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**CALIFORNIA 1992 LEGISLATIVE SERVICE
1992 Portion of 1991-92 Regular Session**

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CHAPTER 1128
A.B. No. 1672
INSURANCE

AN ACT to amend Section 6254 of the Government Code, to amend Sections 1343 and 1367 of, to add Section 1393.6 to, and to add Articles 3.1 (commencing with Section 1357) and 3.15 (commencing with Section 1357.50) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 12700, 12710, and 12739.2 of, to add Article 7 (commencing with Section 10198.6) to Chapter 1 of Part 2 of Division 2 of, and to add Chapter 14 (commencing with Section 10700) to Part 2 of Division 2, of the Insurance Code, relating to health insurance, and making an appropriation therefor.

[Approved by Governor September 28, 1992.]

[Filed with Secretary of State September 29, 1992.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1672, Margolin. Insurance.

Existing law does not require health insurers and related entities such as health care service plans, nonprofit hospital service plans, or other related entities, to provide health coverage for specific groups of people. Existing law does provide for a major medical insurance program to provide health coverage to certain persons, which program may provide coverage through participating health plans.

This bill would enact a comprehensive scheme for providing health insurance to small employer groups, which would, among other things, do all of the following:

(1) State legislative intent.

(2) Define "small employer" to mean any person, firm, corporation, partnership, or association who is actively engaged in business who, on at least 50% of its working days during the preceding calendar quarter, employed until July 1, 1994, at least 5 eligible employees, until July 1, 1995, at least 4 eligible employees, and thereafter, at least 3 eligible employees, but not more than 50 eligible employees.

(3) Enact parallel regulations for health care service plans and for health plans subject to the jurisdiction of the Department of Insurance.

(4) Require health care service plans and other health plans to fairly and affirmatively offer, market, and sell health benefits coverage to all small employers in a service area in which the carrier makes coverage available or provides benefits.

(5) Regulate those plans as to preexisting condition provisions, requirements that coverage be offered and renewed for small employers, rates and rate distinctions, and other matters.

How to Qualify for GUARANTEED Coverage under AB 1672

(Publication page references are not available for this document.)

(6) Authorize the creation of the California Small Group Reinsurance Fund, to provide reinsurance to those electing to participate, and would authorize the fund to impose assessments on members.

(7) Create the Voluntary Alliance Uniting Employers Purchasing Program in the Health and Welfare Agency, to be administered by the Major Risk Medical Insurance Board. Health plans could satisfy their obligation to market health benefits coverage to small employers by participating in the program. It would enter into contracts with these carriers to provide health benefits coverage to eligible employees. The board would establish a mechanism to collect premiums, and to pay contractors. The bill would create the Voluntary Alliance Uniting Employers Fund and make provisions for continuous appropriation from it, thus making an appropriation.

(8) Provide for the adoption of regulations by the Commissioner of Corporations and the Insurance Commissioner.

(9) The bill would enact various related provisions, including provisions for administrative fines against health care service plans and provisions relating to confidentiality of records.

(10) The bill would authorize the Major Risk Medical Insurance Program to lend money to the Voluntary Alliance Uniting Employers Purchasing Program, and to related entities.

(11) The bill would enact provisions regulating preexisting condition requirements and waiting periods generally.

(12) The bill would transfer the California Major Risk Medical Insurance Program from the Business, Transportation, and Housing Agency to the Health and Welfare Agency.

(13) The bill would become operative July 1, 1993, except for specified provisions which would become operative March 1, 1993.

(14) This bill would incorporate additional amendments to Section 6254 of the Government Code proposed by SB 315, contingent upon the prior enactment of that bill.

This bill would incorporate additional amendments to Section 1343 of the Health and Safety Code proposed by SB 1708, contingent upon the prior enactment of that bill.

(15) Since a violation of provisions relating to health care service plans would be a misdemeanor, the bill would impose a state-mandated local program.

(16) 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.

Appropriation: yes.

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

SECTION 1. It is the intent of the Legislature in enacting this act to guarantee the availability and renewability of health insurance to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, to improve the

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efficiency and fairness of the small group health coverage marketplace, and to help make coverage more affordable by establishing a purchasing pool for small employers. The provisions of this act are developed to assure the availability of appropriate health benefit plans to small employers that employ 3 to 50 employees and to establish a purchasing pool to provide health benefits coverage to employees of participating employers in the manner of a single large group. Carriers in the small employer market are required to rate within prescribed limits, to guarantee the issuance and renewability of health coverage, to guarantee the continuity of coverage, to adhere to limitations on the exclusion of preexisting conditions, and to adhere to rules regarding minimum participation requirements.

The Voluntary Alliance Uniting Employers Purchasing Program will make available through its contracting process a choice of carriers that provide, arrange, or pay for quality health services in a cost-effective manner. It will provide its participants with the benefits of its contracting expertise and the administrative savings that can result from the pooling of small groups.

SEC. 2. Section 6254 of the Government Code is amended to read:

<< CA GOVT § 6254 >>

6254. Except as provided in Section 6254.7, nothing in this chapter shall be construed to require disclosure of records that are any of the following:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda which are not retained by the public agency in the ordinary course of business, provided that the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, which are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the

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Department of Justice, and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes, except that state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, vandalism, vehicle theft, or a crime as defined by subdivision (c) of Section 13960, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files which reflect the analysis or conclusions of the investigating officer.

Other provisions of this subdivision notwithstanding, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name, current address, and occupation of every individual arrested by the agency, the individual's physical description including date of birth, color of eyes and hair, sex, height and weight, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, the time and manner of release or the location where the individual is currently being held, and all charges the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) <<-* * *->> <<+Subject to the restrictions imposed by Section 841.5 of the Penal Code, t+>>he time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name, age, and current address of the victim, except that the address of the victim of any crime defined by Section 261, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, or 422.75 of the Penal Code shall not be disclosed, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 261, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, or 422.75 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined by Section 261, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6, 422.7, or 422.75 of the Penal Code may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as

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provided for in Chapter 3 (commencing with Section 99150) of Part 65 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes which is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition purposes. The exemption in this subdivision shall not apply to records of fines imposed on the borrowers.

(k) Records the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

(l) Correspondence of and to the Governor or employees of the Governor's office or in the custody of or maintained by the Governor's legal affairs secretary, provided that public records shall not be transferred to the custody of the Governor's legal affairs secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this section and for making available to the public those portions of an application which are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512) of Division 4 of Title 1, Chapter 10.5 (commencing with Section 3525) of Division 4 of Title 1, and Chapter 12 (commencing with Section 3560) of Division 4 of Title 1, which reveal a state agency's deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work products, theories, or strategy, or which provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under the above chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) Records of state agencies related to activities governed by Articles 2.6 (commencing

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with Section 14081), 2.8 (commencing with Section 14087.5), and 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, which reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or which provide instruction, advice, or training to employees.

Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. In the event that a contract for inpatient services which is entered into prior to April 1, 1984, is amended on or after April 1, 1984, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

Notwithstanding any other provision of law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments until such time as a contract or amendment is fully open to inspection by the public.

(r) Records of Native American graves, cemeteries, and sacred places maintained by the Native American Heritage Commission.

(s) A final accreditation report of the Joint Commission on Accreditation of Hospitals which has been transmitted to the State Department of Health Services pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, <<+or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of this code,+>> which relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(u) Information contained in applications for licenses to carry concealed weapons issued by the sheriff of a county or the chief or other head of a municipal police department which indicates when or where the applicant is vulnerable to attack or which concerns the applicant's medical or psychological history or that of members of his or her family.

(v) Residence addresses contained in licensure applications and registration applications for collection agencies as may be required by the Bureau of Collection and Investigative Services of the Department of Consumer Affairs pursuant to Sections 6876.2, 6877, 6878, and 6894.3 of the Business and Professions Code.

(w) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Part 6.3 (commencing with Section 12695), and Part 6.5 (commencing with Section 12700), of Division 2 of the Insurance Code, and which reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with

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health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Part 6.3 (commencing with Section 12695), or Part 6.5 (commencing with Section 12700), of Division 2 of the Insurance Code, on or after July 1, 1991, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract for health coverage that is entered into prior to July 1, 1991, is amended on or after July 1, 1991, the amendment, except for any portion containing the rates of payment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

<<+(x) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.+>>

<<+(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.+>>

<<+(3) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (2).+>>

Nothing in this section prevents any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

Nothing in this section prevents any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act.

SEC. 2.5. Section 6254 of the Government Code is amended to read:

<< CA GOVT § 6254 >>

(Publication page references are not available for this document.)

6254. Except as provided in Section 6254.7, nothing in this chapter shall be construed to require disclosure of records that are any of the following:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda which are not retained by the public agency in the ordinary course of business, provided that the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, which are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes, except that state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, vandalism, vehicle theft, or a crime as defined by subdivision (c) of Section 13960, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files which reflect the analysis or conclusions of the investigating officer.

Other provisions of this subdivision notwithstanding, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure

(Publication page references are not available for this document.)

of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name, current address, and occupation of every individual arrested by the agency, the individual's physical description including date of birth, color of eyes and hair, sex, height and weight, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, the time and manner of release or the location where the individual is currently being held, and all charges the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) <<-* * *->> <<+Subject to the restrictions imposed by Section 841.5 of the Penal Code, t+>>he time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name, age, and current address of the victim, except that the address of the victim of any crime defined by Section 261, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, or 422.75 of the Penal Code shall not be disclosed, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 261, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, or 422.75 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined by Section 261, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6, 422.7, or 422.75 of the Penal Code may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing with Section 99150) of Part 65 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes which is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition purposes. The exemption in this subdivision shall not apply to records of fines imposed on the borrowers.

(k) Records the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

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(l) Correspondence of and to the Governor or employees of the Governor's office or in the custody of or maintained by the Governor's legal affairs secretary, provided that public records shall not be transferred to the custody of the Governor's legal affairs secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this section and for making available to the public those portions of an application which are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512) of Division 4 of Title 1, Chapter 10.5 (commencing with Section 3525) of Division 4 of Title 1, and Chapter 12 (commencing with Section 3560) of Division 4 of Title 1, which reveal a state agency's deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work products, theories, or strategy, or which provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under the above chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) Records of state agencies related to activities governed by Articles 2.6 (commencing with Section 14081), 2.8 (commencing with Section 14087.5), and 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, which reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or which provide instruction, advice, or training to employees.

Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. In the event that a contract for inpatient services which is entered into prior to April 1, 1984, is amended on or after April 1, 1984, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

Notwithstanding any other provision of law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit

(Publication page references are not available for this document.)

Committee shall maintain the confidentiality of the contracts and amendments until such time as a contract or amendment is fully open to inspection by the public.

(r) Records of Native American graves, cemeteries, and sacred places maintained by the Native American Heritage Commission.

(s) A final accreditation report of the Joint Commission on Accreditation of Hospitals which has been transmitted to the State Department of Health Services pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, <<+or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of this code,+>> which relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(u) Information contained in applications for licenses to carry concealed weapons issued by the sheriff of a county or the chief or other head of a municipal police department which indicates when or where the applicant is vulnerable to attack or which concerns the applicant's medical or psychological history or that of members of his or her family.

(v) Residence addresses contained in licensure applications and registration applications for collection agencies as may be required by the Bureau of Collection and Investigative Services of the Department of Consumer Affairs pursuant to Sections <<-* * *->> <<+6896, 6899, 6900, 6910+>>, and <<+6916+>> of the Business and Professions Code.

(w) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Part 6.3 (commencing with Section 12695), and Part 6.5 (commencing with Section 12700), of Division 2 of the Insurance Code, and which reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Part 6.3 (commencing with Section 12695), or Part 6.5 (commencing with Section 12700), of Division 2 of the Insurance Code, on or after July 1, 1991, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract for health coverage that is entered into prior to July 1, 1991, is amended on or after July 1, 1991, the amendment, except for any portion containing the rates of payment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection

pursuant to paragraph (3).

<<+(x) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.+>>

<<+(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.+>>

<<+(3) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The Joint Legislative Audit Committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (2).+>>

Nothing in this section prevents any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

Nothing in this section prevents any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act.

SEC. 3. Section 1343 of the Health and Safety Code, as amended by Section 1 of Chapter 1043 of the Statutes of 1990, is amended to read:

<< CA HLTH & S § 1343 >>

1343. (a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (n) of Section 1345.

(b) The commissioner may by the adoption of rules <<+or the issuance of orders+>> deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the commissioner finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The commissioner, upon request of the Director of Health Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of Health Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The commissioner may exempt non-county-operated pilot programs upon request of the <<+State+>> Director of Health Services. Those exemptions may be subject to conditions the <<+State+>> Director of Health Services deems appropriate.

(d) Except as otherwise provided, this chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance

(Publication page references are not available for this document.)

Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

(3) (A) A nonprofit corporation formed under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, except that the following sections and regulations adopted under those sections shall apply to those corporations: Section 1341, subdivisions (d) and (f) of Section 1342, Sections 1344 and 1345, Section 1346 excluding subdivision (g), Sections 1351.1 and 1371, Article 6 (commencing with Section 1375.1) excluding Sections 1375.2, 1379, and 1380, Article 7 (commencing with Section 1386) excluding Sections 1388 and 1389, Article 8 (commencing with Section 1390), and Article 9 (commencing with Section 1395) excluding Sections 1399 and 1399.1.

The corporation shall maintain the surplus as required by the Insurance Commissioner, and shall also comply with the financial viability requirements of Section 1375.1.

(B) Nothing in this paragraph shall preclude the Insurance Commissioner from taking any action authorized by the Insurance Code.

(C) Each nonprofit hospital service plan shall apply for licensure under this chapter no later than September 30, 1991.

(4) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569) of this division.

(C) Has obtained a certificate of authority from the State Department of Social Services.

<<+(5) The Major Risk Medical Insurance Board when engaging in activities under Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code, and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code.+>>

<<+(6) The California Small Group Reinsurance Fund.+>>

(e) This section shall remain in effect only until April 1, 1993, and as of that date is repealed, unless a later enacted statute, which is enacted before April 1, 1993, deletes or extends that date.

SEC. 3.5. Section 1343 of the Health and Safety Code, as amended by Section 1 of Chapter 1043 of the Statutes of 1990, is amended to read:

<< CA HLTH & S § 1343 >>

1343. (a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (n) of Section 1345.

(b) The commissioner may by the adoption of rules <<+or the issuance of orders+>> deemed necessary and appropriate, either unconditionally or upon specified terms and conditions

(Publication page references are not available for this document.)

or for specified periods, exempt from this chapter any class of persons or plan contracts if the commissioner finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The commissioner, upon request of the Director of Health Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of Health Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The commissioner may exempt non-county-operated pilot programs upon request of the <<+State+>> Director of Health Services. Those exemptions may be subject to conditions the <<+State+>> Director of Health Services deems appropriate.

(d) Except as otherwise provided, this chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

(3) (A) A nonprofit corporation formed under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code, except that the following sections and regulations adopted under those sections shall apply to those corporations: Section 1341, subdivisions (d) and (f) of Section 1342, Sections 1344 and 1345, Section 1346 excluding subdivision (g), Sections 1351.1 and 1371, Article 6 (commencing with Section 1375.1) excluding Sections 1375.2, 1379, and 1380, Article 7 (commencing with Section 1386) excluding Sections 1388 and 1389, Article 8 (commencing with Section 1390), and Article 9 (commencing with Section 1395) excluding Sections 1399 and 1399.1.

The corporation shall maintain the surplus as required by the Insurance Commissioner, and shall also comply with the financial viability requirements of Section 1375.1.

(B) Nothing in this paragraph shall preclude the Insurance Commissioner from taking any action authorized by the Insurance Code.

(C) Each nonprofit hospital service plan shall apply for licensure under this chapter no later than September 30, 1991.

(4) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569) of this division.

(C) Has obtained a certificate of authority from the State Department of Social Services.

<<+(5) The Major Risk Medical Insurance Board when engaging in activities under Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code, and Part 6.5

(commencing with Section 12700) of Division 2 of the Insurance Code.>>

<<+(6) The California Small Group Reinsurance Fund.>>

<<+(7) Any program developed under the authority of Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code.>>

(e) This section shall remain in effect only until April 1, 1993, and as of that date is repealed, unless a later enacted statute, which is enacted before April 1, 1993, deletes or extends that date.

SEC. 4. Section 1343 of the Health and Safety Code, as amended by Section 2 of Chapter 1043 of the Statutes of 1990, is amended to read:

<< CA HLTH & S § 1343 >>

1343. (a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (n) of Section 1345.

(b) The commissioner may by the adoption of rules <<+or the issuance of orders+>> deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the commissioner finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The commissioner, upon request of the <<+State+>> Director of Health Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of Health Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The commissioner may exempt non-county-operated pilot programs upon request of the <<+State+>> Director of Health Services. Those exemptions may be subject to conditions the <<+State+>> Director of Health Services deems appropriate.

(d) This chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

(3) A nonprofit corporation formed under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(4) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569) of this division.

(Publication page references are not available for this document.)

(C) Has obtained a certificate of authority from the State Department of Social Services.

<<+(5) The Major Risk Medical Insurance Board when engaging in activities under Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code, and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code.>>

<<+(6) The California Small Group Reinsurance Fund.>>

(e) This section shall become operative April 1, 1993.

SEC. 4.5. Section 1343 of the Health and Safety Code, as amended by Section 2 of Chapter 1043 of the Statutes of 1990, is amended to read:

<< CA HLTH & S § 1343 >>

1343. (a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (n) of Section 1345.

(b) The commissioner may by the adoption of rules <<+or the issuance of orders+>> deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the commissioner finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The commissioner, upon request of the State Director of Health Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of Health Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The commissioner may exempt non-county-operated pilot programs upon request of the <<+State+>> Director of Health Services. Those exemptions may be subject to conditions the <<+State+>> Director of Health Services deems appropriate.

(d) This chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

(3) A nonprofit corporation formed under Chapter 11a (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code.

(4) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569) of this division.

(Publication page references are not available for this document.)

(C) Has obtained a certificate of authority from the State Department of Social Services.

<<+(5) The Major Risk Medical Insurance Board when engaging in activities under Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code, and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code.>>

<<+(6) The California Small Group Reinsurance Fund.>>

<<+(7) Any program developed under the authority of Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code.>>

(e) This section shall become operative April 1, 1993.

<< CA HLTH & S Prec. § 1357 >>

SEC. 5. Article 3.1 (commencing with Section 1357) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.1. Small Employer Group Access to Contracts for Health Care Services

<< CA HLTH & S § 1357 >>

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.

(b) "Eligible employee" means 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.

(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. However, an eligible employee 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 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 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

(Publication page references are not available for this document.)

contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, or divorce; 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 and request for enrollment is made within 30 days after issuance of the court order; (4) 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 bold 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).

(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) "Qualifying prior coverage" means:

(1) Any individual or group policy, contract, or program, that is written or administered by a disability insurer, nonprofit hospital service plan, 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, 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.

(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 percent 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

(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, 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 are 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 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

(Publication page references are not available for this document.)

area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(l) "Small employer" means 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, employed at least three, but no more than 50, eligible employees, the majority of whom were employed within this state, which was not formed primarily for purposes of buying health care service plan contracts and in which a bona fide employer-employee relationship exists. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least five eligible employees until July 1, 1994, four eligible employees until July 1, 1995, and three 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 benefit 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.

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

<< CA HLTH & S § 1357.01 >>

1357.01. Every health care service plan offering plan contracts to small employer groups shall in addition to complying with the provisions of this chapter and the rules adopted thereunder comply with the provisions of this article.

<< CA HLTH & S § 1357.02 >>

1357.02. (a) A health care service plan providing or arranging for the provision of basic health care services to small employers shall be subject to this article if either of the following conditions are met:

(1) Any portion of the premium is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The plan contract is treated by the small employer or any of the covered individuals as part of a plan or program for the purposes of Section 106 or 162 of the Internal Revenue Code.

(b) This article shall not apply to health plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the Department of Health Services, long-term care coverage, or specialized health plan contracts.

<< CA HLTH & S § 1357.03 >>

1357.03. (a) Upon the effective date of this article, a plan shall fairly and affirmatively offer, market, and sell all of the plan's small employer health care service plan contracts to all small employers in each service area in which the plan provides or arranges for the provision of health care services. A plan contracting to participate in the voluntary purchasing pool for small employers provided for under Article 4 (commencing

(Publication page references are not available for this document.)

with Section 10730) of Chapter 14 of Part 2 of Division 2 of the Insurance Code shall be deemed in compliance with this requirement for a contract offered through the voluntary purchasing pool established under Article 4 (commencing with Section 10730) of Chapter 14 of Part 2 of Division 2 of the Insurance Code in those geographic regions in which plans participate in the pool, if the contract is offered exclusively through the pool. Each plan shall make available to each small employer all small employer health care service plan contracts which the plan offers and sells to small employers in this state. No plan or solicitor shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from a health care service plan contract that is provided in connection with the employee's employment.

(b) Every plan shall file with the commissioner the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group. Employer contribution requirements shall not vary by employer size.

(c) The plan may not reject an application from a small employer for a health care service plan contract if all of the following are met:

(1) The small employer offers health benefits to 100 percent of its eligible employees. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(3) The small employer agrees to inform the small employers' employees of the availability of coverage and the provision that those not electing coverage must wait one year to obtain coverage through the group if they later decide they would like to have coverage.

(4) The employees and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(d) No plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(2) Encourage or direct small employers to seek coverage from another plan or the voluntary purchasing pool established under Article 4 (commencing with Section 10730) of Chapter 14 of Part 2 of Division 2 of the Insurance Code because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(e) No plan shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of

(Publication page references are not available for this document.)

premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

<< CA HLTH & S § 1357.04 >>

1357.04. Small employer health care service plan contracts shall become effective within 31 days of receipt of the small employer's completed application and premium payment.

<< CA HLTH & S § 1357.05 >>

1357.05. Except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a plan may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that employee. No plan contract may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 1357.06.

<< CA HLTH & S § 1357.06 >>

1357.06. (a) Preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A plan that does not utilize a preexisting condition provision may impose a waiting period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting period no premiums shall be charged to the enrollee or the subscriber.

(c) In determining whether a preexisting condition provision applies to any person, a plan shall credit the time the person was covered under qualifying prior coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 30 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under qualifying prior coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 90 days, exclusive of any waiting period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

<< CA HLTH & S § 1357.07 >>

1357.07. No plan contract may exclude late enrollees from coverage for more than 12 months from the date of the late enrollees application for coverage. No premium shall be charged to the late enrollee until the exclusion period has ended.

<< CA HLTH & S § 1357.08 >>

1357.08. All health care service plan contracts offered to a small employer shall provide to subscribers and enrollees at least all of the basic health care services included in subdivision (b) of Section 1345, and in Section 1300.67 of the California Code of

Regulations.

<< CA HLTH & S § 1357.09 >>

1357.09. No plan shall be required to offer a health care service plan contract or accept applications for such a contract pursuant to this article in the case of any of the following:

(a) To a small employer, where the small employer is not physically located in a plan's approved service areas, or where an employee and eligible dependents who are to be covered by the plan contract do not work or reside within a plan's approved service areas.

(b) Within a specific service area or portion of a service area where a plan reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have sufficient health care delivery resources to assure that health care services will be available and accessible to the eligible employee and dependents of the employee because of its obligations to existing enrollees.

(1) A plan that cannot offer a health care service plan contract to small employers because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a contract in the area in which the plan is not offering coverage to small employers to new employer groups with more than 50 eligible employees until the plan notifies the commissioner that it has the ability to deliver services to small employer groups, and certifies to the commissioner that from the date of the notice it will enroll all small employer groups requesting coverage in that area from the plan unless the plan has met the requirements of subdivision (d).

(2) Nothing in this article shall be construed to limit the commissioner's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity have become impaired.

(c) Offer coverage to a small employer group which, within 12 months of application for coverage, disenrolled from a plan contract offered by the plan.

(d) The commissioner approves the plan's certification that the number of eligible employees and dependents enrolled under contracts issued during the current calendar year equals or exceeds (1) in the case of a plan that administers any self-funded health coverage arrangements in California, 10 percent of the total enrollment of the plan in California as of December 31 of the preceding year, or (2) in the case of a plan that does not administer any self-funded health coverage arrangements in California, 8 percent of the total enrollment of the plan in California as of December 31 of the preceding year.

(1) If a health care service plan treats an affiliate or subsidiary as a separate carrier for the purpose of this article because one health care service plan is qualified under the federal Health Maintenance Organization Act and does not offer coverage to small employers, while the affiliate or subsidiary offers a plan contract that is not qualified under the federal Health Maintenance Organization Act and offers plan contracts to small employers, the health care service plan offering coverage to small employers shall enroll new eligible employees and dependents, equal to the applicable percentage of the total enrollment of both the health care service plan qualified under the federal Health Maintenance Organization Act and its affiliate or subsidiary.

(2) The certified statement filed pursuant to this subdivision shall state the following:

(A) Whether the plan administers any self-funded health coverage arrangements in California.

(Publication page references are not available for this document.)

(B) The plan's total enrollment as of December 31 of the preceding year.

(C) The number or [FN1] eligible employees and dependents enrolled under contracts issued to small employer groups during the current calendar year.

The commissioner shall, within 45 days, approve or disapprove the certified statement. If the certified statement is disapproved, the plan shall continue to issue coverage as required by Section 1357.03 and be subject to disciplinary action as set forth in Article 7 (commencing with Section 1386).

(e) A health care service plan that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and 50 percent or more of the plan's total enrollment have premiums paid by the Medi-Cal program.

<< CA HLTH & S § 1357.10 >>

1357.10. The commissioner may require a plan to discontinue the offering of contracts or acceptance of applications from any small employer or group with more than 50 employees upon a determination by the commissioner that the plan does not have sufficient financial viability, or organizational and administrative capacity to assure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the commissioner shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.

<< CA HLTH & S § 1357.11 >>

1357.11. All health care service plan contracts offered to a small employer shall be renewable with respect to all eligible employees or dependents at the option of the contractholder or small employer except:

(a) For nonpayment of the required premiums or contributions toward the premiums by the contractholder or small employer.

(b) For fraud or misrepresentation by the contractholder or small employer or, with respect to coverage of individuals, the individuals or their representatives.

(c) When the plan ceases to provide or arrange for the provision of health care services for new small employer health care service plan contracts in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing small employer health benefits plans in this state is provided to the commissioner and to either the contractholder or small employer.

(2) Small employer health care service plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan which remains in force, any plan that ceases to offer for sale new small employer health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.

(3) Except as authorized under subdivision (d) of Section 1357.09 and Section 1357.10, a plan that ceases to write new small employer business in this state after the effective date of this article shall be prohibited from offering for sale new small employer health care service plan contracts in this state for a period of three years from the date of notice to the commissioner.

(Publication page references are not available for this document.)

(d) When the plan withdraws a health care service plan contract from the small employer market; provided, the plan makes available to the small employer all plan contracts that it makes available to new small employer business; and provided, that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.12.

<< CA HLTH & S § 1357.12 >>

1357.12. Premiums for contracts offered or delivered by plans on or after the effective date of this article shall be subject to the following requirements:

(a) (1) The premium for new business shall be determined for an employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(2) The premium charged a small employer for new business shall be equal to the sum of the risk adjusted employee risk rates.

(3) The premium charged a small employer for new business shall be in effect for no less than six months.

(b) (1) The premium for renewal of in force business shall be determined for an employee in a particular risk category after applying a risk adjustment factor to the plan's standard employee risk rates. The risk adjusted employee risk rates may not be more than 120 percent or less than 80 percent of the plan's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

(2) The premium charged a small employer for renewal of in force business shall be equal to the sum of the risk adjusted employee risk rates and shall be in effect for no less than six months.

(3) For a contract that a plan has discontinued offering, the risk adjustment factor applied to the standard employee risk rates for the first rating period of the new contract that the small employer elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, the risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the plan's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

<< CA HLTH & S § 1357.13 >>

1357.13. Plans shall apply standard employee risk rates consistently with respect to all small employers.

<< CA HLTH & S § 1357.14 >>

1357.14. In connection with the offering for sale of any plan contract to a small

(Publication page references are not available for this document.)

employer, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in service costs or actual or expected variation in health condition of the employees and dependents of the small employer.

(b) The provisions concerning the plan's right to change premium rates and the factors other than provision of services experience that affect changes in premium rates.

(c) Provisions relating to the guaranteed issue of contracts.

(d) Provisions relating to the effect of any preexisting condition provision.

(e) Provisions relating to the small employer's right to apply for any contract written, issued, or administered by the plan at the time of application for a new health care service plan contract, or at the time of renewal of a health care service plan contract.

(f) The availability, upon request, of a listing of all the plan's contracts offered to small employers, including the rates for each contract.

(g) At the time it offers a contract to a small employer, each plan shall provide the small employer with a statement of all of its plan contracts offered to small employers, including the rates for each plan contract, in the service area in which the employer's employees and eligible dependents who are to be covered by the plan contract work or reside. For purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one health plan.

(h) Each plan shall do all of the following:

(1) Prepare a brochure that summarizes all of its plan contracts offered to small employers and to make this summary available to any small employer and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, and a phone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to small employers, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide to small employers and solicitors, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted employee risk rates. When requesting this information, small employers, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the small employer's risk adjusted employee risk rate.

(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from small employers.

For purposes of this subdivision, companies that are affiliated companies or that are

eligible to file a consolidated income tax return shall be treated as one health plan.

(i) Every solicitor or solicitor firm contracting with one or more plans to solicit enrollments or subscriptions from small employers shall do all of the following:

(1) When providing information on contracts to a small employer but making no specific recommendations on particular plan contracts:

(A) Advise the small employer of the plan's obligation to sell to any small employer any plan contract it offers to small employers and provide them, upon request, with the actual rates that would be charged to that employer for a given contract.

(B) Notify the small employer that the solicitor or solicitor firm will procure rate and benefit information for the small employer on any plan contract offered by a plan whose contract the solicitor sells.

(C) Notify the small employer that upon request the solicitor or solicitor firm will provide the small employer with the summary brochure required under paragraph (1) of subdivision (h) for any plan contract offered by a plan with whom the solicitor or solicitor firm has contracted with to solicit enrollments or subscriptions.

(2) When offering a small employer a particular contract:

(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the small employer with the benefit summary required in paragraph (1) of subdivision (h) and the sum of the standard employee risk rates for that particular employer.

(B) Notify the small employer that, upon request, the solicitor or solicitor firm will provide the small employer with an evidence of coverage brochure for each contract the plan offers.

(C) Notify the small employer that, from July 1, 1993, to July 1, 1996, actual rates may be 20 percent higher or lower than the sum of the standard employee risk rates, and from July 1, 1996, and thereafter, actual rates may be 10 percent higher or lower than the sum of the standard employee risk rates, depending on how the plan assesses the risk of the small employer's group.

(D) Notify the small employer that, upon request, the solicitor or solicitor firm will submit information to the plan to ascertain the small employer's sum of the risk adjusted employee risk rate for any contract the plan offers.

(j) Coverage under a plan contract for which a small employer has applied shall not take effect until 10 days after the small employer has received from the plan the sum of the risk adjusted employee risk rate for that plan contract unless the small employer waives in writing the right to that information.

<< CA HLTH & S § 1357.15 >>

1357.15. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article which will be in force on the operative date of this article, a plan shall file a notice of material modification with the commissioner in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. The certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will

(Publication page references are not available for this document.)

be used in setting the rates at which the contract will be renewed or amended. Any action by the commissioner, as permitted under Section 1352, to disapprove, suspend or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(b) At least 20 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the commissioner in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. The certified statement shall set forth the standard employee risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Plans that will be offering to a small employer plan contracts approved by the commissioner prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the commissioner, as permitted under Section 1352, to disapprove, suspend or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.

(c) Prior to making any changes in the risk categories, risk adjustment factors or standard employee risk rates filed with the commissioner pursuant to subdivision (a) or (b), the plan shall file as an amendment a statement setting forth the changes and certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.12. A plan may commence offering plan contracts utilizing the changed risk categories set forth in the certified statement on the 31st day from the date of the filing, or at an earlier time determined by the commissioner, unless the commissioner disapproves the amendment by written notice, stating the reasons therefor. If only the standard employee risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence offering plan contracts utilizing the changed standard employee risk rate upon filing the certified statement unless the commissioner disapproves the amendment by written notice.

(d) Periodic changes to the standard employee risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).

(e) Each plan shall maintain at its principal place of business all of the information required to be filed with the commissioner pursuant to this section.

(f) Each plan shall make available to the commissioner, on request, the risk adjustment factor used in determining the rate for any particular small employer.

(g) Nothing in this section shall be construed to limit the commissioner's authority to enforce the rating practices set forth in this article.

<< CA HLTH & S § 1357.17 >>

1357.17. The commissioner may issue regulations that are necessary to carry out the purposes of this article. Prior to the public comment period required on the regulations under the Administrative Procedure Act, the commissioner shall provide the Insurance Commissioner with a copy of the proposed regulations. The Insurance Commissioner shall have 30 days to notify the commissioner in writing of any comments on the regulations. The Insurance Commissioner's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government

(Publication page references are not available for this document.)

Code). Until December 31, 1994, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety or general welfare.

<< CA HLTH & S § 1357.18 >>

1357.18. The Department of Corporations shall monitor the standard employee risk rates for those health care service plan contracts under which providers are not prospectively paid to determine whether pricing patterns emerge which reflect either adverse selection of particular products by high- or low-risk groups or unfairly competitive, predatory pricing strategies by particular carriers. The department shall also monitor the effects of the contract premium rating requirements of this chapter on affordability of small group health insurance and the relation, if any, between price sensitivity and continuation of coverage. The department shall report its findings to the Assembly Insurance Committee and the Senate Insurance, Claims, and Corporations Committee on July 1, 1994, and July 1, 1996.

<< CA HLTH & S Prec. § 1357.50 >>

SEC. 6. Article 3.15 (commencing with Section 1357.50) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.15. Preexisting Condition Provisions and Late Enrollees

<< CA HLTH & S § 1357.50 >>

1357.50. For purposes of this article:

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

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

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

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

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

(Publication page references are not available for this document.)

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, or divorce.

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

(2) The individual is employed by an employer that 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 and request for enrollment is made within 30 days after issuance of the court order.

(4) The plan cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in bold 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).

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

(d) "Qualifying prior coverage" means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, nonprofit hospital service plan, 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, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(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.

<< CA HLTH & S § 1357.51 >>

(Publication page references are not available for this document.)

1357.51. (a) No plan contract that covers three or more enrollees shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A plan that does not utilize a preexisting condition provision may impose a waiting period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(c) In determining whether a preexisting condition provision or a waiting period applies to any enrollee, a plan shall credit the time the enrollee was covered under qualifying prior coverage, provided the enrollee becomes eligible for coverage under the succeeding plan contract within 30 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage under the succeeding plan within the applicable enrollment period.

However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under qualifying prior coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 90 days, exclusive of any waiting period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(d) No plan shall exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

SEC. 7. Section 1367 of the Health and Safety Code is amended to read:

<< CA HLTH & S § 1367 >>

1367. Each health care service plan, and where applicable, each specialized health care service plan, shall meet the following requirements:

(a) All facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, if such licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where such licensure or certification is required by law.

(c) All equipment required to be licensed or registered by law shall be so licensed or registered and the operating personnel for such equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at such times as may be appropriate consistent

with good professional practice.

(e) All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) All contracts with subscribers and enrollees, including group contracts, and all contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter.

(i) Each health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the commissioner may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from such requirement. The commissioner shall by rule define the scope of each basic health care service which health care service plans shall be required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that such copayments, deductibles, or limitations are reported to, and held unobjectionable by, the commissioner and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

Nothing in this section shall be construed to permit the commissioner to establish the rates charged subscribers and enrollees for contractual health care services.

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<<+The commissioner's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.+>>

SEC. 8. Section 1393.6 is added to the Health and Safety Code, to read:

<< CA HLTH & S § 1393.6 >>

1393.6. For violations of Article 3.1 (commencing with Section 1357) and Article 3.15 (commencing with Section 1357.50), the commissioner may, after appropriate notice and opportunity for hearing, by order levy administrative penalties as follows:

(a) Any person, solicitor, or solicitor firm, other than a health care service plan, who willfully violates any provision of this chapter, or who willfully violates any rule or order adopted or issued pursuant to this chapter, is liable for administrative penalties of not less than two hundred fifty dollars (\$250) for each first violation, and of not less than one thousand dollars (\$1,000) and not more than two thousand five hundred dollars (\$2,500) for each subsequent violation.

(b) Any health care service plan that willfully violates any provision of this chapter, or that willfully violates any rule or order adopted or issued pursuant to this chapter,

(Publication page references are not available for this document.)

is liable for administrative penalties of not less than two thousand five hundred dollars (\$2,500) for each first violation, and of not less than five thousand dollars (\$5,000) nor more than ten thousand dollars (\$10,000) for each second violation, and of not less than fifteen thousand dollars (\$15,000) and not more than one hundred thousand dollars (\$100,000) for each subsequent violation.

(c) The administrative penalties shall be paid to the State Corporations Fund.

(d) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the commissioner to enforce the provisions of this chapter.

<< CA INS Prec. § 10198.6 >>

SEC. 9. Article 7 (commencing with Section 10198.6) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 7. Preexisting Condition Provisions and Late Enrollees

<< CA INS § 10198.6 >>

10198.6. For purposes of this article:

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

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

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

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

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

(Publication page references are not available for this document.)

individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, or divorce.

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

(2) The individual is employed by an employer that 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 and request for enrollment is made within 30 days after issuance of the court order.

(4) The carrier cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in bold 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 twelve months as well as a six month preexisting condition exclusion, unless the individual meets the criteria specified in paragraphs (1), (2), or (3).

(c) "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.

(d) "Qualifying prior coverage" means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, nonprofit hospital service plan, 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, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(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.

<< CA INS § 10198.7 >>

10198.7. (a) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee

(Publication page references are not available for this document.)

welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A carrier that does not utilize a preexisting condition provision may impose a waiting period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(c) In determining whether a preexisting condition provision or a waiting period applies to any person, all health benefit plans shall credit the time the person was covered under qualifying prior coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 30 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage under the succeeding plan within the applicable enrollment period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated or, an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under qualifying prior coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 90 days, exclusive of any waiting period, and applies for coverage under the succeeding plan within the applicable enrollment period.

(d) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(e) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

<< CA INS § 10198.8 >>

10198.8. This article applies to all health benefit plans that provide hospital, medical, or surgical benefits to residents of this state regardless of the situs of the contract or group master policyholder.

<< CA INS Prec. § 10700 >>

SEC. 10. Chapter 14 (commencing with Section 10700) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 14. SMALL EMPLOYER HEALTH INSURANCE
Article 1. Definitions

<< CA INS § 10700 >>

10700. As used in this chapter:

(a) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a carrier is in compliance with the provisions of this chapter, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.

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

(c) "Benefit plan design" means a specific health coverage product issued by a carrier to small employers or to trustees of associations that include small employers. 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.

(d) "Board" means the Major Risk Medical Insurance Board.

(e) "Carrier" means any disability insurance company, nonprofit hospital service plan, or any other entity that writes, issues, or administers group 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.

(f) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(g) "Eligible employee" means 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 work week 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.

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

(i) "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.

(j) "Fund" means the California Small Group Reinsurance Fund.

(k) "Health benefit plan" means a policy or contract written or administered by a carrier

(Publication page references are not available for this document.)

that arranges or provides health care benefits for the enrolled 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.

(l) "In force business" means an existing health benefit plan issued by the carrier to a small employer.

(m) "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. However, an eligible employee 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 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 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 or dependent's coverage, death of the person through whom the individual was covered as a dependent, or divorce; and (D) requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or (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; or (3) a court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order; or (4) 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 bold 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).

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

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

(p) "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).

(Publication page references are not available for this document.)

(q) "Program" means the Voluntary Alliance Uniting Employers Purchasing Program.

(r) "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.

(s) "Qualifying prior coverage" means:

(1) Any individual or group policy, contract, or program, that is written or administered by a disability insurer, nonprofit hospital service plan, 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, 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.

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

(u) "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.

(v) "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.

(w) "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

(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 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 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.

(x) "Small employer" means 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, employed at least three, 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. However, for purposes of subdivisions (b) and (h) of Section 10705, the definition shall include employers with at least five eligible employees until July 1, 1994, four eligible employees until July 1, 1995, and three 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.

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

(z) An association is 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 small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which 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, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to that date, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

<< CA INS Prec. § 10702 >>

Article 2. Small Employer Carrier Requirements

<< CA INS § 10702 >>

10702. All carriers writing, issuing, or administering health benefit plans that cover employees of small employers shall be subject to this chapter if any one of the following conditions are met:

(a) Any portion of the premium for any health benefit plan or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(b) The health benefit plan is treated by the small employer or any of the covered individuals as part of a plan or program for the purposes of Section 106 or 162 of the Internal Revenue Code.

<< CA INS § 10703 >>

10703. The commissioner shall have the authority to determine whether a health benefit plan is covered by this chapter, and to determine whether an employer is a small employer within the meaning of Section 10700.

<< CA INS § 10704 >>

10704. The commissioner may issue regulations that are necessary to carry out the purposes of this article. Prior to the public comment period required on the regulations under the Administrative Procedure Act, the commissioner shall provide the Commissioner of Corporations with a copy of the proposed regulations. The Commissioner of Corporations shall have 30 days to notify the commissioner in writing of any comments on the regulations. The Commissioner of Corporations' comments shall be included in the public notice issued on the regulations. Any rules and regulations issued pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until December 31, 1994, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The regulations shall be enforced by the commissioner.

<< CA INS § 10705 >>

10705. Upon the effective date of this act:

(a) No group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10717.

(b) Each carrier, except a self-funded employer, shall fairly and affirmatively offer, market, and sell all of the carrier's benefit plan designs that are sold to small employers or to associations that include small employers to all small employers in each geographic region in which the carrier makes coverage available or provides benefits. A carrier contracting to participate in the Voluntary Alliance Uniting Employers Purchasing Program shall be deemed to be in compliance with this requirement for a benefit plan design offered through the program in those geographic regions in which the carrier participates in the program and the benefit plan design is offered exclusively through the program.

(1) Nothing in this section shall be construed to require an association to offer, market or sell a benefit plan design to those who are not members of the association. However, if the association markets, offers or sells a benefit plan design to those who are not members of the association it is subject to the requirements of this section.

(2) A carrier which (A) effective January 1, 1992, and at least 20 years prior to that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer or sell any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers or sells any benefit plan design or any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits to those who are not members of the association it is subject to the requirements of this section.

(3) Each carrier that sells health benefit plans to members of one association pursuant to paragraph (2) shall submit an annual statement to the commissioner which states that the carrier is selling health benefit plans pursuant to paragraph (2) and which, for the one association, lists all the information required by paragraph (4).

(4) Each carrier that sells health benefit plans to members of any association shall submit an annual statement to the commissioner which lists each association to which the carrier sells health benefit plans, the industry or profession which is served by the association, the association's membership criteria, a list of officers, the state in which the association is organized, and the site of its principal office.

(c) Each carrier shall make available to each small employer all benefit plan designs that the carrier offers or sells to small employers or to associations that include small employers. Notwithstanding subdivision (e) of Section 10700, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(d) Each carrier shall do all of the following:

(Publication page references are not available for this document.)

(1) Prepare a brochure that summarizes all of its benefit plan designs and make this summary available to small employers, agents and brokers upon request. The summary shall include for each benefit plan design information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, and a phone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send copies to agents and brokers representing the carrier. Any entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan design.

(2) For each benefit plan design, prepare a more detailed evidence of coverage and make it available to small employers, agents and brokers upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making selection of benefit plan designs. An entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be required to prepare an evidence of coverage for that benefit plan design.

(3) Provide to small employers, agents, and brokers, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted standard employee risk rates. When requesting this information, small employers, agents and brokers shall provide the carrier with the information the carrier needs to determine the small employer's risk adjusted employee risk rate.

(4) Provide copies of the current summary brochure to all agents or brokers who represent the carrier and, upon updating the brochure, send copies of the updated brochure to agents and brokers representing the carrier for the purpose of selling health benefit plans.

(5) Notwithstanding subdivision (e) of Section 10700, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(e) Every agent or broker representing one or more carriers for the purpose of selling health benefit plans to small employers shall do all of the following:

(1) When providing information on a health benefit plan to a small employer but making no specific recommendations on particular benefit plan designs:

(A) Advise the small employer of the carrier's obligation to sell to any small employer any of the benefit plan designs it offers to small employers and provide them, upon request, with the actual rates that would be charged to that employer for a given benefit plan design.

(B) Notify the small employer that the agent or broker will procure rate and benefit information for the small employer on any benefit plan design offered by a carrier for whom the agent or broker sells health benefit plans.

(C) Notify the small employer that, upon request, the agent or broker will provide the small employer with the summary brochure required in paragraph (1) of subdivision (d) for any benefit plan design offered by a carrier whom the agent or broker represents.

(2) When offering a small employer a particular health benefit plan:

(A) For each of the benefit plan designs offered by the carrier whose benefit plan design the agent or broker is presenting, provide the small employer with the benefit summary

required in paragraph (1) of subdivision (d) and the sum of the standard employee risk rates for that particular employer.

(B) Notify the small employer that, upon request, the agent or broker will provide the small employer with an evidence of coverage brochure for each benefit plan design the carrier offers.

(C) Notify the small employer that, from July 1, 1993 to July 1, 1996, actual rates may be 20 percent higher or lower than the sum of the standard employee risk rates, and from July 1, 1996, and thereafter, actual rates may be 10 percent higher or lower than the sum of the standard employee risk rates depending on how the carrier assesses the risk of the small employer's group.

(D) Notify the small employer that, upon request, the agent or broker will submit information to the carrier to ascertain the small employer's sum of the risk adjusted standard employee risk rate for any benefit plan design the carrier offers.

(f) Coverage under a particular health benefit plan design for which a small employer has applied shall not take effect until 10 days after the small employer has received from a carrier the sum of the risk adjusted standard employee risk rates for that benefit plan design, unless the small employer waives in writing the right to that information.

(g) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from a health benefit plan which is provided in connection with the employee's employment.

(h) No carrier shall reject an application from a small employer for a benefit plan design provided:

(1) The small employer offers health benefits to 100 percent of its eligible employees. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(i) No carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(2) Encourage or direct small employers to seek coverage from another carrier or the program because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(j) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer or the small employer's employees. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(Publication page references are not available for this document.)

(k) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

(1) (1) With respect to the obligation to provide coverage newly issued under subdivision (d), the carrier may cease enrolling new small employer groups if it certifies to the commissioner that the number of eligible employees and dependents, of the employers newly enrolled or insured during the current calendar year by the carrier equals or exceeds: (A) in the case of a carrier that administers any self-funded health benefits arrangement in California, 10 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured in California by that carrier as of December 31 of the preceding year, or (B) in the case of a carrier that does not administer any self-funded health benefit arrangements in California, 8 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured by the carrier in California as of December 31 of the preceding year.

(2) Certification shall be deemed approved if not disapproved within 45 days after submission to the commissioner. If the certification is not approved, the carrier shall continue to issue coverage as required by subdivision (d) and be subject to administrative penalties as established in Section 10718.

<< CA INS § 10706 >>

10706. Every carrier shall file with the commissioner the reasonable participation requirements and employer contribution requirements that are to be included in its health benefit plans. Participation requirements shall be applied uniformly among all small employer groups, except that a carrier may vary application of minimum employer participation requirements by the size of the small employer group. Employer contribution requirements shall not vary by employer size.

<< CA INS § 10706.5 >>

10706.5. A health benefit plan shall be effective no later than the 31st day after receipt by the carrier of the small employer's completed application and submission of premium. All eligible employees and dependents listed on the small employer's completed application shall be covered on the effective date of the health benefit plan. For all eligible employees who are employed by the small employer after the effective date of the health benefit plan, a health benefit plan may impose a maximum waiting period of no more than 60 days upon each enrollee from the date of the eligible employee's application for enrollment. During the waiting period the plan is not required to provide health care services and no premiums shall be charged to the subscriber or enrollee.

<< CA INS § 10707 >>

10707. Except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a carrier may not exclude any eligible employee or dependent who would otherwise be covered, on the basis of an actual or expected health condition of that employee. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 10708.

<< CA INS § 10708 >>

10708. (a) Preexisting condition provisions of health benefit plans shall not exclude

(Publication page references are not available for this document.)

coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including the use of prescription medications, was recommended by or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A carrier that does not utilize a preexisting condition provision may impose a waiting period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting period, the carrier is not required to provide health care benefits and no premiums shall be charged to the subscriber or enrollee.

(c) In determining whether a preexisting condition provision applies to any person, a plan shall credit the time the person was covered under qualifying prior coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 30 days of termination of prior coverage, exclusive of any waiting period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under qualifying prior coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 90 days, exclusive of any waiting period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

(d) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning preexisting condition provisions and waiting periods.

<< CA INS § 10709 >>

10709. (a) No health benefit plan may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No premiums shall be charged to the late enrollee until the exclusion period has ended.

(b) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning late enrollees.

<< CA INS § 10711 >>

10711. No carrier shall be required by the provisions of this chapter:

(a) To offer coverage to, or accept applications from, a small employer, where the small employer is not physically located in a carrier's approved service areas.

(b) To include in a health benefits plan an otherwise eligible employee or dependent, when the employee or dependent does not work or reside within a carrier's approved service area.

(c) To offer coverage to, or accept applications from, a small employer for a benefits plan design within an area if the commissioner has found that the carrier will not have the capacity within the area in its network of providers to deliver service adequately to the eligible employees and dependents of that employee because of its obligations to existing group contractholders and enrollees and that the action is not unreasonable or clearly inconsistent with the intent of this chapter.

(Publication page references are not available for this document.)

A carrier that cannot offer coverage to small employers in a specific service area because it is lacking sufficient capacity may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups, and certifies to the commissioner that from the date of the notice it will enroll all small groups requesting coverage from the carrier until the carrier has met the requirements of subdivision (h) of Section 10705.

(d) To offer coverage to a small employer group which within 12 months of application for coverage disenrolled from a health benefit plan offered by the carrier.

<< CA INS § 10712 >>

10712. (a) A carrier shall not be required to offer coverage or accept applications for benefit plan designs pursuant to this chapter where the commissioner determines that the acceptance of an application or applications would place the carrier in a financially impaired condition.

(b) The commissioner's determination shall follow an evaluation that includes a certification by the commissioner that the acceptance of an application or applications would place the carrier in a financially impaired condition.

(c) A carrier that has not offered coverage or accepted applications pursuant to this chapter shall not offer coverage or accept applications for any individual or group health benefit plan until the commissioner has determined that the carrier has ceased to be financially impaired.

<< CA INS § 10713 >>

10713. All health benefit plans written, issued, or administered by carriers on or after the effective date of this chapter, and all health benefit plans in force on or after the effective date of this chapter shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder, or small employer except as follows:

(a) For nonpayment of the required premiums by the policyholder, contractholder, or small employer.

(b) For fraud or misrepresentation by the policyholder, contractholder, or small employer or, with respect to coverage of individual enrollees, the enrollees or their representative.

(c) When the carrier ceases to write, issue, or administer new small employer health benefit plans in this state, provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease writing, issuing, or administering new or existing small employer health benefits plans in this state is provided to the commissioner, and to either the policyholder, contractholder, or small employer.

(2) Small employer health benefit plans subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1). For that business of a carrier that remains in force, any carrier that ceases to write, issue, or administer new health benefit plans shall continue to be governed by this chapter.

(3) Except in the case where a certification has been approved pursuant to subdivision

(Publication page references are not available for this document.)

(h) of Section 10705 or the commissioner has made a determination pursuant to subdivision (a) of Section 10712, a carrier that ceases to write, issue, or administer new health benefit plans to small employers in this state after the passage of this chapter shall be prohibited from writing, issuing, or administering new health benefit plans to small employers in this state for a period of three years from the date of notice to the commissioner.

(d) When a carrier withdraws a benefit plan design from the small employer market, provided that the carrier makes available to the small employer all small employer benefit plan designs which it markets and satisfies the requirements of paragraph (3) of subdivision (b) of Section 10714.

<< CA INS § 10714 >>

10714. Premiums for benefit plan designs written, issued, or administered by carriers on or after the effective date of this act, shall be subject to the following requirements:

(a) (1) The premium for new business shall be determined for an employee in a particular risk category after applying a risk adjustment factor to the carrier's standard employee risk rates. The risk adjusted employee risk rate may not be more than 120 percent or less than 80 percent of the carrier's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, the risk adjusted employee risk rate may not be more than 110 percent or less than 90 percent.

(2) The premium charged a small employer for new business shall be equal to the sum of the risk adjusted employee risk rates.

(3) The premium charged a small employer for new business shall be in effect for no less than six months.

(b) (1) The premium for renewal of in force business shall be determined for an employee in a particular risk category after applying a risk adjustment factor to the carrier's standard employee risk rates. The risk adjusted employee risk rates may not be more than 120 percent or less than 80 percent of the carrier's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, the risk adjusted employee risk rate may not be more than 110 percent or less than 90 percent. The risk adjustment factor applied to a small employer may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

(2) The premium charged a small employer for renewal of in force business shall be equal to the sum of the risk adjusted employee risk rates and shall be in effect for no less than six months.

(3) For a benefit plan design that a carrier has discontinued offering, the risk adjustment factor applied to the standard employee risk rates for the first rating period of the new benefit plan design that the small employer elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued benefit plan design. However, the risk adjusted employee rate may not be more than 120 percent or less than 80 percent of the carrier's applicable standard employee risk rate until July 1, 1996. Effective July 1, 1996, the risk adjusted employee risk rate may not be more than 110 percent or less than 90 percent. The risk adjustment factor for a small employer may not be modified more frequently than every 12 months.

<< CA INS § 10715 >>

10715. Carriers shall apply standard employee risk rates consistently with respect to all small employers.

<< CA INS § 10716 >>

10716. In connection with the offering for sale of any benefit plan design to small employers:

Each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) The extent to which the premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health conditions of the employees and dependents of the small employer.

(b) The provisions concerning the carrier's ability to change premium rates and the factors other than claim experience which affect changes in premium rates.

(c) Provisions relating to the guaranteed issue of policies and contracts.

(d) Provisions relating to the effect of any preexisting condition provision.

(e) Provisions relating to the small employer's right to apply for any benefit plan design written, issued, or administered by the carrier at the time of application for a new health benefit plan, or at the time of renewal of a health benefit plan.

(f) The availability, upon request, of a listing of all the carrier's benefit plan designs, including the rates for each benefit plan design.

<< CA INS § 10717 >>

10717. (a) No carrier shall provide or renew coverage subject to this chapter until it has done all of the following:

(1) A statement has been filed with the commissioner listing all of the carrier's benefit plan designs currently in force that are offered or proposed to be offered for sale in this state, identified by form number, and, if previously approved by the commissioner, the date approved by the commissioner as well as the standard employee risk rate for each risk category for each benefit plan design and the highest and lowest risk adjustment factors that the carrier intends to use in determining rates for each benefit plan design. When filing a new benefit plan design pursuant to Section 10705, carriers may submit both the policy form and the standard employee risk rates for each risk category at the same time.

(2) Either:

(A) Thirty days expires after that statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter.

(B) Prior to that time the commissioner gives the carrier written notice that the carrier's risk categories and risk adjustment factors as filed comply with the requirements of this chapter.

(b) No carrier shall issue, deliver, renew, or revise a benefit plan design lawfully provided pursuant to subdivision (a), and no carrier shall change the risk categories,

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risk adjustment factors, or standard employee risk rates for any benefit plan design until all of the following requirements are met:

(1) The carrier files with the commissioner a statement of the specific changes which the carrier proposes in the risk categories, risk adjustment factors, or standard employee risk rates.

(2) Either:

(A) Thirty days expires after such statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter.

(B) Prior to that time the commissioner gives the carrier written notice that the carrier's risk categories and risk adjustment factors as filed comply with the requirements of this chapter.

(c) Notwithstanding any provision to the contrary, when a carrier is changing the standard employee risk rates of a benefit plan design lawfully provided under (a) or (b) above but is not changing the risk categories or risk adjustment factors which have been previously authorized, the carrier need not comply with the requirements of paragraph (2) of subdivision (b), but instead shall submit the revised standard employee risk rates for the benefit plan design prior to offering or renewing the benefit plan design.

(d) When submitting filings under subdivision (a), (b), or (c), a carrier may also file with the commissioner at the time of the filings a statement of the standard employee risk rate for each risk category the carrier intends to use for each month in the 12 months subsequent to the date of the filing. Once the requirements of the applicable subdivision (a), (b), or (c), have been met, these rates shall be used by the carrier for the 12-month period unless the carrier is otherwise informed by the commissioner in his or her response to the filings submitted under subdivision (a), (b), or (c), provided that any subsequent change in the standard employee risk rates charged by the carrier which differ from those previously filed with the commissioner must be newly filed in accordance with this subdivision and provided that the carrier does not change the risk categories or risk adjustment factors for the benefit plan design.

(e) If the commissioner notifies the carrier, in writing, that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter, specifying the reasons for his or her opinion, it is unlawful for the carrier, at any time after the receipt of such notice, to utilize the noncomplying health benefit plan, benefit plan design, risk categories, or risk adjustment factors in conjunction with the health benefit plans or benefit plan designs for which the filing was made.

(f) Each carrier shall maintain at its principal place of business copies of all information required to be filed with the commissioner pursuant to this section.

(g) Each carrier shall make the information and documentation described in this section available to the commissioner upon request.

(h) Nothing in this section shall be construed to permit the commissioner to establish or approve the rates charged to policyholders for health benefit plans.

<< CA INS § 10718 >>

10718. (a) In addition to any other remedy permitted by law, the commissioner shall have the administrative authority to assess penalties against carriers, insurance producers,

(Publication page references are not available for this document.)

and other entities engaged in the business of insurance or other persons or entities for violations of this chapter.

(b) Upon a showing of a violation of this chapter in any civil action, a court may also assess the penalties described in this chapter, in addition to any other remedies provided by law.

(c) Any production agent or other person or entity engaged in the business of insurance, other than a carrier, that violates this chapter is liable for administrative penalties of not more than two hundred fifty dollars (\$250) for the first violation.

(d) Any production agent or other person or entity engaged in the business of insurance, other than a carrier, that engages in practices prohibited by this chapter a second or subsequent time, or who commits a knowing violation of this chapter, is liable for administrative penalties of not less than one thousand dollars (\$1,000) and not more than two thousand five hundred dollars (\$2,500) for each violation.

(e) Any carrier that violates this chapter is liable for administrative penalties of not more than two thousand five hundred dollars (\$2,500) for the first violation and not more than five thousand dollars (\$5,000) for each subsequent violation.

(f) Any carrier that violates this chapter with a frequency that indicates a general business practice or commits a knowing violation of this chapter, is liable for administrative penalties of not less than fifteen thousand dollars (\$15,000) and not more than one hundred thousand dollars (\$100,000) for each violation.

(g) An act or omission that is inadvertent and that results in incorrect premium rates being charged to more than one policyholder shall be a single violation for the purpose of this section.

<< CA INS § 10718.5 >>

10718.5. (a) (1) In addition to any other remedy permitted by law, whenever the commissioner shall have reason to believe that any carrier, production agent, or other person or entity engaged in the business of insurance has violated this chapter, and that a proceeding by the commissioner in respect thereto would be in the interest of the public, the commissioner may issue and serve upon that entity an order to show cause containing a statement of the charges, a statement of the entity's potential liability under this chapter, and a notice of a public hearing thereon before the Administrative Law Bureau of the department to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the commissioner should issue an order to that entity to pay the penalty imposed by this chapter and such order or orders as shall be reasonably necessary to correct, eliminate, or remedy the alleged violations of this chapter, including, but not limited to, an order to cease and desist from the specified violations of this chapter.

(2) The hearings provided by this subdivision shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

(b) (1) Whenever it appears to the commissioner that irreparable loss and injury has occurred or may occur to an insured, employer, employee, or other member of the public because a carrier, production agent, or other person or entity engaged in the business of insurance has violated this chapter, the commissioner may, before hearing, but after notice and opportunity to submit relevant information, issue and cause to be served upon

(Publication page references are not available for this document.)

the entity such order or orders as shall be reasonably necessary to correct, eliminate, or remedy the alleged violations of this chapter, including, but not limited to, an order requiring the entity to forthwith cease and desist from engaging further in the violations which are causing or may cause such irreparable injury.

(2) At the same time an order is served pursuant to paragraph (1) of this subdivision, the commissioner shall issue and also serve upon the person a notice of public hearing before the Administrative Law Bureau of the department to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof.

(3) The hearings provided by this subdivision shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the commissioner shall have all the powers granted therein.

(4) At any time prior to the commencement of a hearing as provided in this subdivision, the entity against which the commissioner has served an order may waive the hearing and have judicial review of the order by means of any remedy afforded by law without first exhausting administrative remedies or procedures.

(c) If, after hearing as provided by subdivision (a) or (b), the charges, or any of them, that an entity has violated this chapter are found to be justified, the commissioner shall issue and cause to be served upon that entity an order requiring that entity to pay the penalty imposed by this chapter and such order or orders as shall be reasonably necessary to correct, eliminate, or remedy the alleged violations of this chapter, including, but not limited to, an order to cease and desist from the specified violations of this chapter.

(d) In addition to any other penalty provided by law or the availability of any administrative procedure, if a carrier, after notice and hearing, is found to have violated this chapter knowingly or as a general business practice the commissioner may suspend the carrier's certificate of authority to transact disability insurance. The order of suspension shall prescribe the period of such suspension. The proceedings shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code and the commissioner shall have all the powers granted therein.

<< CA INS § 10718.6 >>

10718.6. The Department of Insurance shall monitor the standard employee risk rates for carriers benefit plan designs to determine whether pricing patterns emerge which reflect either adverse selection of particular products by high- or low-risk groups or unfairly competitive, predatory pricing strategies by particular carriers. The department shall also monitor the effects of the contract premium rating requirements of this chapter on affordability of small group health insurance and the relation, if any, between price sensitivity and continuation of coverage. The department shall report its findings to the Assembly Insurance Committee and the Senate Insurance, Claims, and Corporations Committee on July 1, 1994, and July 1, 1996.

<< CA INS § 10718.7 >>

10718.7. Notwithstanding any other provision of law, no provision of this chapter shall be construed to limit the applicability of any other provision of the Insurance Code unless such provision is in conflict with the requirements of this chapter.

<< CA INS Prec. § 10719 >>

Article 3. Voluntary Reinsurance Mechanism

<< CA INS § 10719 >>

10719. The California Small Group Reinsurance Fund is hereby authorized to be created solely to allow carriers to share in financing the cost of covering high risk small employer groups. It shall be organized as a nonprofit corporation, which consists of all small employer carriers and small employer health care service plans which elect to participate in the fund pursuant to subdivision (d) of Section 10720. These carriers may cede that portion of risk to the fund that the fund has agreed to accept.

<< CA INS § 10720 >>

10720. (a) The fund shall be governed by a board of directors, which shall initially be elected by small employer carriers and small employer health care service plans. The initial board shall be elected by a weighted vote based on net health insurance premiums derived from the state in the previous calendar year in the small employer market. The initial board shall consist of at least five and not more than nine representatives of small employer carriers and small employer health care service plans.

(b) Within 180 days of the election of the initial board, the board shall adopt a plan of operation which provides for the reasonable and equitable administration of the fund.

(c) The plan of operation shall, among other things, do all of the following:

- (1) Establish procedures to assure the fair, reasonable, and equitable administration of the fund and provide for the sharing of fund gains or losses on an equitable and proportionate basis.
- (2) Establish procedures for handling and accounting of program assets and moneys.
- (3) Establish terms of office and procedures for filling vacancies on the board.
- (4) Establish procedures for reinsuring risks in accordance with the provisions of this chapter.
- (5) Establish procedures for collecting assessments from members to provide for claims reinsured by the fund and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.

(d) Within 60 days of the board's adoption of the plan of operation, small employer carriers and small employer health care service plans shall elect to be either a participant or nonparticipant of the fund. All participants of the fund shall be members of the fund, and only members of the fund shall continue to be members of the board. Members may elect new members of the board, if necessary, to replace initial board members who elect to be nonparticipants of the fund, subject to subdivision (a). The election shall be binding for a three-year period. Thereafter, each small employer carrier shall notify the board 90 days prior to the end of the election period whether or not they will be a member of the fund.

<< CA INS § 10720.1 >>

10720.1. The fund shall have the general powers and authority granted under the laws of California to insurance companies and health care service plans licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, thereto, the fund shall have the specific authority to:

- (a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.
- (b) Sue or be sued, including taking any legal actions necessary or proper for recovering any assessments and penalties for, on behalf of, or against the fund.
- (c) Take any legal action necessary to avoid the payment of improper claims against the fund.
- (d) Issue reinsurance policies, in accordance with the requirements of this chapter.
- (e) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risk by the fund.
- (f) Establish actuarial functions as appropriate for the operation of the fund.
- (g) Assess members of the fund and take advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year.
- (h) Appoint from among fund members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the fund, policy and contract design, and any other function within the authority of the fund.
- (i) Borrow money to effect the purposes of the fund. Any notes or other evidence of indebtedness of the fund not in default shall be legal investments for fund members and may be carried as admitted assets.

<< CA INS § 10721 >>

10721. The fund shall provide for the financing of its reinsurance and operating costs, including actuarially sound reserves for unpaid losses, by charging members a reinsurance contribution and, as necessary, making assessments and collections from members in proportion to their participation in the program. Neither the state or any officer, agent, or employee shall be liable for any costs of the fund, or for any debts or liabilities incurred by the fund.

<< CA INS § 10722 >>

10722. If assessments exceed actual losses and administrative expenses of the fund, the excess shall be held at interest and used by the fund to offset future losses or to reduce fund premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

<< CA INS § 10723 >>

10723. Any unsatisfied net liability or outstanding assessment owed by an insolvent member participating in the fund shall be assumed by and apportioned among the remaining members in the fund in the same manner in which assessments are levied by the fund. The fund shall have all rights allowed by law on behalf of the remaining members against the insolvent member for sums due the fund.

<< CA INS § 10724 >>

10724. Carriers choosing to participate shall comply with all requirements for participation established by the fund.

<< CA INS § 10725 >>

10725. The fund's board of directors shall establish the rules, conditions, and procedures pertaining to the reinsurance of members' risks by the fund.

<< CA INS § 10726 >>

10726. Nothing in this article relieves members of participating in the fund from complying with the underwriting and rating provisions included in Article 1 (commencing with Section 10700) and Article 2 (commencing with Section 10702) in the case of small employer carriers, or in Article 3.1 (commencing with Section 1357) and with Article 3.14 (commencing with Section 1357.50) of the Health and Safety Code, in the case of small employer health care service plans.

<< CA INS § 10727 >>

10727. The fund shall be exempt from any and all taxes.

<< CA INS § 10728 >>

10728. For purposes of agreements entered into pursuant to this article, the fund, and its officers, directors, agents, and employees shall have no liability for any damages other than actual damages.

<< CA INS § 10729 >>

10729. The fund shall establish rules, conditions, and procedures relating to the indemnification of any person or member of the fund made a party to any claim, action, suit, or proceeding because the person or member served on the board of directors of the fund, or on a committee, or was an officer or employee of the fund, provided, such rules, conditions, and procedures do not authorize indemnification in excess of that expressly permitted by Section 317 of the Corporations Code.

<< CA INS Prec. § 10730 >>

Article 4. Purchasing Pool for Small Employers

<< CA INS § 10730 >>

10730. (a) The Voluntary Alliance Uniting Employers Purchasing Program is hereby created and shall be administered by the Major Risk Medical Insurance Board.

(b) No member of the Major Risk Medical Insurance Board and no decisionmaker for any nonprofit entity that assumes administrative and fiscal responsibility for operation of the program pursuant to Sections 10748.5 and 10748.6 shall make, participate in making, or in any way attempt to use his or her official position to influence the making of any decision that he or she knows or has reason to know will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on him or her or a member of his or her immediate family, or on any of the following:

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars (\$250) or more in value provided to, received by, or promised to the member of the Major Risk Medical Insurance

Board or decisionmaker for a nonprofit entity that assumes administrative and fiscal responsibility for operation of the program pursuant to Sections 10748.5 and 10748.6 within 12 months prior to the time when the decision is made.

(2) Any business entity in which the member of the Major Risk Medical Insurance Board or decisionmaker for a nonprofit entity that assumes administrative and fiscal responsibility for operation of the program pursuant to Sections 10748.5 and 10748.6 is a director, officer, partner, trustee, employee, or holds any position of management.

(c) Commencing January 1, 1994, no member of the Major Risk Medical Insurance Board and no decisionmaker for any nonprofit entity that assumes administrative and fiscal responsibility for the program pursuant to Sections 10748.5 and 10748.6, may be an employee, a consultant or a member of the board of directors of any insurer, hospital service plan or health care service plan, or an insurance broker or agent doing business in California.

<< CA INS § 10731 >>

10731. The board may do any of the following:

(a) Enter into contracts with carriers to provide health benefits coverage to eligible employees and their dependents. Any contract entered into pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract, but may allocate funds to each contract based on projected and actual subscriber enrollments.

(b) Enter into other contracts as are necessary or proper to carry out the provisions of this part.

(c) Employ necessary staff.

(d) Sue or be sued, including taking any legal actions necessary or proper for recovering any penalties for, on behalf of, or against, the program or any board member.

(e) Define the health benefits coverage which the program will contract to purchase from participating carriers.

(f) Appoint committees, as necessary, to provide technical assistance in the operation of the program.

(g) Assess participating employers a reasonable fee for necessary costs in connection with the program.

(h) Undertake activities necessary to administer the program, including marketing and publicizing the program, and assuring carrier, employer, and enrollee compliance with program requirements.

(i) Establish rules, conditions, and procedures for participation for employers.

(j) Establish rules, conditions, and procedures for participation for participating carriers.

(k) Establish a financial relationship directly with agents or brokers to provide services pursuant to this program.

(l) Approve the benefit plan designs sold by carriers participating in the pool.

(Publication page references are not available for this document.)

(m) Issue rules and regulations as necessary to administer the program. Any rules and regulations issued pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until December 31, 1994, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare.

(n) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

(o) From money appropriated to the Major Risk Medical Insurance Fund, the Major Risk Medical Insurance Board may loan funds for operating expenses to establish the program. These funds shall be repaid to the Major Risk Medical Insurance Fund prior to transitioning administrative and financial responsibility for the program to a qualified nonprofit entity pursuant to Sections 10748.5 and 10748.6.

<< CA INS § 10732 >>

10732. The board shall establish geographic areas within which participating carriers may offer health coverage to eligible employees and dependents.

<< CA INS § 10733 >>

10733. On or after the effective date of this chapter, the board shall enter into contracts with carriers for the purpose of providing health benefits coverage to eligible employees and dependents. Participating carriers shall have, but need not be limited to, all of the following operating characteristics satisfactory to the board:

(a) Strong financial condition, including the ability to assume the risk of providing and paying for covered services. A participating carrier may utilize reinsurance, provider risk sharing, and other appropriate mechanisms to share a portion of the risk.

(b) Adequate administrative management.

(c) In the case of the health care service plan, the following requirements must be met: (1) on the effective date of the contract, the health care service plan must be in compliance with the minimum tangible net equity requirements of the Commissioner of Corporations as those requirements will be in effect on January 1, 1995, and must remain in compliance with these requirements throughout the duration of the contract; (2) (A) before the effective date of the contract, the health care service plan must have devised a system for identifying in a simple and clear fashion both in its own records and in the medical records of subscribers and enrollees the fact that the services provided are provided under the program; and (B) throughout the duration of the contract, the health care service plan must use that system; and (3) at least 30 days before the effective date of any contract with the board, the health care service plan must inform the Commissioner of Corporations in writing of the health care service plan's intent to enter into the contract and must demonstrate in that letter, to the satisfaction of the Commissioner of Corporations, that it has complied with the requirements of paragraphs (1) and (2).

(d) A satisfactory grievance procedure.

(e) Participating carriers that contract with or employ health care providers shall have mechanisms to accomplish all of the following, in a manner satisfactory to the board, in consultation with the carrier's licensing agency.

(1) Review the quality of care covered.

(2) Review the appropriateness of care covered.

(3) Provide accessible health care services.

<< CA INS § 10734 >>

10734. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Corporations, as the case may be.

(b) Participating carriers that contract with the program shall be licensed and in good standing with their licensing agencies.

<< CA INS § 10735 >>

10735. The board shall contract with a broad range of carriers in an area, if available, to ensure that enrollees have a choice from among a reasonable number and types of competing carriers. The board shall develop and make available objective criteria for carrier selection and provide adequate notice of the application process to permit all carriers a reasonable and fair opportunity to participate. The criteria and application process shall allow participating carriers to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this chapter. Carrier selection shall be based on the criteria developed by the board.

The administrator shall not eliminate any carrier from selection solely because of the carrier's size or limited service area.

<< CA INS § 10737 >>

10737. The board shall use appropriate and efficient means to notify small employers of the availability of sponsored health coverage from the program.

<< CA INS § 10738 >>

10738. The board shall make available to small employers marketing materials that accurately summarize the benefits plans and rates that are offered by the carrier through the program.

<< CA INS § 10739 >>

10739. Unless authorized by the board, no participating carrier shall, in an area served by the program, directly, or through an employee, agent, or contractor, provide a small group or enrollee with any marketing material relating to benefits or rates provided under the program.

<< CA INS § 10740 >>

10740. Participating carriers may contract with agents or brokers to provide marketing and servicing of health benefits coverage offered through the program. Any commissions set and paid pursuant to this section shall be determined by the participating carrier and the agent or broker.

<< CA INS § 10741 >>

10741. The board shall enforce conditions of participation in the program for small employers and enrollees which shall conform with the requirements of this chapter.

<< CA INS § 10742 >>

10742. The board shall establish a mechanism to collect premiums from small employers, including remittance of the share of the premium paid by the enrollee.

<< CA INS § 10743 >>

10743. The board may prohibit employers or employees who drop coverage after enrolling in the pool from reenrolling in the program for up to 12 months.

<< CA INS § 10744 >>

10744. The board shall arrange to pay contractors as specified in program contracts.

<< CA INS § 10745 >>

10745. The board shall pay participating carriers their contracted rates.

<< CA INS § 10746 >>

10746. Participating carriers shall offer rates to small employers or enrollees in the program that, at a minimum, are consistent with the program regulations and existing statutes and regulations regulating health insurance offerings to small employers.

<< CA INS § 10747 >>

10747. The board may adjust payments made to a carrier if the board finds that the carrier has a significantly disproportionate share of high- or low-risk enrollees. Prior to making this finding, the program shall obtain valid data from participating carriers. Reporting requirements shall be administratively compatible with the methods of operation of the carrier. Any adjustments to payments shall be prospective and shall utilize demographic and other factors which are actuarially related to risk.

<< CA INS § 10748 >>

10748. If a small employer, employee, or dependent of a small employer is dissatisfied with any action or failure to act which has occurred in connection with eligibility for, or enrollment in the program, the employer or employee shall have the right to appeal to the board and shall be accorded an opportunity for a fair hearing. Hearings shall be conducted, insofar as practicable, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

<< CA INS § 10748.5 >>

10748.5. No later than three years from the effective date of this article, the board shall issue a request for proposals that solicits nonprofit entities to submit bids to assume administrative and fiscal responsibility for operation of the program on a regional basis. The geographic boundaries of the regions shall be designated by the board. The board shall assess bidder's qualifications in the areas of administrative capacity, financial responsibility, local experience, and demonstrated ability.

Within six months of issuing the request for proposals, the board shall select from among the qualified bidders and award administrative and financial responsibility for the program to the selected regional nonprofit entities. If no qualified nonprofit entity submits a bid pursuant to the board's request for proposals, one year from the date that bids were due the board shall reissue a request for proposals if the board has reason to believe that there is a possibility for a response from a qualified nonprofit entity.

(Publication page references are not available for this document.)

The board shall provide for an orderly transition of administrative and financial responsibility for the program.

<< CA INS § 10748.6 >>

10748.6. The board shall accept and review proposals submitted from nonprofit entities for assumption of administrative and financial responsibility of the program at any time prior to the process described in Section 10748.5. If the board determines that a qualified entity exists, the board may relinquish administrative and financial responsibility for the program to the nonprofit entity. Any contract entered into pursuant to this section shall be exempt from any provision of law relating to competitive bidding and shall be exempt from the review or approval of any division of the Department of General Services.

<< CA INS § 10748.7 >>

10748.7. There is in the program a five-member small employer advisory panel to be appointed by the board to provide consultation to the board on program design and implementation. The composition of the panel shall reflect varying sizes of small employers and a variety of occupational categories.

<< CA INS § 10749 >>

10749. There is created a Voluntary Alliance Uniting Employers Fund which shall consist of moneys collected pursuant to this article and any funds loaned by the board for operating expenses. Moneys in the fund shall be continuously appropriated without regard to fiscal year, to the board for the purposes specified in this part. Costs of the Voluntary Alliance for Uniting Employers Purchasing Program shall not be paid with state funds other than funds loaned by the board for operating expenses. Moneys within the fund shall be utilized for the purposes of this article.

SEC. 11. Section 12700 of the Insurance Code is amended to read:

<< CA INS § 12700 >>

12700. The Legislature finds and declares all of the following:

(a) That many Californians, <<-* * *->> do not have employer-sponsored group health coverage and are unable to secure adequate health coverage for themselves and their dependents because of preexisting medical conditions<<+, and a number of employer sponsored groups have difficulty obtaining or maintaining their health coverage because some members of the group either have or are viewed as being at risk for having high medical costs+>>.

(b) That, even where uninsured persons with preexisting conditions are able to secure coverage, the cost of coverage is prohibitively high or is secured only by waiving coverage for the preexisting conditions for which they are most likely to need care.

(c) That adverse selection precludes private health plans regulated by the State of California from enrolling medically uninsurable persons in the face of the escalating health care costs, and a highly competitive market.

(d) That, left to face the cost of major medical care without health coverage, all but the extremely affluent uninsured persons must ultimately look to publicly funded programs including Medi-Cal or MISIP in the event of severe illness or injury.

(e) That a prudent means of making major medical coverage available to <<+ individuals+>>

(Publication page references are not available for this document.)

presently unable to purchase it, is to subsidize their purchase of private health coverage from participating health plans.

<<+(f) That a prudent means of making major medical coverage available to groups presently unable to purchase or having difficulty maintaining major medical coverage is to facilitate purchase of private health coverage from participating health plans.+>>

SEC. 12. Section 12710 of the Insurance Code is amended to read:

<< CA INS § 12710 >>

12710. The California Major Risk Medical Insurance Program is hereby created in the <<-* * *->> <<+Health and Welfare+>> Agency. The program shall be managed by the Major Risk Medical Insurance Board. The board shall consist of seven members, five of whom shall be appointed as follows:

The Governor shall appoint three members, subject to confirmation by the Senate, and shall designate one of these appointees as chair of the board. The Senate Committee on Rules shall appoint one member. The Speaker of the Assembly shall appoint one member. The terms of appointment shall be four years.

The Secretary of Business, Transportation, and Housing, or his or her designee, and the Secretary of Health and Welfare, or his or her designee, shall serve on the board as ex officio, nonvoting members.

The board shall appoint an executive director for the board, who shall serve at the pleasure of the board. The executive director shall receive the salary established by the Department of Personnel Administration for exempt officials. The executive director shall administer the affairs of the board as directed by the board, and shall direct the staff of the board. The executive director may appoint, with the approval of the board, staff necessary to carry out the provisions of this part.

SEC. 13. Section 12739.2 of the Insurance Code is amended to read:

<< CA INS § 12739.2 >>

12739.2. From money appropriated by the Legislature to the fund, the board may expend sufficient funds <<-* * *->> <<+to carry+>> out the <<+ purposes+>> of this part.

However, the state shall not be liable beyond the assets of the fund for any obligations incurred, or liabilities sustained, in the operation of the California Major Risk Medical Insurance Program.

<< Note: CA INS §§ 10716, 10717 >>

SEC. 14. Carriers may file the statement required by Sections 10716 and 10717 of the Insurance Code and health plans may file the notice required by Section 1357.15 beginning March 1, 1993. The Department of Insurance and the Department of Corporations shall respond to the filings under the same terms, conditions, and timeframes as are required by those sections.

<< Note: CA GOVT § 6254 >>

<< Note: CA HLTH & S §§ 1343, 1357, 1357.01, 1357.02, 1357.03, 1357.04, 1357.05, 1357.06, 1357.07, 1357.08, 1357.09, 1357.10, 1357.11, 1357.12, 1357.13, 1357.14, 1357.15, 1357.17, 1357.18, 1357.50, 1357.51, 1367, 1393.6 >>

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<< Note: CA INS §§ 10198.6, 10198.7, 10198.8, 10700, 10702, 10703, 10704, 10705, 10706, 10706.5, 10707, 10708, 10709, 10711, 10712, 10713, 10714, 10715, 10716, 10717, 10718, 10718.5, 10718.6, 10718.7, 10719, 10720, 10720.1, 10721, 10722, 10723, 10724, 10725, 10726, 10727, 10728, 10729, 10730, 10731, 10732, 10733, 10734, 10735, 10737, 10738, 10739, 10740, 10741, 10742, 10743, 10744, 10745, 10746, 10747, 10748, 10748.5, 10748.6, 10748.7, 10749, 12700, 12710, 12739.2 >>

SEC. 15. This act shall become operative July 1, 1993, except for Section 14 which shall become operative March 1, 1993.

<< Note: CA GOVT § 6254 >>

SEC. 15.3. Section 2.5 of this bill incorporates amendments to Section 6254 of the Government Code proposed by both this bill and SB 315. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 1993, (2) each bill amends Section 6254 of the Government Code, and (3) this bill is enacted after SB 315, in which case Section 6254 of the Government Code, as amended by SB 315, shall remain operative only until the operative date of this bill, at which time Section 2.5 of this bill shall become operative, and Section 2 of this bill shall not become operative.

<< Note: CA HLTH & S § 1343 >>

SEC. 15.5. Sections 3.5 and 4.5 of this bill incorporate amendments to Section 1343 of the Health and Safety Code proposed by both this bill and SB 1708. They shall only become operative if (1) both bills are enacted and become effective on or before January 1, 1993, (2) each bill amends Section 1343 of the Health and Safety Code, and (3) this bill is enacted after SB 1708, in which case Sections 3 and 4 of this bill shall not become operative.

SEC. 16. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs which may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction. Notwithstanding Section 17580 of the Government Code, unless otherwise specified in this act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

[FN1] So in enrolled bill.

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END OF DOCUMENT