# SENATE BILL No. 796

**Introduced by Senators Alquist and Pavley**

February 27, 2009

An act to amend Sections 1366.35 and 1399.801 of, and to repeal Section 1399.818 of, the Health and Safety Code, and to amend Sections 10785 and 10900 of, and to repeal Section 10902.6 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 796, as introduced, Alquist. Health care coverage: continuation coverage.

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

Existing law requires health care service plans and health insurers to offer continuation of group coverage for a specified period of time to persons who become ineligible for the group coverage, otherwise known as COBRA or Cal-COBRA. Existing law allows persons qualifying as "federally eligible defined individuals" for purposes of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) to enroll in individual health care coverage offered by plans and insurers without preexisting condition exclusions, providing they meet certain requirements, including the election and exhaustion of COBRA or Cal-COBRA coverage available to them.

This bill would delete the requirement that a person must elect and exhaust COBRA or Cal-COBRA coverage in order to qualify for access to individual health care coverage as a federally eligible defined individual under HIPAA. By modifying the requirements applicable to

health care service plans, the bill would change the definition of a crime and would thereby 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:*

SECTION 1. Section 1366.35 of the Health and Safety Code is amended to read:

1366.35. (a) A health care service plan providing coverage for hospital, medical, or surgical benefits under an individual health care service plan contract may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, "federally eligible defined individual" means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

~~(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.~~

(c) Every health care service plan shall comply with applicable federal statutes and regulations regarding the provision of coverage

to federally eligible defined individuals, including any relevant application periods.

(d) A health care service plan shall offer the following health benefit plan contracts under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the plan in compliance with federal law. A health care service plan that offers only one health benefit plan contract to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this article if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this article.

(e) (1) In the case of a health care service plan that offers health insurance coverage in the individual market through a network plan, the plan may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area of the plan, deny coverage to individuals if the plan has demonstrated to the director that the plan will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contractholders and enrollees and individual enrollees, and that the plan is applying this paragraph uniformly to individuals without regard to any health status related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A health care service plan, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer coverage in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A health care service plan may deny health insurance coverage in the individual market to a federally eligible defined

individual if the plan has demonstrated to the director both of the following:

(A) The plan does not have the financial reserves necessary to underwrite additional coverage.

(B) The plan is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible individuals.

(2) A health care service plan, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the issuer has demonstrated to the director that the plan has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health insurance coverage offered by a health care service plan in the individual market in the same manner as it applies to a health care service plan in connection with a group health benefit plan.

(h) A health care service plan shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the plan compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan contract.

(i) Every health care service plan shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996~~, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits~~ in order to become a federally eligible defined individual.

(j) No health care service plan may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

~~( *l*) This section shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.~~

SEC. 2. Section 1399.801 of the Health and Safety Code is amended to read:

1399.801. As used in this article:

(a) "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 plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, 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.

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

(3) The medicaid program pursuant to Title XIX of the Social 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.A. Chapter 55 (commencing with Section 1071) (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.A. Chapter 89 (commencing with Section 8901) (FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)( *l*) 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 22 U.S.C.A. 2504(e) of the Peace Corps Act.

(b) "Dependent" means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health care plan contract covering the eligible person.

(c) "Federally eligible defined individual" means an individual who as of the date on which the individual seeks coverage under this part, (1) has 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and has no other health insurance coverage, *and* (3) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud~~, and (4) if offered continuation coverage under COBRA or Cal-COBRA, had elected and exhausted this coverage~~.

(d) "In force business" means an existing health benefit plan contract issued by the plan to a federally eligible defined individual.

(e) "New business" means a health care service plan contract issued to an eligible individual that is not the plan's in force business.

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

SEC. 3. Section 1399.818 of the Health and Safety Code is repealed.

~~1399.818. This article shall apply to health care service plan contracts offered, delivered, amended, or renewed on or after January 1, 2001.~~

SEC. 4. Section 10785 of the Insurance Code is amended to read:

10785. (a) A disability insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan as defined in subdivision (a) of Section 10198.6 may not, with respect to a federally eligible defined individual desiring to enroll in individual health insurance coverage, decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion with respect to the coverage.

(b) For purposes of this section, "federally eligible defined individual" means an individual who, as of the date on which the individual seeks coverage under this section, meets all of the following conditions:

(1) Has had 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002).

(2) Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have other health insurance coverage.

(3) Was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud.

~~(4) If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.~~

(c) Every disability insurer that covers hospital, medical, or surgical expenses shall comply with applicable federal statutes and regulations regarding the provision of coverage to federally eligible defined individuals, including any relevant application periods.

(d) A disability insurer shall offer the following health benefit plans under this section that are designed for, made generally available to, are actively marketed to, and enroll, individuals: (1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the insurer in compliance with federal law. An insurer that offers only one health benefit plan to individuals,

excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this chapter if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this chapter.

(e) (1) In the case of a disability insurer that offers health benefit plans in the individual market through a network plan, the insurer may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area covered by the health benefit plan, deny coverage to individuals if the insurer has demonstrated to the commissioner that the insured will not have the capacity to deliver services adequately to additional individual insureds because of its obligations to existing group policyholders, group contractholders and insureds, and individual insureds, and that the insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer health benefit plans through a network in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A disability insurer may deny health insurance coverage in the individual market to a federally eligible defined individual if the insurer has demonstrated to the commissioner both of the following:

(A) The insurer does not have the financial reserves necessary to underwrite additional coverage.

(B) The insurer is applying this subdivision uniformly to all individuals in the individual market and without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying individual health insurance coverage in any service area in accordance with paragraph (1), may not offer that coverage in the individual market within that service area for a period of 180 days after the date the coverage is denied or until the insurer has demonstrated to the

commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(g) The requirement pursuant to federal law to furnish a certificate of creditable coverage shall apply to health benefits plans offered by a disability insurer in the individual market in the same manner as it applies to an insurer in connection with a group health benefit plan policy or group health benefit plan contract.

(h) A disability insurer shall compensate a life agent or fire and casualty broker-agent whose activities result in the enrollment of federally eligible defined individuals in the same manner and consistent with the renewal commission amounts as the insurer compensates life agents or fire and casualty broker-agents for other enrollees who are not federally eligible defined individuals and who are purchasing the same individual health benefit plan.

(i) Every disability insurer shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996~~, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual~~.

(j) No disability insurer may request documentation as to whether or not a person is a federally eligible defined individual other than is permitted under applicable federal law or regulations.

(k) This section shall not apply to coverage defined as excepted benefits pursuant to Section 300gg(c) of Title 42 of the United States Code.

~~(*l*) This section shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.~~

SEC. 5. Section 10900 of the Insurance Code is amended to read:

10900. As used in this chapter:

(a) "Benefit plan design" means a specific health coverage policy issued by a carrier to individuals, to trustees of associations that cover individuals. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality

health services that has significant incentives for the covered individuals to use the system.

(b) "Carrier" means any disability insurance company or any other entity that writes, issues, or administers health benefit plans, as defined in subdivision (a) of Section 10198.6, that cover individuals, regardless of the situs of the contract or master policyholder.

(c) "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 plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Champus supplement, Medicare supplement, long-term care, 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.

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

(3) The medicaid program pursuant to Title XIX of the Social 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.A. Chapter 55 (commencing with Section 1071) (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.A. Chapter 89 (commencing with Section 8901) (FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(*l*) of the Public Health Service Act, as amended by Public Law 104-191.

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

(d) "Dependent" means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health benefit plan covering the eligible person.

(e) "Federally eligible defined individual" means an individual who as of the date on which the individual seeks coverage under this part, (1) has 18 or more months of creditable coverage, and whose most recent prior creditable coverage was under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under an employer-sponsored health benefit plan, Medicare, or Medi-Cal, and has no other health insurance coverage, *and* (3) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud~~, and (4) if offered continuation coverage under COBRA or Cal-COBRA, had elected and exhausted such coverage~~.

(f) "In force business" means an existing health benefit plan issued by a carrier to a federally eligible defined individual.

(g) "New business" means a health benefit plan issued to an eligible individual that is not the carrier's in force business.

(h) "Preexisting condition provision" means a policy provision that excludes coverage for charges and expenses incurred during a specified period following the eligible individual's effective date, 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.

SEC. 6. Section 10902.6 of the Insurance Code is repealed.

~~10902.6. This chapter shall apply to policies or contracts offered, delivered, amended, or renewed on or after January 1, 2001.~~

SEC. 7. The changes made by Sections 1, 2, 4, and 5 of this act shall apply to plan contracts, or policies or contracts, as the case may be, that are offered, delivered, amended, or renewed on or after January 1, 2010.

SEC. 8. 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.

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