

AMENDED IN SENATE JULY 23, 2009

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 Medi-Cal *program* 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~~ *align state law with*
3 *the provision of Section 311 of the federal Children’s Health*
4 *Insurance Program Reauthorization Act of 2009 (Public Law*
5 *111-3) that extends the period of time during which an employee*
6 *or dependent may enroll in group health care coverage, if he or*
7 *she is otherwise eligible, after termination of his or her coverage*
8 *under Medicaid or another state child health plan.*

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

3 1357. As used in this article:

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

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

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

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

31 (B) The employer offers the employees health coverage under
32 a health benefit plan.

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

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

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

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

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

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

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or ~~Medi-Cal coverage~~ *the Medi-Cal program* at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, or ~~Medi-Cal coverage~~ *the Medi-Cal program* was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan’s

coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, loss of coverage under the AIM Program, or loss of Medi-Cal coverage, the AIM Program, or the Medi-Cal program.

(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

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

(3) A court has ordered that coverage be provided for a spouse 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 (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the 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 plan 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 association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the 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

1 (A), (C), and (D) of paragraph (1) or meets the requirements of
2 paragraph (2) or (3).

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

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

19 (6) The individual is a dependent of an enrolled eligible
20 employee who has lost or will lose his or her coverage under the
21 ~~Healthy Families Program as a result of exceeding the program’s~~
22 ~~income or age limits, coverage under the AIM Program, or~~
23 ~~Medi-Cal coverage and requests enrollment within Healthy~~
24 ~~Families Program, the AIM Program, or the Medi-Cal program~~
25 ~~and requests enrollment within 60 days after termination of that~~
26 ~~coverage.~~

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

1 be provided by the employer to an employee at or before the time
2 the employee is offered an opportunity to enroll in plan coverage.

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

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

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

28 (g) “Creditable coverage” means:

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

1 without regard to fault and that is statutorily required to be
2 contained in any liability insurance policy or equivalent
3 self-insurance.

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

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

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

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

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

15 (7) A state health benefits risk pool.

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

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

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

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

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

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

34 (j) "Risk adjustment factor" means the percentage adjustment
35 to be applied equally to each standard employee risk rate for a
36 particular small employer, based upon any expected deviations
37 from standard cost of services. This factor may not be more than
38 120 percent or less than 80 percent until July 1, 1996. Effective
39 July 1, 1996, this factor may not be more than 110 percent or less
40 than 90 percent.

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

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

7 Under 30

8 30–39

9 40–49

10 50–54

11 55–59

12 60–64

13 65 and over

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

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

22 (A) Single.

23 (B) Married couple.

24 (C) One adult and child or children.

25 (D) Married couple and child or children.

26 (3) (A) In determining rates for small employers, a plan that
27 operates statewide shall use no more than nine geographic regions
28 in the state, have no region smaller than an area in which the first
29 three digits of all its ZIP Codes are in common within a county,
30 and divide no county into more than two regions. Plans shall be
31 deemed to be operating statewide if their coverage area includes
32 90 percent or more of the state’s population. Geographic regions
33 established pursuant to this section shall, as a group, cover the
34 entire state, and the area encompassed in a geographic region shall
35 be separate and distinct from areas encompassed in other
36 geographic regions. Geographic regions may be noncontiguous.

37 (B) (i) In determining rates for small employers, a plan that
38 does not operate statewide shall use no more than the number of
39 geographic regions in the state that is determined by the following
40 formula: the population, as determined in the last federal census,

1 of all counties that are included in their entirety in a plan's service
2 area divided by the total population of the state, as determined in
3 the last federal census, multiplied by nine. The resulting number
4 shall be rounded to the nearest whole integer. No region may be
5 smaller than an area in which the first three digits of all its ZIP
6 Codes are in common within a county and no county may be
7 divided into more than two regions. The area encompassed in a
8 geographic region shall be separate and distinct from areas
9 encompassed in other geographic regions. Geographic regions
10 may be noncontiguous. No plan shall have less than one geographic
11 area.

12 (ii) If the formula in clause (i) results in a plan that operates in
13 more than one county having only one geographic region, then the
14 formula in clause (i) shall not apply and the plan may have two
15 geographic regions, provided that no county is divided into more
16 than one region.

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

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

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

1 size of a small employer shall be determined annually. Except as
2 otherwise specifically provided in this article, provisions of this
3 article that apply to a small employer shall continue to apply until
4 the plan contract anniversary following the date the employer no
5 longer meets the requirements of this definition. It includes any
6 small employer as defined in this paragraph who purchases
7 coverage through a guaranteed association, and any employer
8 purchasing coverage for employees through a guaranteed
9 association.

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

12 (m) “Standard employee risk rate” means the rate applicable to
13 an eligible employee in a particular risk category in a small
14 employer group.

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

1 of a statewide association contracting separately with the same
2 carrier cover at least 1,000 persons in the aggregate.

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

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

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

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

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

30 1357.50. For purposes of this article:

31 (a) "Health benefit plan" means any individual or group
32 insurance policy or health care service plan contract that provides
33 medical, hospital, and surgical benefits. The term does not include
34 accident only, credit, disability income, coverage of Medicare
35 services pursuant to contracts with the United States government,
36 Medicare supplement, long-term care insurance, dental, vision,
37 coverage issued as a supplement to liability insurance, insurance
38 arising out of a workers' compensation or similar law, automobile
39 medical payment insurance, or insurance under which benefits are
40 payable with or without regard to fault and that is statutorily

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

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

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

13 (A) The individual was covered under another employer health
14 benefit plan, the Healthy Families Program, the Access for Infants
15 and Mothers (AIM) Program, or ~~Medi-Cal coverage~~ *the Medi-Cal*
16 *program* at the time the individual was eligible to enroll.

17 (B) The individual certified, at the time of the initial enrollment,
18 that coverage under another employer health benefit plan, the
19 Healthy Families Program, the AIM Program, or ~~Medi-Cal~~
20 ~~coverage~~ *the Medi-Cal program* was the reason for declining
21 enrollment provided that, if the individual was covered under
22 another employer health benefit plan, the individual was given the
23 opportunity to make the certification required by this subdivision
24 and was notified that failure to do so could result in later treatment
25 as a late enrollee.

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

39 (D) The individual requests enrollment within 30 days after
40 termination of coverage, or cessation of employer contribution

1 toward coverage provided under another employer health benefit
2 plan, or requests enrollment within 60 days after termination of
3 Medi-Cal *program* coverage, AIM Program coverage, or Healthy
4 Families Program coverage.

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

8 (3) A court has ordered that coverage be provided for a spouse
9 or minor child under a covered employee's health benefit plan.
10 The health benefit plan shall enroll a dependent child within 30
11 days after receipt of a court order or request from the district
12 attorney, either parent or the person having custody of the child
13 as defined in Section 3751.5 of the Family Code, the employer,
14 or the group administrator. In the case of children who are eligible
15 for medicaid, the State Department of Health *Care* Services may
16 also make the request.

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

28 (5) The individual is an employee or dependent who meets the
29 criteria described in paragraph (1) and was under a COBRA
30 continuation provision, and the coverage under that provision has
31 been exhausted. For purposes of this section, the definition of
32 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
33 apply.

34 (6) The individual is a dependent of an enrolled eligible
35 employee who has lost or will lose his or her coverage under the
36 ~~Healthy Families Program as a result of exceeding the program's~~
37 ~~income or age limits, coverage under the AIM Program, or~~
38 ~~Medi-Cal coverage and requests enrollment within Healthy~~
39 ~~Families Program, the AIM Program, or the Medi-Cal program~~

1 *and requests enrollment within 60 days of termination of that*
2 *coverage.*

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

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

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

1 (d) “Creditable coverage” means:

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

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

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

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

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

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

29 (7) A state health benefits risk pool.

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

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

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

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

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

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

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

10198.6. For purposes of this article:

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

(b) “Late enrollee” means 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 a health benefit plan of that employer; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

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

(A) The individual was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or ~~Medi-Cal coverage~~ *the Medi-Cal program* at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment that coverage under another employer health benefit plan, the

1 Healthy Families Program, the AIM Program, or ~~Medi-Cal~~
2 ~~coverage the Medi-Cal program~~ was the reason for declining
3 enrollment provided that, if the individual was covered under
4 another employer health benefit plan, the individual was given the
5 opportunity to make the certification required by this subdivision
6 and was notified that failure to do so could result in later treatment
7 as a late enrollee.

8 (C) The individual has lost or will lose coverage under another
9 employer health benefit plan as a result of termination of
10 employment of the individual or of a person through whom the
11 individual was covered as a dependent, change in employment
12 status of the individual or of a person through whom the individual
13 was covered as a dependent, termination of the other plan's
14 coverage, cessation of an employer's contribution toward an
15 employee or dependent's coverage, death of a person through
16 whom the individual was covered as a dependent, legal separation,
17 divorce, loss of coverage under the Healthy Families Program as
18 ~~a result of exceeding the program's income or age limits, loss of~~
19 ~~coverage under the AIM Program, or loss of Medi-Cal coverage,~~
20 *the AIM Program, or the Medi-Cal program.*

21 (D) The individual requests enrollment within 30 days after
22 termination of coverage, or cessation of employer contribution
23 toward coverage provided under another employer health benefit
24 plan, or requests enrollment within 60 days after termination of
25 Medi-Cal *program* coverage, AIM Program coverage, or Healthy
26 Families Program coverage.

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

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

32 (4) The carrier cannot produce a written statement from the
33 employer stating that, prior to declining coverage, the individual
34 or the person through whom the individual was eligible to be
35 covered as a dependent was provided with, and signed
36 acknowledgment of, explicit written notice in boldface type
37 specifying that failure to elect coverage during the initial
38 enrollment period permits the carrier to impose, at the time of the
39 individual's later decision to elect coverage, an exclusion from
40 coverage for a period of 12 months as well as a six-month

1 preexisting condition exclusion, unless the individual meets the
2 criteria specified in paragraph (1), (2), or (3).

3 (5) The individual is an employee or dependent who meets the
4 criteria described in paragraph (1) and was under a COBRA
5 continuation provision and the coverage under that provision has
6 been exhausted. For purposes of this section, the definition of
7 “COBRA” set forth in subdivision (e) of Section 10116.5 shall
8 apply.

9 (6) The individual is a dependent of an enrolled eligible
10 employee who has lost or will lose his or her coverage under the
11 ~~Healthy Families Program as a result of exceeding the program’s~~
12 ~~income or age limits, coverage under the AIM Program, or~~
13 ~~Medi-Cal coverage and requests enrollment within Healthy~~
14 ~~Families Program, the AIM Program, or the Medi-Cal program~~
15 ~~and requests enrollment within 60 days of termination of that~~
16 coverage.

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

23 (d) “Creditable coverage” means:

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

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

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

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

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

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

10 (7) A state health benefits risk pool.

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

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

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

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

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

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

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

32 10700. As used in this chapter:

33 (a) “Agent or broker” means a person or entity licensed under
34 Chapter 5 (commencing with Section 1621) of Part 2 of Division
35 1.

36 (b) “Benefit plan design” means a specific health coverage
37 product issued by a carrier to small employers, to trustees of
38 associations that include small employers, or to individuals if the
39 coverage is offered through employment or sponsored by an
40 employer. It includes services covered and the levels of copayment

1 and deductibles, and it may include the professional providers who
2 are to provide those services and the sites where those services are
3 to be provided. A benefit plan design may also be an integrated
4 system for the financing and delivery of quality health care services
5 which has significant incentives for the covered individuals to use
6 the system.

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

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

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

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

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

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

3 (B) The employer offers the employee health coverage under a
4 health benefit plan.

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

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

13 (2) Any member of a guaranteed association as defined in
14 subdivision (z).

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

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

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

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

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

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

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

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

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

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or ~~Medi-Cal coverage~~ *the Medi-Cal program* at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, or ~~Medi-Cal coverage~~ *the Medi-Cal program* was the reason for declining enrollment provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual, or of a person through whom the individual was covered as a dependent, the termination of the other plan’s coverage, cessation of an employer’s contribution toward an employee or dependent’s coverage, death of the person through 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 Medi-Cal coverage,
4 *the AIM Program, or the Medi-Cal program.*

5 (D) He or she requests enrollment within 30 days after
6 termination of coverage or employer contribution toward coverage
7 provided under another employer health benefit plan, or requests
8 enrollment within 60 days after termination of Medi-Cal *program*
9 coverage, AIM Program coverage, or Healthy Families Program
10 coverage.

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

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

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

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

17 (6) The individual is a dependent of an enrolled eligible
18 employee who has lost or will lose his or her coverage under the
19 ~~Healthy Families Program as a result of exceeding the program’s~~
20 ~~income or age limits, coverage under the AIM Program, or~~
21 ~~Medi-Cal coverage and requests enrollment within Healthy~~
22 ~~Families Program, the AIM Program, or the Medi-Cal program~~
23 ~~and requests enrollment within 60 days after termination of that~~
24 ~~coverage.~~

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

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

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

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

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

(p) "Program" means the Health Insurance Plan of California.

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

(r) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit,

1 coverage for onsite medical clinics, disability income, Medicare
2 supplement, long-term care, dental, vision, coverage issued as a
3 supplement to liability insurance, insurance arising out of a
4 workers' compensation or similar law, automobile medical payment
5 insurance, or insurance under which benefits are payable with or
6 without regard to fault and that is statutorily required to be
7 contained in any liability insurance policy or equivalent
8 self-insurance.

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

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

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

15 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
16 (Civilian Health and Medical Program of the Uniformed Services
17 (CHAMPUS)).

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

20 (7) A state health benefits risk pool.

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

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

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

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

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

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

39 (u) "Risk adjustment factor" means the percent adjustment to
40 be applied equally to each standard employee risk rate for a

1 particular small employer, based upon any expected deviations
2 from standard claims. This factor may not be more than 120 percent
3 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
4 this factor may not be more than 110 percent or less than 90
5 percent.

6 (v) "Risk category" means the following characteristics of an
7 eligible employee: age, geographic region, and family size of the
8 employee, plus the benefit plan design selected by the small
9 employer.

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

12 Under 30

13 30–39

14 40–49

15 50–54

16 55–59

17 60–64

18 65 and over

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

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

26 (A) Single.

27 (B) Married couple.

28 (C) One adult and child or children.

29 (D) Married couple and child or children.

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

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

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

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

1 of this definition. It includes any small employer as defined in this
2 paragraph who purchases coverage through a guaranteed
3 association, and any employer purchasing coverage for employees
4 through a guaranteed association.

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

7 (x) “Standard employee risk rate” means the rate applicable to
8 an eligible employee in a particular risk category in a small
9 employer group.

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

37 This subdivision applies regardless of whether a master policy
38 by an admitted insurer is delivered directly to the association or a
39 trust formed for or sponsored by an association to administer
40 benefits for association members.

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

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

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

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

CORRECTIONS:
Text—Page 14.