

AMENDED IN SENATE AUGUST 8, 1996
AMENDED IN SENATE JULY 10, 1996
AMENDED IN ASSEMBLY APRIL 29, 1996
AMENDED IN ASSEMBLY APRIL 22, 1996
AMENDED IN ASSEMBLY MARCH 27, 1996

CALIFORNIA LEGISLATURE—1995–96 REGULAR SESSION

ASSEMBLY BILL

No. 3142

Introduced by Assembly Member Granlund

February 23, 1996

An act to amend ~~Sections 10198.6, 10700, and Section 12725~~ of, *and to add Sections 10198.61 and 10701 to*, the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 3142, as amended, Granlund. Insurance: health coverage.

Existing law limits exclusions for preexisting conditions or late enrollees by a health benefit plan. Under existing law, a health benefit plan is a group or individual policy or contract that provides medical, hospital, and surgical benefits, but does not include accident only, credit, disability income, and certain other forms of coverage.

Existing law regulates health benefit plans offered by small employer carriers. Under existing law, a health benefit plan is a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered

eligible employees of a small employer and their dependents, but does not include accident only, credit, disability income, and certain other forms of coverage.

This bill would also exclude from both definitions of “health benefit plan” set forth above, policies or certificates of specified disease and policies or certificates of hospital confinement indemnity if the carrier offering those policies or certificates files a certificate with the Insurance Commissioner containing specified information.

Existing law establishes the Major Risk Medical Insurance Program, in which persons unable to secure adequate private health coverage may apply for health coverage. To be eligible, a person must have been rejected for coverage by at least one private health plan.

This bill would provide that rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described, shall not be deemed to be rejection for the purposes of determining eligibility for the Major Risk Medical Insurance Program.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 ~~SECTION 1.—Section 10198.6 of the Insurance Code is~~
2 *SECTION 1. Section 10198.61 is added to the*
3 *Insurance Code, to read:*
4 *10198.61. (a) For purposes of this article, “health*
5 *benefit plan” does not include policies or certificates of*
6 *specified disease or hospital confinement indemnity*
7 *provided that the carrier offering those policies or*
8 *certificates complies with the following:*
9 *(1) The carrier files, on or before March 1 of each year,*
10 *a certification with the commissioner that contains the*
11 *statement and information described in paragraph (2).*
12 *(2) The certification required in paragraph (1) shall*
13 *contain the following:*
14 *(A) A statement from the carrier certifying that*
15 *policies or certificates described in this section (i) are*
16 *being offered and marketed as supplemental health*



1 insurance and not as a substitute for hospital or medical
2 expense insurance, health care service plans, or major
3 medical expense insurance, (ii) the disclosure forms as
4 described in Section 10603 contains the following
5 statement prominently on the first page: "This is a
6 supplement to health insurance. It is not a substitute for
7 hospital or medical expense insurance, a health
8 maintenance organization (HMO) contract, or major
9 medical expense insurance," and (iii) are not being
10 offered, marketed, or sold in a manner that would make
11 the purchase of the policies contingent upon the sale of
12 any product sold under Sections 10700 and 10718, or
13 under Section 1357 of the Health and Safety Code.

14 (B) A summary description of each policy or
15 certificate described in this section, including the average
16 annual premium rates, or range of premium rates in cases
17 where premiums vary by age, gender, or other factors,
18 charged for the policies and certificates in this state.

19 (3) In the case of a policy or certificate described in
20 this section and that is offered for the first time in this
21 state on or after January 1, 1997, the carrier files with the
22 commissioner the information and statement required in
23 paragraph (2) at least 30 days prior to the date such a
24 policy or certificate is issued or delivered in this state.

25 (b) As used in this section, "policies or certificates of
26 specified disease" and "policies or certificates of hospital
27 confinement indemnity" mean policies or certificates of
28 insurance sold to an insured to supplement other health
29 insurance coverage as specified in this section. An insurer
30 issuing a "policy or certificate of specified disease" or a
31 "policy or certificate of hospital confinement indemnity"
32 shall require that the person to be insured is covered by
33 an individual or group policy or contract that arranges or
34 provides medical, hospital, and surgical coverage not
35 designed to supplement other private or governmental
36 plans.

37 SEC. 2. Section 10701 is added to the Insurance Code,
38 to read:

39 10701. (a) For purposes of this chapter, "health
40 benefit plan" does not include policies or certificates of



1 *specified disease or hospital confinement indemnity*
2 *provided that the carrier offering those policies or*
3 *certificates complies with the following:*

4 (1) *The carrier files, on or before March 1 of each year,*
5 *a certification with the commissioner that contains the*
6 *statement and information described in paragraph (2).*

7 (2) *The certification required in paragraph (1) shall*
8 *contain the following:*

9 (A) *A statement from the carrier certifying that*
10 *policies or certificates described in this section (i) are*
11 *being offered and marketed as supplemental health*
12 *insurance and not as a substitute for hospital or medical*
13 *expense insurance, health care service plans, or major*
14 *medical expense insurance, (ii) the disclosure forms as*
15 *described in Section 10603 contains the following*
16 *statement prominently on the first page: "This is a*
17 *supplement to health insurance. It is not a substitute for*
18 *hospital or medical expense insurance, a health*
19 *maintenance organization (HMO) contract, or major*
20 *medical expense insurance," and (iii) are not being*
21 *offered, marketed, or sold in a manner that would make*
22 *the purchase of the policies contingent upon the sale of*
23 *any product sold under Sections 10700 and 10718, or*
24 *under Section 1357 of the Health and Safety Code.*

25 (B) *A summary description of each policy or*
26 *certificate described in this section, including the average*
27 *annual premium rates, or range of premium rates in cases*
28 *where premiums vary by age, gender, or other factors,*
29 *charged for the policies and certificates in this state.*

30 (3) *In the case of a policy or certificate that is*
31 *described in this section and that is offered for the first*
32 *time in this state on or after January 1, 1997, the carrier*
33 *files with the commissioner the information and*
34 *statement required in paragraph (2) at least 30 days prior*
35 *to the date such a policy or certificate is issued or*
36 *delivered in this state.*

37 (b) *As used in this section, "policies or certificates of*
38 *specified disease" and "policies or certificates of hospital*
39 *confinement indemnity" mean policies or certificates of*
40 *insurance sold to an insured to supplement other health*



1 insurance coverage as specified in this section. An insurer
2 issuing a “policy or certificate of specified disease” or a
3 “policy or certificate of hospital confinement indemnity”
4 shall require that the person to be insured is covered by
5 an individual or group policy or contract that arranges or
6 provides medical, hospital, and surgical coverage not
7 designed to supplement other private or governmental
8 plans.

9 amended to read:

10 10198.6. For purposes of this article:

11 (a) (1) ~~“Health benefit plan” means any group or~~
12 ~~individual policy or contract that provides medical,~~
13 ~~hospital, and surgical benefits.~~

14 (2) ~~“Health benefit plan” does not include accident~~
15 ~~only, credit, disability income, coverage of medicare~~
16 ~~services pursuant to contracts with the United States~~
17 ~~government, medicare supplement, long-term care~~
18 ~~insurance, dental, vision, coverage issued as a supplement~~
19 ~~to liability insurance, insurance arising out of a workers’~~
20 ~~compensation or similar law, automobile medical~~
21 ~~payment insurance, or insurance under which benefits~~
22 ~~are payable with or without regard to fault and that is~~
23 ~~statutorily required to be contained in any liability~~
24 ~~insurance policy or equivalent self-insurance.~~

25 (3) ~~“Health benefit plan” does not include policies or~~
26 ~~certificates of specified disease or hospital confinement~~
27 ~~indemnity provided that the carrier offering those~~
28 ~~policies or certificates complies with the following:~~

29 (A) ~~The carrier files, on or before March 1 of each year,~~
30 ~~a certification with the commissioner that contains the~~
31 ~~statement and information described in subparagraph~~
32 ~~(B).~~

33 (B) ~~The certification required in subparagraph (A)~~
34 ~~shall contain the following:~~

35 (i) ~~A statement from the carrier certifying that~~
36 ~~policies or certificates described in this paragraph (I) are~~
37 ~~being offered and marketed as supplemental health~~
38 ~~insurance and not as a substitute for hospital or medical~~
39 ~~expense insurance, health care service plans, or major~~
40 ~~medical expense insurance, (II) the disclosure forms as~~



1 ~~described in Section 10603 contains the following~~
 2 ~~statement prominently on the first page: “This is a~~
 3 ~~supplement to health insurance. It is not a substitute for~~
 4 ~~hospital or medical expense insurance, a health~~
 5 ~~maintenance organization (HMO) contract, or major~~
 6 ~~medical expense insurance,” and (H) are not being~~
 7 ~~offered, marketed, or sold in a manner that would make~~
 8 ~~the purchase of the policies contingent upon the sale of~~
 9 ~~any product sold under Sections 10700 and 10718, or~~
 10 ~~under Section 1357 of the Health and Safety Code.~~

11 ~~(ii) A summary description of each policy or~~
 12 ~~certificate described in this paragraph, including the~~
 13 ~~average annual premium rates, or range of premium~~
 14 ~~rates in cases where premiums vary by age, gender, or~~
 15 ~~other factors, charged for the policies and certificates in~~
 16 ~~this state.~~

17 ~~(C) In the case of a policy or certificate that is~~
 18 ~~described in this paragraph and that is offered for the first~~
 19 ~~time in this state on or after January 1, 1997, the carrier~~
 20 ~~files with the commissioner the information and~~
 21 ~~statement required in subparagraph (B) at least 30 days~~
 22 ~~prior to the date such a policy or certificate is issued or~~
 23 ~~delivered in this state.~~

24 ~~(4) As used in paragraph (3), “policies or certificates~~
 25 ~~of specified disease” and “policies or certificates of~~
 26 ~~hospital confinement indemnity” mean policies or~~
 27 ~~certificates of insurance sold to an insured to supplement~~
 28 ~~other health insurance coverage as specified in this~~
 29 ~~paragraph. An insurer issuing a “policy or certificate of~~
 30 ~~specified disease” or a “policy or certificate of hospital~~
 31 ~~confinement indemnity” shall require that the person to~~
 32 ~~be insured is covered by an individual or group policy or~~
 33 ~~contract that arranges or provides medical, hospital, and~~
 34 ~~surgical coverage not designed to supplement other~~
 35 ~~private or governmental plans.~~

36 ~~(b) “Late enrollee” means an eligible employee or~~
 37 ~~dependent who has declined health coverage under a~~
 38 ~~health benefit plan offered through employment or~~
 39 ~~sponsored by an employer at the time of the initial~~
 40 ~~enrollment period provided under the terms of the~~



1 ~~health benefit plan, and who subsequently requests~~
2 ~~enrollment in a health benefit plan of that employer;~~
3 ~~provided that the initial enrollment period shall be a~~
4 ~~period of at least 30 days. However, an eligible employee~~
5 ~~or dependent shall not be considered a late enrollee if any~~
6 ~~of the following is applicable:~~

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

9 ~~(A) The individual was covered under another~~
10 ~~employer health benefit plan at the time the individual~~
11 ~~was eligible to enroll.~~

12 ~~(B) The individual certified, at the time of the initial~~
13 ~~enrollment that coverage under another employer health~~
14 ~~benefit plan was the reason for declining enrollment~~
15 ~~provided that, if the individual was covered under~~
16 ~~another employer health plan, the individual was given~~
17 ~~the opportunity to make the certification required by this~~
18 ~~subdivision and was notified that failure to do so could~~
19 ~~result in later treatment as a late enrollee.~~

20 ~~(C) The individual has lost or will lose coverage under~~
21 ~~another employer health benefit plan as a result of~~
22 ~~termination of employment of the individual or of a~~
23 ~~person through whom the individual was covered as a~~
24 ~~dependent, change in employment status of the~~
25 ~~individual or of a person through whom the individual~~
26 ~~was covered as a dependent, termination of the other~~
27 ~~plan's coverage, cessation of an employer's contribution~~
28 ~~toward an employee or dependent's coverage, death of a~~
29 ~~person through whom the individual was covered as a~~
30 ~~dependent, or divorce.~~

31 ~~(D) The individual requests enrollment within 30 days~~
32 ~~after termination of coverage, or cessation of employer~~
33 ~~contribution toward coverage provided under another~~
34 ~~employer health benefit plan.~~

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

38 ~~(3) A court has ordered that coverage be provided for~~
39 ~~a spouse or minor child under a covered employee's~~



1 ~~health benefit plan and request for enrollment is made~~
2 ~~within 30 days after issuance of the court order.~~

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

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

22 ~~(d) "Qualifying prior coverage" means:~~

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

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

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

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

8 ~~SEC. 2. Section 10700 of the Insurance Code is~~
9 ~~amended to read:~~

10 ~~10700. As used in this chapter:~~

11 ~~(a) "Agent or broker" means a person or entity~~
12 ~~licensed under Chapter 5 (commencing with Section~~
13 ~~1621) of Part 2 of Division 1.~~

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

27 ~~(c) "Board" means the Major Risk Medical Insurance~~
28 ~~Board.~~

29 ~~(d) "Carrier" means any disability insurance~~
30 ~~company, nonprofit hospital service plan, or any other~~
31 ~~entity that writes, issues, or administers health benefit~~
32 ~~plans that cover the employees of small employers,~~
33 ~~regardless of the situs of the contract or master~~
34 ~~policyholder. For the purposes of Articles 3 (commencing~~
35 ~~with Section 10719) and 4 (commencing with Section~~
36 ~~10730), "carrier" also includes health care service plans.~~

37 ~~(e) "Dependent" means the spouse or child of an~~
38 ~~eligible employee, subject to applicable terms of the~~
39 ~~health benefit plan covering the employee, and includes~~
40 ~~dependents of guaranteed association members if the~~



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

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

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

23 (2) Any member of a guaranteed association as
24 defined in subdivision (z).

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

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

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

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

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

37 (j) “Health benefit plan” means a policy or contract
38 written or administered by a carrier that arranges or
39 provides health care benefits for the covered eligible
40 employees of a small employer and their dependents.



1 ~~(2) “Health benefit plan” does not include accident~~
2 ~~only, credit, disability income, coverage of medicare~~
3 ~~services pursuant to contracts with the United States~~
4 ~~government, medicare supplement, long term care~~
5 ~~insurance, dental, vision, coverage issued as a supplement~~
6 ~~to liability insurance, automobile medical payment~~
7 ~~insurance, or insurance under which benefits are payable~~
8 ~~with or without regard to fault and that is statutorily~~
9 ~~required to be contained in any liability insurance policy~~
10 ~~or equivalent self-insurance.~~

11 ~~(3) “Health benefit plan” does not include policies or~~
12 ~~certificates of specified disease or hospital confinement~~
13 ~~indemnity provided that the carrier offering those~~
14 ~~policies or certificates complies with the following:~~

15 ~~(A) The carrier files, on or before March 1 of each year,~~
16 ~~a certification with the commissioner that contains the~~
17 ~~statement and information described in subparagraph~~
18 ~~(B).~~

19 ~~(B) The certification required in subparagraph (A)~~
20 ~~shall contain the following:~~

21 ~~(i) A statement from the carrier certifying that~~
22 ~~policies or certificates described in this paragraph (I) are~~
23 ~~being offered and marketed as supplemental health~~
24 ~~insurance and not as a substitute for hospital or medical~~
25 ~~expense insurance, health care service plans, or major~~
26 ~~medical expense insurance, (II) the disclosure forms as~~
27 ~~described in Section 10603 contains the following~~
28 ~~statement prominently on the first page: “This is a~~
29 ~~supplement to health insurance. It is not a substitute for~~
30 ~~hospital or medical expense insurance, a health~~
31 ~~maintenance organization (HMO) contract, or major~~
32 ~~medical expense insurance,” and (III) are not being~~
33 ~~offered, marketed, or sold in a manner that would make~~
34 ~~the purchase of the policies contingent upon the sale of~~
35 ~~any product sold under Sections 10700 and 10718, or~~
36 ~~under Section 1357 of the Health and Safety Code.~~

37 ~~(ii) A summary description of each policy or~~
38 ~~certificate described in this paragraph, including the~~
39 ~~average annual premium rates, or range of premium~~
40 ~~rates in cases where premiums vary by age, gender, or~~



1 ~~other factors, charged for the policies and certificates in~~
2 ~~this state.~~

3 ~~(C) In the case of a policy or certificate that is~~
4 ~~described in this paragraph and that is offered for the first~~
5 ~~time in this state on or after January 1, 1997, the carrier~~
6 ~~files with the commissioner the information and~~
7 ~~statement required in subparagraph (B) at least 30 days~~
8 ~~prior to the date such a policy or certificate is issued or~~
9 ~~delivered in this state.~~

10 ~~(4) As used in paragraph (3), “policies or certificates~~
11 ~~of specified disease” and “policies or certificates of~~
12 ~~hospital confinement indemnity” mean policies or~~
13 ~~certificates of insurance sold to an insured to supplement~~
14 ~~other health insurance coverage as specified in this~~
15 ~~paragraph. An insurer issuing a “policy or certificate of~~
16 ~~specified disease” or a “policy or certificate of hospital~~
17 ~~confinement indemnity” shall require that the person to~~
18 ~~be insured is covered by an individual or group policy or~~
19 ~~contract that arranges or provides medical, hospital, and~~
20 ~~surgical coverage not designed to supplement other~~
21 ~~private or governmental plans.~~

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

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



1 for coverage through a guaranteed association pursuant
2 to subdivision (z), or dependent shall not be considered
3 a late enrollee if: (1) the individual meets all of the
4 following: (A) was covered under another employer
5 health benefit plan at the time the individual was eligible
6 to enroll; (B) certified at the time of the initial
7 enrollment, that coverage under another employer
8 health benefit plan was the reason for declining
9 enrollment provided that, if the individual was covered
10 under another employer health plan, the individual was
11 given the opportunity to make the certification required
12 by this subdivision and was notified that failure to do so
13 could result in later treatment as a late enrollee; (C) has
14 lost or will lose coverage under another employer health
15 benefit plan as a result of termination of employment of
16 the individual or of a person through whom the individual
17 was covered as a dependent, change in employment
18 status of the individual, or of a person through whom the
19 individual was covered as a dependent, the termination
20 of the other plan's coverage, cessation of an employer's
21 contribution toward an employee or dependent's
22 coverage, death of the person through whom the
23 individual was covered as a dependent, or divorce; and
24 (D) requests enrollment within 30 days after termination
25 of coverage or employer contribution toward coverage
26 provided under another employer health benefit plan; or
27 (2) the individual is employed by an employer who offers
28 multiple health benefit plans and the individual elects a
29 different plan during an open enrollment period; or (3)
30 a court has ordered that coverage be provided for a
31 spouse or minor child under a covered employee's health
32 benefit plan; or (4) (A) in the case of an eligible employee
33 as defined in paragraph (1) of subdivision (f), the carrier
34 cannot produce a written statement from the employer
35 stating that the individual or the person through whom
36 an individual was eligible to be covered as a dependent,
37 prior to declining coverage, was provided with, and
38 signed acknowledgment of, an explicit written notice in
39 bold type specifying that failure to elect coverage during
40 the initial enrollment period permits the carrier to



1 ~~impose, at the time of the individual's later decision to~~
2 ~~elect coverage, an exclusion from coverage for a period~~
3 ~~of 12 months as well as a six-month preexisting condition~~
4 ~~exclusion unless the individual meets the criteria~~
5 ~~specified in paragraph (1), (2), or (3); (B) in the case of~~
6 ~~an eligible employee who is a guaranteed association~~
7 ~~member, the plan cannot produce a written statement~~
8 ~~from the guaranteed association stating that the~~
9 ~~association sent a written notice in bold type to all~~
10 ~~association members at their last known address prior to~~
11 ~~the initial enrollment period informing members that~~
12 ~~failure to elect coverage during the initial enrollment~~
13 ~~period permits the plan to impose, at the time of the~~
14 ~~member's later decision to elect coverage, an exclusion~~
15 ~~from coverage for a period of 12 months as well as a~~
16 ~~six-month preexisting condition exclusion unless the~~
17 ~~member can demonstrate that he or she meets the~~
18 ~~requirements of subparagraphs (A), (C), and (D) of~~
19 ~~paragraph (1) or paragraph (2) or (3); or (C) in the case~~
20 ~~of an employer or person who is not a member of an~~
21 ~~association, was eligible to purchase coverage through a~~
22 ~~guaranteed association, and did not do so, and would not~~
23 ~~be eligible to purchase guaranteed coverage unless~~
24 ~~purchased through a guaranteed association, the~~
25 ~~employer or person can demonstrate that he or she meets~~
26 ~~the requirements of subparagraphs (A), (C), and (D) of~~
27 ~~paragraph (1), or paragraph (2) or (3), or that he or she~~
28 ~~recently had a change in status that would make him or~~
29 ~~her eligible and that application for coverage was made~~
30 ~~within 30 days of the change.~~

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

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

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



1 ~~(p) “Program” means the Voluntary Alliance Uniting~~
2 ~~Employers Purchasing Program.~~

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

10 ~~(r) “Qualifying prior coverage” means:~~

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

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

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

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

36 ~~(s) “Rating period” means the period for which~~
37 ~~premium rates established by a carrier are in effect and~~
38 ~~shall be no less than six months.~~

39 ~~(t) “Risk adjusted employee risk rate” means the rate~~
40 ~~determined for an eligible employee of a small employer~~



1 in a particular risk category after applying the risk
2 adjustment factor.

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

10 (v) “Risk category” means the following
11 characteristics of an eligible employee: age, geographic
12 region, and family size of the employee, plus the benefit
13 plan design selected by the small employer.

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

16 Under 30

17 30-39

18 40-49

19 50-54

20 55-59

21 60-64

22 65 and over

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

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

32 (A) Single.

33 (B) Married couple.

34 (C) One adult and child or children.

35 (D) Married couple and child or children.

36 (3) (A) In determining rates for small employers, a
37 carrier that operates statewide shall use no more than
38 nine geographic regions in the state, have no region
39 smaller than an area in which the first three digits of all
40 its ZIP Codes are in common within a county and shall



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

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

27 (w) ~~“Small employer” means either of the following:~~

28 (1) ~~Any person, proprietary or nonprofit firm,~~
29 ~~corporation, partnership, public agency, or association~~
30 ~~that is actively engaged in business or service that, on at~~
31 ~~least 50 percent of its working days during the preceding~~
32 ~~calendar quarter, employed at least three, but not more~~
33 ~~than 50, eligible employees, the majority of whom were~~
34 ~~employed within this state, that was not formed primarily~~
35 ~~for purposes of buying health insurance and in which a~~
36 ~~bona fide employer-employee relationship exists.~~
37 ~~However, for purposes of subdivisions (b) and (h) of~~
38 ~~Section 10705, the definition shall include employers with~~
39 ~~at least five eligible employees until July 1, 1994, four~~
40 ~~eligible employees until July 1, 1995, and three eligible~~



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

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

21 (x) “Standard employee risk rate” means the rate
22 applicable to an eligible employee in a particular risk
23 category in a small employer group.

24 (y) “Guaranteed association” means a nonprofit
25 organization comprised of a group of individuals or
26 employers who associate based solely on participation in
27 a specified profession or industry, accepting for
28 membership any individual or employer meeting its
29 membership criteria which (1) includes one or more
30 small employers as defined in paragraph (1) of
31 subdivision (w), (2) does not condition membership
32 directly or indirectly on the health or claims history of any
33 person, (3) uses membership dues solely for and in
34 consideration of the membership and membership
35 benefits, except that the amount of the dues shall not
36 depend on whether the member applies for or purchases
37 insurance offered by the association, (4) is organized and
38 maintained in good faith for purposes unrelated to
39 insurance, (5) has been in active existence on January 1,
40 1992, and for at least five years prior to that date, (6) has



1 ~~been offering health insurance to its members for at least~~
2 ~~five years prior to January 1, 1992, (7) has a constitution~~
3 ~~and bylaws, or other analogous governing documents that~~
4 ~~provide for election of the governing board of the~~
5 ~~association by its members, (8) offers any benefit plan~~
6 ~~design that is purchased to all individual members and~~
7 ~~employer members in this state, (9) includes any~~
8 ~~member choosing to enroll in the benefit plan design~~
9 ~~offered to the association provided that the member has~~
10 ~~agreed to make the required premium payments, and~~
11 ~~(10) covers at least 1,000 persons with the carrier with~~
12 ~~which it contracts. The requirement of 1,000 persons may~~
13 ~~be met if component chapters of a statewide association~~
14 ~~contracting separately with the same carrier cover at~~
15 ~~least 1,000 persons in the aggregate.~~

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

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

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



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

3 SEC. 3. Section 12725 of the Insurance Code is
4 amended to read:

5 12725. Each resident of the state meeting the
6 eligibility criteria of this section and who is unable to
7 secure adequate private health coverage is eligible to
8 apply for major risk medical coverage through the
9 program. To be eligible for enrollment in the program an
10 applicant shall have been rejected for health care
11 coverage by at least one private health plan. An applicant
12 shall be deemed to have been rejected if the only private
13 health coverage which the applicant could secure would
14 (1) impose substantial waivers which the program
15 determines would leave a subscriber without adequate
16 coverage for medically necessary services, or (2) would
17 afford such limited coverage, as the program determines
18 would leave the subscriber without adequate coverage
19 for medically necessary services, or (3) would afford
20 coverage only at an excessive price, which the board
21 determines is significantly above standard average
22 individual coverage rates. Rejection for policies or
23 certificates of specified disease or policies or certificates
24 of hospital confinement indemnity, as described in
25 ~~paragraph (3) of subdivision (a) of Section 10198.6~~
26 *Section 10198.61*, shall not be deemed to be rejection for
27 the purposes of eligibility for enrollment. The board may
28 permit dependents of eligible subscribers to enroll in
29 major risk medical coverage through the program if the
30 board determines the enrollment can be carried out in an
31 actuarially and administratively sound manner.

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