AMENDED IN SENATE JUNE 24, 1999

AMENDED IN SENATE JUNE 9, 1999

AMENDED IN ASSEMBLY MAY 3, 1999

AMENDED IN ASSEMBLY APRIL 26, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 1032

Introduced by Assembly Member Thomson
(Coauthors: Assembly Members Aroner, Knox, Kuehl, Longville, Mazzoni, Romero, and Strom-Martin)

February 25, 1999

An act to amend Section 1357 of the Health and Safety Code, and to amend Sections 10700, 10733.5, 12693.43, 12698, 12705, and 12725 of the Insurance Code, relating to health insurance, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1032, as amended, Thomson. Health coverage: federally recognized California Indian tribes.

(1) Existing law imposes various requirements on health care service plans and disability insurers with respect to small employer health coverage. Existing law provides that a willful violation of provisions regulating health care service plans is a crime. Existing law defines ''small employer'' for these purposes to mean an employer that employs at least 2, but not more than 50 employees, or a guaranteed association, as defined, that purchases health insurance for its members.

Existing law also provides for creation of a health insurance purchasing pool for small employers known as the Health Insurance Plan of California, which is administered by the Managed Risk Medical Insurance Board.

This bill would modify the definition of ''small employer'' for these purposes by providing that ''small employer'' also includes any federally recognized California Indian ~~tribe~~ *tribal government* that purchases health coverage for eligible members of the tribe under specified circumstances. Because a violation of the bill's requirements with respect to health care service plans would be a crime, this bill would impose a state-mandated local program by expanding the definition of an existing crime.

(2) Existing law creates the Healthy Families Program, which is also administered by the Managed Risk Medical Insurance Board, to provide health care coverage to eligible children meeting certain income and other eligibility requirements and subject to certain required family contributions.

This bill would authorize a federally recognized California Indian ~~tribe~~ *tribal government* or an Indian health service facility to make required family contributions on behalf of a member of the tribe.

(3) Existing law creates the Access for Infants and Mothers Program, which is also administered by the Managed Risk Medical Insurance Board, to provide coverage for perinatal and infant care to residents of this state meeting certain income and other eligibility requirements and paying certain subscriber contributions. Funding for the program is provided by the Perinatal Insurance Fund, a continuously appropriated fund.

This bill would provide that a member of a federally recognized California Indian tribe is a resident of this state for these purposes. This bill would authorize a federally recognized California Indian ~~tribe~~ *tribal government* or an Indian health service facility to make required subscriber contributions on behalf of a member of the tribe. Because this bill would result in an increase in revenues to the fund and an increase in expenditures from the fund, it would thereby make an appropriation.

(4) Existing law creates the California Major Risk Medical Insurance Program, which is also administered by the board, to provide major risk health coverage to residents of this state who are unable to secure adequate private health coverage because of preexisting medical conditions and who meet other eligibility requirements and pay certain subscriber contributions. Funding for the program is provided by the Major Risk Medical Insurance Fund, a continuously appropriated fund.

This bill would provide that a member of a federally recognized California Indian tribe is a resident of this state for these purposes. This bill would authorize a federally recognized California Indian ~~tribe~~ *tribal government* or an Indian health service facility to make required subscriber contributions on behalf of a member of the tribe. Because this bill would result in an increase in revenues to the fund and an increase in expenditures from the fund, it would thereby make an appropriation.

(5) 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: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. This act shall be known and may be cited as the California Indian Health Insurance Purchase Act of 1999.

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

1357. As used in this article:

(a) ''Dependent'' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its

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

(b) ''Eligible employee'' means any of the following:

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

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

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

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

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

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

(3) Any member of a federally recognized California Indian tribe if both of the following apply:

(A) The member is not offered health coverage through his or her employer.

(B) The member is not eligible for the federal Medicare program (Title XIX of the federal Social Security Act), the medicaid program (Title XIX of the federal Social Security Act), or the Healthy Families Program (Part 2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(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 dependent shall not be considered a late enrollee if: (1) the individual meets all of the following: (A) he or she was covered under another employer health benefit plan or no share-of-cost Medi-Cal coverage 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 or no share-of-cost Medi-Cal coverage 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~~ *employee's* or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, or loss of no share-of-cost Medi-Cal coverage; and (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; (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 (A), (C), and (D) of paragraph (1) or paragraph (2) or (3); or (C) in the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change; (5) the individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of ''COBRA'' set forth in subdivision (e) of Section 1373.621 shall apply; or (6) the individual is a dependent of an enrolled eligible employee who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of coverage.

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

(f) ''Preexisting condition provision'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee'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.

(g) ''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, coverage for onsite medical clinics, 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) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

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

(7) A state health benefits risk pool.

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

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

104-191, the Health Insurance Portability and Accountability Act of 1996.

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

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

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

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

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

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

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

Under 30
30–39
40–49
50–54
55–59
60–64
65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the federal

Medicare program pursuant to Title XVIII of the federal Social Security Act.

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

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

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

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

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

(*l*) ''Small employer'' means any of the following:

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

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

(3) Any federally recognized California Indian ~~tribe~~ *tribal government* that purchases health coverage for members of the tribe and that meets all of the following requirements:

(A) The ~~tribe~~ *tribal government* contributes an amount equal to at least ~~50 percent of the lowest available monthly employee-only comprehensive individual medical premium.~~ *50 percent of the cost of the health benefit plan chosen by the eligible tribal member.*

(B) The ~~tribe~~ *tribal government* enrolls at least 70 percent of the eligible tribal members, as described in paragraph (3) of subdivision (b), in the health benefit plan.

(C) The ~~tribe~~ *tribal government* sends a notice to each member of the tribe, at the member's last known address, advising that the member may elect coverage through the ~~tribe~~ *tribal government* if the member is an eligible tribal member.

(D) The ~~tribe provides a~~ *tribal government provides an annual open enrollment* period of at least 30 calendar days to each eligible tribal member during which the eligible tribal member may decide whether to apply for coverage and, upon deciding, select a health benefit plan. This shall be done in a consistent time and manner.

(E) The ~~tribe~~ *tribal government* makes available, if requested, documentation that illustrates that a member for whom health coverage is purchased is an eligible tribal member.

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

(n) ''Guaranteed association'' means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more

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

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

(o) ''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 also may 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 these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

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

SEC. 3. Section 10700 of the Insurance Code is amended to read:

10700. As used in this chapter:

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

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

(c) ''Board'' means the ~~Major~~ *Managed* Risk Medical Insurance Board.

(d) ''Carrier'' means any disability insurance company or any other entity that writes, issues, or administers health benefit plans that cover the employees of small

employers, regardless of the situs of the contract or master policyholder. For the purposes of Articles 3 (commencing with Section 10719) and 4 (commencing with Section 10730), ''carrier'' also includes health care service plans.

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

(f) ''Eligible employee'' means any of the following:

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

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

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

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

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

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

(3) Any member of a federally recognized California Indian tribe if both of the following apply:

(A) The member is not offered health coverage through his or her employer.

(B) The member is not eligible for the federal Medicare program (Title XIX of the federal Social Security Act), the medicaid program (Title XIX of the federal Social Security Act), or the Healthy Families Program (Part 2 (commencing with Section 12693) of Division 2).

(g) ''Enrollee'' means an eligible employee or dependent who receives health coverage through the program from a participating carrier.

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

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

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

(i) ''Fund'' means the California Small Group Reinsurance Fund.

(j) ''Health benefit plan'' means 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. 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, 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.

(k) ''In force business'' means an existing health benefit plan 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 dependent shall not be considered a late enrollee if: (1) the individual meets all of the following: (A) was covered under another employer health benefit plan or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll; (B) certified at the time of the initial enrollment that coverage under another employer health benefit plan or no share-of-cost Medi-Cal coverage 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) 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~~ *employee's* or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, or loss of no share-of-cost Medi-Cal coverage; and (D) requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; (2) the individual is employed by an employer who offers multiple health benefit plans and the individual 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 (f), the carrier cannot produce a written statement from the employer stating that the individual or the person through whom an individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the individual meets the criteria specified in paragraph (1), (2), or (3); (B) in the case of an eligible employee who is a guaranteed association member, the plan cannot produce a written statement from the guaranteed association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose,

at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or paragraph (2) or (3); or (C) in the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for coverage was made within 30 days of the change; (5) the individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of ''COBRA'' set forth in subdivision (e) of Section 1373.62 shall apply; or (6) the individual is a dependent of an enrolled eligible employee who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of 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, coverage for onsite medical clinics, 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) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

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

(7) A state health benefits risk pool.

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

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

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

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

(t) ''Risk adjusted employee risk rate'' means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

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

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

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

Under 30
30–39
40–49
50–54
55–59
60–64

65 and over

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

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

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

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

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

into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No carrier shall have less than one geographic area.

(w) ''Small employer'' means any of the following:

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

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

(3) Any federally recognized California Indian ~~tribe~~ *tribal government* that purchases health coverage for members of the tribe and that meets all of the following requirements:

(A) The ~~tribe~~ *tribal government* contributes an amount equal to at least ~~50 percent of the lowest available monthly employee-only comprehensive individual medical premium.~~ *50 percent of the cost of the health benefit plan chosen by the eligible tribal member.*

(B) The ~~tribe~~ *tribal government* enrolls at least 70 percent of the eligible tribal members, as described in paragraph (3) of subdivision (f), in the health benefit plan.

(C) The ~~tribe~~ *tribal government* sends a notice to each member of the tribe, at the member's last known address, advising that the member may elect coverage through the ~~tribe~~ *tribal government* if the member is an eligible tribal member.

(D) The ~~tribe provides a~~ *tribal government provides an annual open enrollment* period of at least 30 calendar days to each eligible tribal member during which the eligible tribal member may decide whether to apply for coverage and, upon deciding, select a health benefit plan. This shall be done in a consistent time and manner.

(E) The ~~tribe~~ *tribal government* makes available, if requested, documentation that illustrates that a member for whom health coverage is purchased is an eligible tribal member.

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

(y) ''Guaranteed association'' means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more

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

This subdivision applies regardless of whether a master policy by an admitted insurer is delivered directly to the association or a trust formed for or sponsored by an association to administer 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. 4. Section 10733.5 of the Insurance Code is amended to read:

10733.5. (a) Notwithstanding any other provision of law, an employer purchasing coverage through the program shall not be determined to be no longer eligible to participate in the program solely because the employer employs more than 50 eligible employees, provided the employer employs no more than 100 eligible employees.

(b) Notwithstanding any other provision of law, a federally recognized California Indian ~~tribe~~ *tribal government* that is defined to be a small employer pursuant to paragraph (3) of subdivision (w) of Section 10700 shall be eligible to purchase health coverage for members of the tribe through the program.

SEC. 5. Section 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by

the applicant that exceed the cost to the program of the highest cost Family Value Package in a given geographic area.

(b) In each geographic area the board shall designate one or more Family Value Packages for which the required total family contribution is:

(1) Seven dollars ($7) per child with a maximum required contribution of fourteen dollars ($14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost Family Value Package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost Family Value Package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area which has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars ($6) per child with a maximum required contribution of eighteen dollars ($18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level.

(e) Applicants who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act. If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

(g) Notwithstanding any other provision of law, a federally recognized California Indian ~~tribe~~ *tribal government*, or an Indian health service facility, may make the required family contributions on behalf of a member of the tribe.

SEC. 6. Section 12698 of the Insurance Code is amended to read:

12698. To be eligible to participate in the program, a person shall meet all of the following requirements:

(a) Be a resident of the state for at least six continuous months prior to application. A person who is a member of a federally recognized California Indian tribe is a resident of the state for these purposes.

(b) (1) Until the first day of the second month following the effective date of the amendment made to this subdivision in 1994, have a household income that does not exceed 250 percent of the official federal poverty level unless the board determines that the program funds are adequate to serve households above that level.

(2) Upon the first day of the second month following the effective date of the amendment made to this subdivision in 1994, have a household income that is above 200 percent of the official federal poverty level but does not exceed 250 percent of the official federal poverty level unless the board determines that the program funds are adequate to serve households above the 250 percent of the official federal poverty level.

(c) Pay an initial subscriber contribution of not more than fifty dollars ($50), and agree to the payment of the complete subscriber contribution. A federally recognized California Indian ~~tribe~~ *tribal government*, or an Indian health service facility, may make the initial and complete subscriber contributions on behalf of a member of the tribe.

SEC. 7. Section 12705 of the Insurance Code is amended to read:

12705. For the purposes of this part, the following terms have the following meanings:

(a) ''Applicant'' means an individual who applies for major risk medical coverage through the program.

(b) ''Board'' means the Managed Risk Medical Insurance Board.

(c) ''Fund'' means the Major Risk Medical Insurance Fund, from which the program may authorize expenditures to pay for medically necessary services which exceed subscribers' contributions, and for administration of the program.

(d) ''Major risk medical coverage'' means the payment for medically necessary services provided by institutional and professional providers.

(e) ''Participating health plan'' means a private insurer (1) holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit hospital service plan qualifying under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2, a nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code), or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service agreements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and (2) which contracts with the

program to administer major risk medical coverage to program subscribers.

(f) ''Plan rates'' means the total monthly amount charged by a participating health plan for a category of risk.

(g) ''Program'' means the California Major Risk Medical Insurance Program.

(h) ''Subscriber'' means an individual who is eligible for and receives major risk medical coverage through the program, and includes a member of a federally recognized California Indian tribe.

(i) ''Subscriber contribution'' means the portion of participating health plan rates paid by the subscriber, or paid on behalf of the subscriber by a federally recognized California Indian ~~tribe~~ *tribal government*, or by an Indian health service facility.

SEC. 8. Section 12725 of the Insurance Code is amended to read:

12725. Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. For these purposes, ''resident'' includes a member of a federally recognized California Indian tribe. To be eligible for enrollment in the program an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage which the applicant could secure would (1) impose substantial waivers which the program determines would leave a subscriber without adequate coverage for medically necessary services, or (2) would afford such limited coverage, as the program determines would leave the subscriber without adequate coverage for medically necessary services, or (3) would afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates. Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in

Section 10198.61, shall not be deemed to be rejection for the purposes of eligibility for enrollment. The board may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the board determines the enrollment can be carried out in an actuarially and administratively sound manner.

SEC. 9. 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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