

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**

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

February 25, 1999

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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:*

1 SECTION 1. This act shall be known and may be cited  
2 as the California Indian Health Insurance Purchase Act of  
3 1999.

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

6 1357. As used in this article:

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



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

3 (b) “Eligible employee” means any of the following:

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

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

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

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

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

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



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

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

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

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

14 (d) “Late enrollee” means an eligible employee or  
15 dependent who has declined enrollment in a health  
16 benefit plan offered by a small employer at the time of the  
17 initial enrollment period provided under the terms of the  
18 health benefit plan and who subsequently requests  
19 enrollment in a health benefit plan of that small  
20 employer, provided that the initial enrollment period  
21 shall be a period of at least 30 days. It also means any  
22 member of an association that is a guaranteed association  
23 as well as any other person eligible to purchase through  
24 the guaranteed association when that person has failed to  
25 purchase coverage during the initial enrollment period  
26 provided under the terms of the guaranteed association’s  
27 plan contract and who subsequently requests enrollment  
28 in the plan, provided that the initial enrollment period  
29 shall be a period of at least 30 days. However, an eligible  
30 employee, any other person eligible for coverage through  
31 a guaranteed association pursuant to subdivision (o), or  
32 dependent shall not be considered a late enrollee if: (1)  
33 the individual meets all of the following: (A) he or she was  
34 covered under another employer health benefit plan or  
35 no share-of-cost Medi-Cal coverage at the time the  
36 individual was eligible to enroll; (B) he or she certified at  
37 the time of the initial enrollment that coverage under  
38 another employer health benefit plan or no share-of-cost  
39 Medi-Cal coverage was the reason for declining  
40 enrollment, provided that, if the individual was covered



1 under another employer health plan, the individual was  
2 given the opportunity to make the certification required  
3 by this subdivision and was notified that failure to do so  
4 could result in later treatment as a late enrollee; (C) he  
5 or she has lost or will lose coverage under another  
6 employer health benefit plan as a result of termination of  
7 employment of the individual or of a person through  
8 whom the individual was covered as a dependent, change  
9 in employment status of the individual or of a person  
10 through whom the individual was covered as a  
11 dependent, termination of the other plan's coverage,  
12 cessation of an employer's contribution toward an  
13 ~~employee~~ *employee's* or dependent's coverage, death of  
14 the person through whom the individual was covered as  
15 a dependent, legal separation, divorce, or loss of no  
16 share-of-cost Medi-Cal coverage; and (D) he or she  
17 requests enrollment within 30 days after termination of  
18 coverage or employer contribution toward coverage  
19 provided under another employer health benefit plan;  
20 (2) the employer offers multiple health benefit plans and  
21 the employee elects a different plan during an open  
22 enrollment period; (3) a court has ordered that coverage  
23 be provided for a spouse or minor child under a covered  
24 employee's health benefit plan; (4) (A) in the case of an  
25 eligible employee as defined in paragraph (1) of  
26 subdivision (b), the plan cannot produce a written  
27 statement from the employer stating that the individual  
28 or the person through whom the individual was eligible  
29 to be covered as a dependent, prior to declining coverage,  
30 was provided with, and signed, acknowledgment of an  
31 explicit written notice in boldface type specifying that  
32 failure to elect coverage during the initial enrollment  
33 period permits the plan to impose, at the time of the  
34 individual's later decision to elect coverage, an exclusion  
35 from coverage for a period of 12 months as well as a  
36 six-month preexisting condition exclusion, unless the  
37 individual meets the criteria specified in paragraph (1),  
38 (2), or (3); (B) in the case of an association member who  
39 did not purchase coverage through a guaranteed  
40 association, the plan cannot produce a written statement



1 from the association stating that the association sent a  
2 written notice in boldface type to all potentially eligible  
3 association members at their last known address prior to  
4 the initial enrollment period informing members that  
5 failure to elect coverage during the initial enrollment  
6 period permits the plan to impose, at the time of the  
7 member's later decision to elect coverage, an exclusion  
8 from coverage for a period of 12 months as well as a  
9 six-month preexisting condition exclusion unless the  
10 member can demonstrate that he or she meets the  
11 requirements of subparagraphs (A), (C), and (D) of  
12 paragraph (1) or paragraph (2) or (3); or (C) in the case  
13 of an employer or person who is not a member of an  
14 association, was eligible to purchase coverage through a  
15 guaranteed association, and did not do so, and would not  
16 be eligible to purchase guaranteed coverage unless  
17 purchased through a guaranteed association, the  
18 employer or person can demonstrate that he or she meets  
19 the requirements of subparagraphs (A), (C), and (D) of  
20 paragraph (1), or paragraph (2) or (3), or that he or she  
21 recently had a change in status that would make him or  
22 her eligible and that application for enrollment was made  
23 within 30 days of the change; (5) the individual is an  
24 employee or dependent who meets the criteria described  
25 in paragraph (1) and was under a COBRA continuation  
26 provision and the coverage under that provision has been  
27 exhausted. For purposes of this section, the definition of  
28 "COBRA" set forth in subdivision (e) of Section 1373.621  
29 shall apply; or (6) the individual is a dependent of an  
30 enrolled eligible employee who has lost or will lose his or  
31 her no share-of-cost Medi-Cal coverage and requests  
32 enrollment within 30 days after notification of this loss of  
33 coverage.

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

37 (f) "Preexisting condition provision" means a contract  
38 provision that excludes coverage for charges or expenses  
39 incurred during a specified period following the  
40 employee's effective date of coverage, as to a condition



1 for which medical advice, diagnosis, care, or treatment  
2 was recommended or received during a specified period  
3 immediately preceding the effective date of coverage.

4 (g) “Creditable coverage” means:

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

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

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

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

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

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

34 (7) A state health benefits risk pool.

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

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





1 104-191, the Health Insurance Portability and  
2 Accountability Act of 1996.

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

5 (11) Any other creditable coverage as defined by  
6 subdivision (c) of Section 2701 of Title XXVII of the  
7 federal Public Health Services Act (42 U.S.C. Sec.  
8 300gg(c)).

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

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

16 (j) "Risk adjustment factor" means the percentage  
17 adjustment to be applied equally to each standard  
18 employee risk rate for a particular small employer, based  
19 upon any expected deviations from standard cost of  
20 services. This factor may not be more than 120 percent or  
21 less than 80 percent until July 1, 1996. Effective July 1,  
22 1996, this factor may not be more than 110 percent or less  
23 than 90 percent.

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

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

30 Under 30

31 30-39

32 40-49

33 50-54

34 55-59

35 60-64

36 65 and over

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



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

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

6 (A) Single.

7 (B) Married couple.

8 (C) One adult and child or children.

9 (D) Married couple and child or children.

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

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



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

5 (l) "Small employer" means any of the following:

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



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

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

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

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

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

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

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

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

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



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

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

31 For purposes of this subdivision, an association formed  
32 by a merger of two or more associations after January 1,  
33 1992, and otherwise meeting the criteria of this  
34 subdivision shall be deemed to have been in active  
35 existence on January 1, 1992, if its predecessor  
36 organizations had been in active existence on January 1,  
37 1992, and for at least five years prior to that date and  
38 otherwise met the criteria of this subdivision.

39 (o) "Members of a guaranteed association" means any  
40 individual or employer meeting the association's



1 membership criteria if that person is a member of the  
2 association and chooses to purchase health coverage  
3 through the association. At the association's discretion, it  
4 also may include employees of association members,  
5 association staff, retired members, retired employees of  
6 members, and surviving spouses and dependents of  
7 deceased members. However, if an association chooses to  
8 include these persons as members of the guaranteed  
9 association, the association shall make that election in  
10 advance of purchasing a plan contract. Health care  
11 service plans may require an association to adhere to the  
12 membership composition it selects for up to 12 months.

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

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

19 10700. As used in this chapter:

20 (a) "Agent or broker" means a person or entity  
21 licensed under Chapter 5 (commencing with Section  
22 1621) of Part 2 of Division 1.

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

36 (c) "Board" means the ~~Major~~ *Managed Risk Medical*  
37 Insurance Board.

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



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

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

13 (f) “Eligible employee” means any of the following:

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

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

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



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

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

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

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

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

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

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

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

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

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

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

33 (j) “Health benefit plan” means a policy or contract  
34 written or administered by a carrier that arranges or  
35 provides health care benefits for the covered eligible  
36 employees of a small employer and their dependents. The  
37 term does not include accident only, credit, disability  
38 income, coverage of Medicare services pursuant to  
39 contracts with the United States government, Medicare  
40 supplement, long-term care insurance, dental, vision,





1 coverage issued as a supplement to liability insurance,  
2 automobile medical payment insurance, or insurance  
3 under which benefits are payable with or without regard  
4 to fault and that is statutorily required to be contained in  
5 any liability insurance policy or equivalent self-insurance.

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

8 (l) “Late enrollee” means an eligible employee or  
9 dependent who has declined health coverage under a  
10 health benefit plan offered by a small employer at the  
11 time of the initial enrollment period provided under the  
12 terms of the health benefit plan, and who subsequently  
13 requests enrollment in a health benefit plan of that small  
14 employer, provided that the initial enrollment period  
15 shall be a period of at least 30 days. It also means any  
16 member of an association that is a guaranteed association  
17 as well as any other person eligible to purchase through  
18 the guaranteed association when that person has failed to  
19 purchase coverage during the initial enrollment period  
20 provided under the terms of the guaranteed association’s  
21 health benefit plan and who subsequently requests  
22 enrollment in the plan, provided that the initial  
23 enrollment period shall be a period of at least 30 days.  
24 However, an eligible employee, another person eligible  
25 for coverage through a guaranteed association pursuant  
26 to subdivision (z), or dependent shall not be considered  
27 a late enrollee if: (1) the individual meets all of the  
28 following: (A) was covered under another employer  
29 health benefit plan or no share-of-cost Medi-Cal coverage  
30 at the time the individual was eligible to enroll; (B)  
31 certified at the time of the initial enrollment that  
32 coverage under another employer health benefit plan or  
33 no share-of-cost Medi-Cal coverage was the reason for  
34 declining enrollment provided that, if the individual was  
35 covered under another employer health plan, the  
36 individual was given the opportunity to make the  
37 certification required by this subdivision and was notified  
38 that failure to do so could result in later treatment as a late  
39 enrollee; (C) has lost or will lose coverage under another  
40 employer health benefit plan as a result of termination of



1 employment of the individual or of a person through  
2 whom the individual was covered as a dependent, change  
3 in employment status of the individual, or of a person  
4 through whom the individual was covered as a  
5 dependent, the termination of the other plan's coverage,  
6 cessation of an employer's contribution toward an  
7 ~~employee~~ *employee's* or dependent's coverage, death of  
8 the person through whom the individual was covered as  
9 a dependent, legal separation, divorce, or loss of no  
10 share-of-cost Medi-Cal coverage; and (D) requests  
11 enrollment within 30 days after termination of coverage  
12 or employer contribution toward coverage provided  
13 under another employer health benefit plan; (2) the  
14 individual is employed by an employer who offers  
15 multiple health benefit plans and the individual elects a  
16 different plan during an open enrollment period; (3) a  
17 court has ordered that coverage be provided for a spouse  
18 or minor child under a covered employee's health benefit  
19 plan; (4) (A) in the case of an eligible employee as  
20 defined in paragraph (1) of subdivision (f), the carrier  
21 cannot produce a written statement from the employer  
22 stating that the individual or the person through whom  
23 an individual was eligible to be covered as a dependent,  
24 prior to declining coverage, was provided with, and  
25 signed acknowledgment of, an explicit written notice in  
26 boldface type specifying that failure to elect coverage  
27 during the initial enrollment period permits the carrier  
28 to impose, at the time of the individual's later decision to  
29 elect coverage, an exclusion from coverage for a period  
30 of 12 months as well as a six-month preexisting condition  
31 exclusion unless the individual meets the criteria  
32 specified in paragraph (1), (2), or (3); (B) in the case of  
33 an eligible employee who is a guaranteed association  
34 member, the plan cannot produce a written statement  
35 from the guaranteed association stating that the  
36 association sent a written notice in boldface type to all  
37 potentially eligible association members at their last  
38 known address prior to the initial enrollment period  
39 informing members that failure to elect coverage during  
40 the initial enrollment period permits the plan to impose,



1 at the time of the member's later decision to elect  
2 coverage, an exclusion from coverage for a period of 12  
3 months as well as a six-month preexisting condition  
4 exclusion unless the member can demonstrate that he or  
5 she meets the requirements of subparagraphs (A), (C),  
6 and (D) of paragraph (1) or paragraph (2) or (3); or (C)  
7 in the case of an employer or person who is not a member  
8 of an association, was eligible to purchase coverage  
9 through a guaranteed association, and did not do so, and  
10 would not be eligible to purchase guaranteed coverage  
11 unless purchased through a guaranteed association, the  
12 employer or person can demonstrate that he or she meets  
13 the requirements of subparagraphs (A), (C), and (D) of  
14 paragraph (1), or paragraph (2) or (3), or that he or she  
15 recently had a change in status that would make him or  
16 her eligible and that application for coverage was made  
17 within 30 days of the change; (5) the individual is an  
18 employee or dependent who meets the criteria described  
19 in paragraph (1) and was under a COBRA continuation  
20 provision and the coverage under that provision has been  
21 exhausted. For purposes of this section, the definition of  
22 "COBRA" set forth in subdivision (e) of Section 1373.62  
23 shall apply; or (6) the individual is a dependent of an  
24 enrolled eligible employee who has lost or will lose his or  
25 her no share-of-cost Medi-Cal coverage and requests  
26 enrollment within 30 days after notification of this loss of  
27 coverage.

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

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

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

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



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

8 (r) “Creditable coverage” means:

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

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

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

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

33 (5) 10 U.S.C.A. Chapter 55 (commencing with Section  
34 1071) (Civilian Health and Medical Program of the  
35 Uniformed Services (CHAMPUS)).

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

38 (7) A state health benefits risk pool.



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

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

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

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

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

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

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

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

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

- 35 Under 30
- 36 30-39
- 37 40-49
- 38 50-54
- 39 55-59
- 40 60-64



1 65 and over

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

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

11 (A) Single.

12 (B) Married couple.

13 (C) One adult and child or children.

14 (D) Married couple and child or children.

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

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



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

6 (w) "Small employer" means any of the following:

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



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

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

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

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

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

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

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

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

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





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

27 This subdivision applies regardless of whether a master  
28 policy by an admitted insurer is delivered directly to the  
29 association or a trust formed for or sponsored by an  
30 association to administer benefits for association  
31 members.

32 For purposes of this subdivision, an association formed  
33 by a merger of two or more associations after January 1,  
34 1992, and otherwise meeting the criteria of this  
35 subdivision shall be deemed to have been in active  
36 existence on January 1, 1992, if its predecessor  
37 organizations had been in active existence on January 1,  
38 1992, and for at least five years prior to that date and  
39 otherwise met the criteria of this subdivision.



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

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

18 SEC. 4. Section 10733.5 of the Insurance Code is  
19 amended to read:

20 10733.5. (a) Notwithstanding any other provision of  
21 law, an employer purchasing coverage through the  
22 program shall not be determined to be no longer eligible  
23 to participate in the program solely because the employer  
24 employs more than 50 eligible employees, provided the  
25 employer employs no more than 100 eligible employees.

26 (b) Notwithstanding any other provision of law, a  
27 federally recognized California Indian ~~tribe~~ *tribal*  
28 *government* that is defined to be a small employer  
29 pursuant to paragraph (3) of subdivision (w) of Section  
30 10700 shall be eligible to purchase health coverage for  
31 members of the tribe through the program.

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

34 12693.43. (a) Applicants applying to the purchasing  
35 pool shall agree to pay family contributions. Family  
36 contribution amounts consist of the following two  
37 components:

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

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



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

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

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

12 (2) Nine dollars (\$9) per child with a maximum  
13 required contribution of twenty-seven dollars (\$27) per  
14 month per family for applicants with annual household  
15 incomes greater than 150 percent and up to and including  
16 200 percent of the federal poverty level.

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

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

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

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



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

5 (f) It is the intent of the Legislature that the family  
6 contribution amounts described in this section comply  
7 with the premium cost sharing limits contained in Section  
8 2103 of Title XXI of the Social Security Act. If the amounts  
9 described in subdivision (a) are not approved by the  
10 federal government, the board may adjust these amounts  
11 to the extent required to achieve approval of the state  
12 plan.

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

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

20 12698. To be eligible to participate in the program, a  
21 person shall meet all of the following requirements:

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

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

32 (2) Upon the first day of the second month following  
33 the effective date of the amendment made to this  
34 subdivision in 1994, have a household income that is above  
35 200 percent of the official federal poverty level but does  
36 not exceed 250 percent of the official federal poverty  
37 level unless the board determines that the program funds  
38 are adequate to serve households above the 250 percent  
39 of the official federal poverty level.



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

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

10 12705. For the purposes of this part, the following  
11 terms have the following meanings:

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

14 (b) "Board" means the Managed Risk Medical  
15 Insurance Board.

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

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

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



1 program to administer major risk medical coverage to  
2 program subscribers.

3 (f) “Plan rates” means the total monthly amount  
4 charged by a participating health plan for a category of  
5 risk.

6 (g) “Program” means the California Major Risk  
7 Medical Insurance Program.

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

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

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

19 12725. Each resident of the state meeting the  
20 eligibility criteria of this section and who is unable to  
21 secure adequate private health coverage is eligible to  
22 apply for major risk medical coverage through the  
23 program. For these purposes, “resident” includes a  
24 member of a federally recognized California Indian tribe.  
25 To be eligible for enrollment in the program an applicant  
26 shall have been rejected for health care coverage by at  
27 least one private health plan. An applicant shall be  
28 deemed to have been rejected if the only private health  
29 coverage which the applicant could secure would (1)  
30 impose substantial waivers which the program  
31 determines would leave a subscriber without adequate  
32 coverage for medically necessary services, or (2) would  
33 afford such limited coverage, as the program determines  
34 would leave the subscriber without adequate coverage  
35 for medically necessary services, or (3) would afford  
36 coverage only at an excessive price, which the board  
37 determines is significantly above standard average  
38 individual coverage rates. Rejection for policies or  
39 certificates of specified disease or policies or certificates  
40 of hospital confinement indemnity, as described in



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

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

