36 For purposes of this subdivision, an association formed by a
37 merger of two or more associations after January 1, 1992, and
38 otherwise meeting the criteria of this subdivision shall be deemed
39 to have been in active existence on January 1, 1992, if its
40 predecessor organizations had been in active existence on January

1 1, 1992, and for at least five years prior to that date and otherwise
2 met the criteria of this subdivision.

3 (o) “Members of a guaranteed association” means any individual
4 or employer meeting the association’s membership criteria if that
5 person is a member of the association and chooses to purchase
6 health coverage through the association. At the association’s
7 discretion, it also may include employees of association members,
8 association staff, retired members, retired employees of members,
9 and surviving spouses and dependents of deceased members.
10 However, if an association chooses to include these persons as
11 members of the guaranteed association, the association shall make
12 that election in advance of purchasing a plan contract. Health care
13 service plans may require an association to adhere to the
14 membership composition it selects for up to 12 months.

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

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

20 1357.50. For purposes of this article:

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

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

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

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

4 (A) The individual was covered under another employer health
5 benefit plan, the Healthy Families Program, *the Access for Infants*
6 *and Mothers (AIM) Program*, or no share-of-cost Medi-Cal
7 coverage at the time the individual was eligible to enroll.

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

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

29 (D) The individual requests enrollment within 30 days after
30 termination of coverage, or cessation of employer contribution
31 toward coverage provided under another employer health benefit
32 plan, or requests enrollment within 60 days after termination of
33 no share-of-cost Medi-Cal coverage, *AIM Program coverage*, or
34 Healthy Families Program coverage.

35 (2) The individual is employed by an employer that offers
36 multiple health benefit plans and the individual elects a different
37 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.
40 The health benefit plan shall enroll a dependent child within 30

1 days after receipt of a court order or request from the district
2 attorney, either parent or the person having custody of the child
3 as defined in Section 3751.5 of the Family Code, the employer,
4 or the group administrator. In the case of children who are eligible
5 for medicaid, the State Department of Health Services may also
6 make the request.

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

18 (5) The individual is an employee or dependent who meets the
19 criteria described in paragraph (1) and was under a COBRA
20 continuation provision, and the coverage under that provision has
21 been exhausted. For purposes of this section, the definition of
22 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
23 apply.

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

30 (7) The individual is an eligible employee who previously
31 declined coverage under an employer health benefit plan and who
32 has subsequently acquired a dependent who would be eligible for
33 coverage as a dependent of the employee through marriage, birth,
34 adoption, or placement for adoption, and who enrolls for coverage
35 under that employer health benefit plan on his or her behalf, and
36 on behalf of his or her dependent within 30 days following the
37 date of marriage, birth, adoption, or placement for adoption, in
38 which case the effective date of coverage shall be the first day of
39 the month following the date the completed request for enrollment
40 is received in the case of marriage, or the date of birth, or the date

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

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

22 (c) "Preexisting condition provision" means a contract provision
23 that excludes coverage for charges or expenses incurred during a
24 specified period following the enrollee's effective date of coverage,
25 as to a condition for which medical advice, diagnosis, care, or
26 treatment was recommended or received during a specified period
27 immediately preceding the effective date of coverage.

28 (d) "Creditable coverage" means:

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

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

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

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

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

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

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

16 (7) A state health benefits risk pool.

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

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

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

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

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

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

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

38 10198.6. For purposes of this article:

39 (a) “Health benefit plan” means any group or individual policy
40 or contract that provides medical, hospital, or surgical benefits.

1 The term does not include accident only, credit, disability income,
2 coverage of Medicare services pursuant to contracts with the United
3 States government, Medicare supplement, long-term care insurance,
4 dental, vision, coverage issued as a supplement to liability
5 insurance, insurance arising out of a workers' compensation or
6 similar law, automobile medical payment insurance, or insurance
7 under which benefits are payable with or without regard to fault
8 and that is statutorily required to be contained in any liability
9 insurance policy or equivalent self-insurance.

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

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

20 (A) The individual was covered under another employer health
21 benefit plan, the Healthy Families Program, *the Access for Infants*
22 *and Mothers (AIM) Program*, or no share-of-cost Medi-Cal
23 coverage at the time the individual was eligible to enroll.

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

32 (C) The individual has lost or will lose coverage under another
33 employer health benefit plan as a result of termination of
34 employment of the individual or of a person through whom the
35 individual was covered as a dependent, change in employment
36 status of the individual or of a person through whom the individual
37 was covered as a dependent, termination of the other plan's
38 coverage, cessation of an employer's contribution toward an
39 employee or dependent's coverage, death of a person through
40 whom the individual was covered as a dependent, legal separation,

1 divorce, loss of coverage under the Healthy Families Program as
2 a result of exceeding the program's income or age limits, *loss of*
3 *coverage under the AIM Program*, or loss of no share-of-cost
4 Medi-Cal coverage.

5 (D) The individual requests enrollment within 30 days after
6 termination of coverage, or cessation of employer contribution
7 toward coverage provided under another employer health benefit
8 plan, or requests enrollment within 60 days after termination of
9 no share-of-cost Medi-Cal coverage, *AIM Program coverage*, or
10 Healthy Families Program coverage.

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

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

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

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

33 (6) The individual is a dependent of an enrolled eligible
34 employee who has lost or will lose his or her coverage under the
35 Healthy Families Program as a result of exceeding the program's
36 income or age limits, *coverage under the AIM Program*, or no
37 share-of-cost Medi-Cal coverage and requests enrollment within
38 60 days of ~~notification of this loss of~~ *termination of that* coverage.

39 (c) "Preexisting condition provision" means a policy provision
40 that excludes coverage for charges or expenses incurred during a

1 specified period following the insured's effective date of coverage,
2 as to a condition for which medical advice, diagnosis, care, or
3 treatment was recommended or received during a specified period
4 immediately preceding the effective date of coverage.

5 (d) "Creditable coverage" means:

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

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

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

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

27 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
28 (Civilian Health and Medical Program of the Uniformed Services
29 (CHAMPUS)).

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

32 (7) A state health benefits risk pool.

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

36 (9) A public health plan as defined in federal regulations
37 authorized by Section 2701(c)(1)(I) of the Public Health Service
38 Act, as amended by Public Law 104-191, the Health Insurance
39 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 subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(e) “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.

(f) “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.

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

10700. As used in this chapter:

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

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

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

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

(e) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed

1 association members if the association elects to include dependents
2 under its health coverage at the same time it determines its
3 membership composition pursuant to subdivision (z).

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

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

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

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

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

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

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

37 (g) “Enrollee” means an eligible employee or dependent who
38 receives health coverage through the program from a participating
39 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, *the Access for Infants*
4 *and Mothers (AIM) Program*, or no share-of-cost Medi-Cal
5 coverage at the time the individual was eligible to enroll.

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

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

27 (D) He or she requests enrollment within 30 days after
28 termination of coverage or employer contribution toward coverage
29 provided under another employer health benefit plan, or requests
30 enrollment within 60 days after termination of no share-of-cost
31 Medi-Cal coverage, *AIM Program coverage*, or Healthy Families
32 Program coverage.

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

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

38 (4) (A) In the case of an eligible employee as defined in
39 paragraph (1) of subdivision (f), the carrier cannot produce a
40 written statement from the employer stating that the individual or

1 the person through whom an individual was eligible to be covered
2 as a dependent, prior to declining coverage, was provided with,
3 and signed acknowledgment of, an explicit written notice in
4 boldface type specifying that failure to elect coverage during the
5 initial enrollment period permits the carrier to impose, at the time
6 of the individual's later decision to elect coverage, an exclusion
7 from 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 (B) In the case of an eligible employee who is a guaranteed
11 association member, the plan cannot produce a written statement
12 from the guaranteed association stating that the association sent a
13 written notice in boldface type to all potentially eligible association
14 members at their last known address prior to the initial enrollment
15 period informing members that failure to elect coverage during
16 the initial enrollment period permits the plan to impose, at the time
17 of the member's later decision to elect coverage, an exclusion from
18 coverage for a period of 12 months as well as a six-month
19 preexisting condition exclusion unless the member can demonstrate
20 that he or she meets the requirements of subparagraphs (A), (C),
21 and (D) of paragraph (1) or meets the requirements of paragraph
22 (2) or (3).

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

33 (5) The individual is an employee or dependent who meets the
34 criteria described in paragraph (1) and was under a COBRA
35 continuation provision and the coverage under that provision has
36 been exhausted. For purposes of this section, the definition of
37 "COBRA" set forth in subdivision (e) of Section 1373.62 shall
38 apply.

39 (6) The individual is a dependent of an enrolled eligible
40 employee who has lost or will lose his or her coverage under the

1 Healthy Families Program as a result of exceeding the program's
2 income or age limits, *coverage under the AIM Program*, or no
3 share-of-cost Medi-Cal coverage and requests enrollment within
4 60 days after ~~notification of this loss of termination of that~~
5 coverage.

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

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

38 (m) "New business" means a health benefit plan issued to a
39 small employer that is not the carrier's in force business.

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

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

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

8 (q) “Preexisting condition provision” means a policy provision
9 that excludes coverage for charges or expenses incurred during a
10 specified period following the insured’s effective date of coverage,
11 as to a condition for which medical advice, diagnosis, care, or
12 treatment was recommended or received during a specified period
13 immediately preceding the effective date of coverage.

14 (r) “Creditable coverage” means:

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

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

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

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

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

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

1 (7) A state health benefits risk pool.

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

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

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

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

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

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

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

27 (v) "Risk category" means the following characteristics of an
28 eligible employee: age, geographic region, and family size of the
29 employee, plus the benefit plan design selected by the small
30 employer.

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

33 Under 30

34 30-39

35 40-49

36 50-54

37 55-59

38 60-64

39 65 and over

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

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

8 (A) Single.

9 (B) Married couple.

10 (C) One adult and child or children.

11 (D) Married couple and child or children.

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

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

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

39 (1) Any person, proprietary or nonprofit firm, corporation,
40 partnership, public agency, or association that is actively engaged

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

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

29 (x) "Standard employee risk rate" means the rate applicable to
30 an eligible employee in a particular risk category in a small
31 employer group.

32 (y) "Guaranteed association" means a nonprofit organization
33 comprised of a group of individuals or employers who associate
34 based solely on participation in a specified profession or industry,
35 accepting for membership any individual or employer meeting its
36 membership criteria which (1) includes one or more small
37 employers as defined in paragraph (1) of subdivision (w), (2) does
38 not condition membership directly or indirectly on the health or
39 claims history of any person, (3) uses membership dues solely for
40 and in consideration of the membership and membership benefits,

1 except that the amount of the dues shall not depend on whether
2 the member applies for or purchases insurance offered by the
3 association, (4) is organized and maintained in good faith for
4 purposes unrelated to insurance, (5) has been in active existence
5 on January 1, 1992, and for at least five years prior to that date,
6 (6) has been offering health insurance to its members for at least
7 five years prior to January 1, 1992, (7) has a constitution and
8 bylaws, or other analogous governing documents that provide for
9 election of the governing board of the association by its members,
10 (8) offers any benefit plan design that is purchased to all individual
11 members and employer members in this state, (9) includes any
12 member choosing to enroll in the benefit plan design offered to
13 the association provided that the member has agreed to make the
14 required premium payments, and (10) covers at least 1,000 persons
15 with the carrier with which it contracts. The requirement of 1,000
16 persons may be met if component chapters of a statewide
17 association contracting separately with the same carrier cover at
18 least 1,000 persons in the aggregate.

19 This subdivision applies regardless of whether a master policy
20 by an admitted insurer is delivered directly to the association or a
21 trust formed for or sponsored by an association to administer
22 benefits for association members.

23 For purposes of this subdivision, an association formed by a
24 merger of two or more associations after January 1, 1992, and
25 otherwise meeting the criteria of this subdivision shall be deemed
26 to have been in active existence on January 1, 1992, if its
27 predecessor organizations had been in active existence on January
28 1, 1992, and for at least five years prior to that date and otherwise
29 met the criteria of this subdivision.

30 (z) "Members of a guaranteed association" means any individual
31 or employer meeting the association's membership criteria if that
32 person is a member of the association and chooses to purchase
33 health coverage through the association. At the association's
34 discretion, it may also include employees of association members,
35 association staff, retired members, retired employees of members,
36 and surviving spouses and dependents of deceased members.
37 However, if an association chooses to include those persons as
38 members of the guaranteed association, the association must so
39 elect in advance of purchasing coverage from a plan. Health plans

1 may require an association to adhere to the membership
2 composition it selects for up to 12 months.

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

6 SEC. 6. No reimbursement is required by this act pursuant to
7 Section 6 of Article XIII B of the California Constitution because
8 the only costs that may be incurred by a local agency or school
9 district will be incurred because this act creates a new crime or
10 infraction, eliminates a crime or infraction, or changes the penalty
11 for a crime or infraction, within the meaning of Section 17556 of
12 the Government Code, or changes the definition of a crime within
13 the meaning of Section 6 of Article XIII B of the California
14 Constitution.