

AMENDED IN SENATE JUNE 16, 2009

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

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

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

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

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

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

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

39 (d) "Late enrollee" means an eligible employee or dependent
40 who has declined enrollment in a health benefit plan offered by a

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

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

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

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

29 (C) He or she has lost or will lose coverage under another
30 employer health benefit plan as a result of termination of
31 employment of the individual or of a person through whom the
32 individual was covered as a dependent, change in employment
33 status of the individual or of a person through whom the individual
34 was covered as a dependent, termination of the other plan's
35 coverage, cessation of an employer's contribution toward an
36 employee or dependent's coverage, death of the person through
37 whom the individual was covered as a dependent, legal separation,
38 divorce, loss of coverage under the Healthy Families Program as
39 a result of exceeding the program's income or age limits, loss of

1 coverage under the AIM Program, or loss of ~~no share of cost~~
2 Medi-Cal coverage.

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

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

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

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

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

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

1 to purchase guaranteed coverage unless purchased through a
2 guaranteed association, the employer or person can demonstrate
3 that he or she meets the requirements of subparagraphs (A), (C),
4 and (D) of paragraph (1), or meets the requirements of paragraph
5 (2) or (3), or that he or she recently had a change in status that
6 would make him or her eligible and that application for enrollment
7 was made within 30 days of the change.

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

14 (6) The individual is a dependent of an enrolled eligible
15 employee who has lost or will lose his or her coverage under the
16 Healthy Families Program as a result of exceeding the program’s
17 income or age limits, coverage under the AIM Program, or ~~no~~
18 ~~share-of-cost~~ Medi-Cal coverage and requests enrollment within
19 60 days after termination of that coverage.

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

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

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

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

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

20 (g) "Creditable coverage" means:

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

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

38 (3) The medicaid program pursuant to Title XIX of the Social
39 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)).

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

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

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

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

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

Under 30

1 30–39

2 40–49

3 50–54

4 55–59

5 60–64

6 65 and over

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

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

15 (A) Single.

16 (B) Married couple.

17 (C) One adult and child or children.

18 (D) Married couple and child or children.

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

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

1 geographic region shall be separate and distinct from areas
2 encompassed in other geographic regions. Geographic regions
3 may be noncontiguous. No plan shall have less than one geographic
4 area.

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

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

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

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

1 purchasing coverage for employees through a guaranteed
2 association.

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

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

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

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

38 For purposes of this subdivision, an association formed by a
39 merger of two or more associations after January 1, 1992, and
40 otherwise meeting the criteria of this subdivision shall be deemed

1 to have been in active existence on January 1, 1992, if its
2 predecessor organizations had been in active existence on January
3 1, 1992, and for at least five years prior to that date and otherwise
4 met the criteria of this subdivision.

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

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

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

22 1357.50. For purposes of this article:

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

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

1 enrollment period shall be a period of at least 30 days. However,
2 an eligible employee or dependent shall not be considered a late
3 enrollee if any of the following is applicable:

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

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

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

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

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

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

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

1 The health benefit plan shall enroll a dependent child within 30
2 days after receipt of a court order or request from the district
3 attorney, either parent or the person having custody of the child
4 as defined in Section 3751.5 of the Family Code, the employer,
5 or the group administrator. In the case of children who are eligible
6 for medicaid, the State Department of Health Services may also
7 make the request.

8 (4) The plan 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 plan 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 1373.621 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, coverage under the AIM Program, or ~~no~~
29 ~~share-of-cost~~ Medi-Cal coverage and requests enrollment within
30 60 days of termination of that coverage.

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

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

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

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

29 (d) "Creditable coverage" means:

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

1 of a workers' compensation or similar law, automobile medical
2 payment insurance, or insurance under which benefits are payable
3 with or without regard to fault and that is statutorily required to
4 be contained in any liability insurance policy or equivalent
5 self-insurance.

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

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

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

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

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

17 (7) A state health benefits risk pool.

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

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

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

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

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

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

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

39 10198.6. For purposes of this article:

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

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

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

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

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

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

1 employee or dependent's coverage, death of a person through
2 whom the individual was covered as a dependent, legal separation,
3 divorce, loss of coverage under the Healthy Families Program as
4 a result of exceeding the program's income or age limits, loss of
5 coverage under the AIM Program, or loss of ~~no share-of-cost~~
6 Medi-Cal coverage.

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

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

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

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

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

35 (6) The individual is a dependent of an enrolled eligible
36 employee who has lost or will lose his or her coverage under the
37 Healthy Families Program as a result of exceeding the program's
38 income or age limits, coverage under the AIM Program, or ~~no~~
39 ~~share-of-cost~~ Medi-Cal coverage and requests enrollment within
40 60 days of termination of that coverage.

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

7 (d) “Creditable coverage” means:

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

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

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

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

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

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

34 (7) A state health benefits risk pool.

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

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

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

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

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

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

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

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

17 10700. As used in this chapter:

18 (a) “Agent or broker” means a person or entity licensed under
19 Chapter 5 (commencing with Section 1621) of Part 2 of Division
20 1.

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

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

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

1 (e) “Dependent” means the spouse or child of an eligible
2 employee, subject to applicable terms of the health benefit plan
3 covering the employee, and includes dependents of guaranteed
4 association members if the association elects to include dependents
5 under its health coverage at the same time it determines its
6 membership composition pursuant to subdivision (z).

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

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

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

28 (B) The employer offers the employee health coverage under a
29 health benefit plan.

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

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

38 (2) Any member of a guaranteed association as defined in
39 subdivision (z).

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

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

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

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

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

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

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

26 (l) “Late enrollee” means an eligible employee or dependent
27 who has declined health coverage under a health benefit plan
28 offered by a small employer at the time of the initial enrollment
29 period provided under the terms of the health benefit plan, and
30 who subsequently requests enrollment in a health benefit plan of
31 that small employer, provided that the initial enrollment period
32 shall be a period of at least 30 days. It also means any member of
33 an association that is a guaranteed association as well as any other
34 person eligible to purchase through the guaranteed association
35 when that person has failed to purchase coverage during the initial
36 enrollment period provided under the terms of the guaranteed
37 association’s health benefit plan and who subsequently requests
38 enrollment in the plan, provided that the initial enrollment period
39 shall be a period of at least 30 days. However, an eligible
40 employee, another person eligible for coverage through a

1 guaranteed association pursuant to subdivision (z), or an eligible
2 dependent shall not be considered a late enrollee if any of the
3 following is applicable:

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

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

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

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

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

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

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

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

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

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

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

1 “COBRA” set forth in subdivision (e) of Section 1373.62 shall
2 apply.

3 (6) The individual is a dependent of an enrolled eligible
4 employee who has lost or will lose his or her coverage under the
5 Healthy Families Program as a result of exceeding the program’s
6 income or age limits, coverage under the AIM Program, or ~~no~~
7 ~~share-of-cost~~ Medi-Cal coverage and requests enrollment within
8 60 days after termination of that coverage.

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

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

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

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

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

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

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

16 (r) “Creditable coverage” means:

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

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

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

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

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

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

3 (7) A state health benefits risk pool.

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

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

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

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

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

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

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

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

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

35 Under 30

36 30-39

37 40-49

38 50-54

39 55-59

40 60-64

1 65 and over

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

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

9 (A) Single.

10 (B) Married couple.

11 (C) One adult and child or children.

12 (D) Married couple and child or children.

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

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

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

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

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

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

(y) "Guaranteed association" means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers as defined in paragraph (1) of subdivision (w), (2) does not condition membership directly or indirectly on the health or

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

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

25 For purposes of this subdivision, an association formed by a
26 merger of two or more associations after January 1, 1992, and
27 otherwise meeting the criteria of this subdivision shall be deemed
28 to have been in active existence on January 1, 1992, if its
29 predecessor organizations had been in active existence on January
30 1, 1992, and for at least five years prior to that date and otherwise
31 met the criteria of this subdivision.

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

1 elect in advance of purchasing coverage from a plan. Health plans
2 may require an association to adhere to the membership
3 composition it selects for up to 12 months.

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

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