STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE
SAN FRANCISCO

Bulletin No. 93-3

April 15, 1993

TO: ALL INSURERS PROVIDING "HEALTH" COVERAGE TO SMALL EMPLOYERS; OTHER INTERESTED PARTIES

SUBJECT: Assembly Bill No. 1672 ("Small Employer Health Insurance Reform")

This Department has received numerous inquiries concerning Assembly Bill No. 1672 (Chapter 1128 of the Statutes of 1992) which makes fundamental changes in our laws pertaining to "health" (medical, hospital and surgical) insurance for small employers, effective July 1, 1993. (Note that parallel Health and Safety Code provisions in the Bill apply to health care service plans.) This Bulletin addresses many of the questions we have received about AB1672. Citations are to the California Insurance Code.

I. HIGHLIGHTS OF THE NEW LEGISLATION. AB 1672 adds §§10198.6 through 10198.9 (applicable to all employment-related health insurance) and §§10700 through 10749 (applicable to "small employer" health insurance) to the California Insurance Code. Note that the legislation is significantly different from the NAIC model small group health insurance law in many respects. Any entity or person providing, administering or marketing health insurance to or through California employers must become familiar with AB 1672. (Note that "administrators" are included within the definition of "carrier" in the legislation.)

SOME OF THE KEY PROVISIONS OF AB 1672 ARE:

- Guaranteed issue of all health insurance products sold to employers of 5 - 50 employees. §§10705(h) and 10707.

- Guaranteed renewal of all health insurance products sold to employers of 3 - 50 employees. §10713.

- "Rate bands" limiting the extent to which a small employer's rates can be varied at issue or increased on renewal to account for differences in health status and similar factors. §10714.

- Standardized demographic rating factors. §10700(w).

- Restrictions, not limited to the small group market, on the use of pre-existing conditions exclusions, waiting periods and "late enrollee" limitations. §§10198.7, 10708 and 10709.

- Establishment of a voluntary small employer coverage reinsurance mechanism. §§10719 - 10729.

- Establishment of a publicly-sponsored small employer coverage purchasing pool. §§10730 - 10749.

The drafters of this legislation fully anticipated that it would cause some disruption in existing markets and could result in the downgrading of some existing coverage. Unfortunately, these side-effects are necessarily concomitant to the effort to correct existing abuses in the small employer market place.

II. FILINGS REQUIRED BY THE LAW. All filings required or provided for by AB1672 should be addressed to the Policy Approval Bureau, Legal Division, California Department of Insurance, 45 Fremont Street, San Francisco, CA 94105. Cover letters should state prominently that the filing is made for compliance with AB 1672. The filings provided for in the new law are summarized below - the cited Code Sections must be consulted for details.

A. MANDATORY FILINGS *(Department approval required):*

1. All policy and/or certificate forms to be delivered in the California small employer health insurance market regardless of the situs of the master policy. §10705(a). Forms previously approved in California need not be refiled for AB1672 compliance.

2. A list of all benefit plan designs; standard employee risk rates (the chart of standard demographic rates) for each risk category for each benefit plan design; participation and employer contribution requirements, and the highest and lowest risk adjustment factors that a carrier plans to use for each benefit plan design. §10717(a).

3. All changes in benefit plan designs, risk categories, risk adjustment factors, or standard employee risk rates. §10717(b). A carrier changing only the standard employee risk rates but not changing previously approved risk categories or risk adjustment factors need only make an informational filing of such rates. §10717(c).

(Department approval not required):

4. Annual certifications that a carrier is exempt from marketing coverage outside an association pursuant to §10705(b)(2) because it has sold health products only to members of that one association since January, 1972. §10705(b)(3).

5. Annual statements listing all associations to which or through which a carrier sells health benefit plans and providing other required information. §10705(b)(4).

B. OPTIONAL FILINGS *(Department approval required);*

1. Certifications that a carrier has met its cap on enrollment of new small employers. §10705(l).

2. Requests that the Commissioner make a finding that a carrier need not accept additional small employer applications because of lack of capacity within its network of providers. §10711(c).

3. Requests that the Commissioner make a finding that acceptance of additional applications would place the carrier in a financially impaired condition. §10712.

III. COMMENTS ON QUESTIONS FREQUENTLY ASKED ABOUT AB1672. The comments below reflect our understanding of the intended operation of AB1672 and are derived from our participation in the legislation's development. They are provided to assist interested persons in their analysis of the law. "Clean-up" or "trailer" legislation, some of which has already been introduced, might affect some of the responses below if it is enacted. We have not yet promulgated emergency regulations, but when we do so, we will give public notice of their provisions at least 30 days prior to their effective date.

A. APPLICABILITY

1. *What employees may be excluded for the purposes of determining whether an employer is a "small employer" for the purpose of AB 1672?*

Refer to the definitions of "eligible employee" in §10700(g) and "small employer" in §10700(x).

2. *Do the small employer provisions of AB 1672 apply to individual (including selected group or "franchise") policies that are written, issued, or administered under the conditions set forth in §10702?*

We believe that the legislation was intended to apply to such products when they are issued under the conditions set forth in §10702. The existing scheme of regulation of such policies could in no way be considered a substitute for the reforms of AB 1672, so there are no obvious policy reasons for excluding those products from the new law.

3. *Are "supplemental coverages" such as "cancer" subject to AB 1672?*

Yes. Such coverages are not exempted in §10700(k). However, they (and all other products) may be exempt from AB1672 under §10702.

4. *Does AB1672 apply to coverages of individuals or employers who are not "small employers", as used in the law, but that are members of an association "which includes small employers"?*

No. We believe that AB1672 was not intended to apply to such persons or employers.

5. *How does AB 1672 apply when an insured large employer contracts to less than 50 employees or an insured small employer grows to three or more employees?*

AB 1672 can be construed to require that the carrier non-renew the employer's plan if it does not want the plan to become subject to the law's requirements. Note that §10700(x) suggests that this need not occur sooner than the anniversary of the health benefit plan following the employer's attainment of "small employer" status.

6. *What happens if a 3 - 50 employer adds or loses employees and ceases to be a "small employer" as defined in AB 1672?*

Nothing in AB 1672 would require a carrier to terminate a health benefit plan when the employer ceased to be a "small employer" as defined in §10700(x). Note that the cited Subsection provides that AB 1672 shall continue to apply to such an employer until the next health benefit plan anniversary.

B. RENEWAL

1. *If a carrier declines to participate in the small employer market under AB 1672, may it continue to renew small employer coverages issued prior to the effective date of the new law?*

No. Such plans generally become subject to AB 1672 - including the obligations to guarantee issue and guarantee renew - on July 1, 1993 or on the next renewal date, depending upon the specific requirement. Carriers withdrawing from the small employer market on or after July 1, 1993, must comply with §10713(c).

2. *If a carrier declines to market a product to new customers, may it renew it to existing small employer customers?*

No. The carrier must non-renew existing small employer coverage under that benefit plan design and offer new benefit plan designs complying with AB 1672 to those employers. This is true whether the existing customers are associations, small employers who are members of

associations or small employers purchasing coverage on their own. Numerous provisions of AB 1672 (§§10716(e), 10714(b)(3) and 10713(d), among others) clearly contemplate that any benefit plan designs continued, even if just renewed for existing business, after July 1, 1993, are subject to the guaranteed issue requirements. §§10705(b) and (h).

3. *What is "renewal" for the purposes of AB 1672?*

AB 1672 does not define "renewal" - policy provisions vary widely on this matter and what "renewal" is may depend on the specific product. From a practical standpoint, the typical group health insurance product "renews" at each premium due date, since the carrier has the right to end coverage and/or change rates as of that date, even if it contains references to "anniversaries", etc. Such a product would be subject to all AB 1672 requirements which attach upon issue or renewal, at the first premium due date on or after July 1, 1993.

Were a product to provide a small employer with a right to continue coverage at a guaranteed stipulated rate for a stipulated period, we would consider "renewal" to occur at the end of the stipulated period. We would not so consider a mere guarantee that coverage would continue for a stipulated period, subject to the carrier's right to raise rates, since the right to raise rates is an effective right to terminate coverage.

4. *If an employer ends coverage by simply ceasing to pay premiums, has it "disenrolled" for the purposes of the penalty imposed by §10711(d)?*

Yes. A voluntary act by an employer indicating that it no longer wants a carrier's coverage should constitute disenrollment under the cited Code Section. However, termination of coverage resulting from circumstances beyond the practical control of the employer (having the wrong number of employees or failing to meet participation [but not contribution] requirements, etc.) should not be deemed to be disenrollment under §10711(d).

C. AGENTS AND BROKERS

1. *Will AB 1672 affect existing exclusive marketing agreements and other arrangements by which carriers market specific products through selected producers or special marketing plans?*

Yes. We are reluctant to interpret AB 1672 as upsetting long-established marketing arrangements among carriers and "producers" (brokers and agents). Nevertheless, arrangements which restrict the availability of plans to less than all of a carrier's producers in a geographical area appear to be inconsistent with the law's requirement that carriers " . . . shall fairly and affirmatively . . . market . . . " to all small employers, all benefit plan designs which they sell in the small employer marketplace. §10705(b). Note that the cited Code Section includes no

caveat authorizing a carrier to require a purchaser to use a particular producer or marketing mechanism.

Subsection (c) and Subdivisions (d)(1) through (d)(4) of §10705 further require that affiliated companies (as defined) be treated as single carriers. These carriers:

(A) must make all their small employer products available to all small employees;

(B) must prepare a consolidated brochure - available to all producers representing the affiliated companies - summarizing all their small employer products; and

(C) must provide sample policies or certificates and detailed premium quotes for specific small employers through all producers representing the affiliated carriers.

From a practical standpoint, the foregoing requirements may mean that carriers and their affiliates will eventually have to permit all of their producers to sell all of their small employer plans. At the very least, the brochure required by §10705(d)(1) would have to disclose the producer(s) through which an employer could purchase a benefit plan design that was not available through all the producers representing the affiliated carriers. Otherwise, the carriers would fail to meet their obligations under §10705(b) and (c).

2. *How will AB 1672 affect producer compensation arrangements which depend on the "profitability" of a small employer product?*

Section 10705(j) effectively prohibits most, if not all, such compensation arrangements, be they prospective or retrospective.

D. RATES

1. *Can a carrier establish a "composite rate" for an employer by "averaging" the risk-adjusted employee risk rates for existing employees, and then covering new employees at that rate regardless of their individual risk categories?*

No. Subsections (a)(1) and (b)(1) of §10714 do not permit this practice.

2. *In defining geographical regions, may a carrier choose between keeping ZIP Code areas whole and keeping counties whole?*

Section 10700(w)(3)(A) does not give carriers such a choice - the 3 digit ZIP Code rule is the primary standard, subject to the caveat that, in any event, a county may not be split into more than two regions.

3. *In applying the standard employee risk rates, is geographical region based on the location of the employee's residence or the employer's principal place of business?*

We believe that a carrier may determine geographical region based upon the employer's principal place of business because the specific references to "geographic regions", in subdivisions (3)(A) and (3)(B) of §10700(w), speak in terms of "small employers". Although §10700(w) speaks of risk categories in terms of the employee (certainly appropriate for "age" and "family category"), we believe that the reference to "geographic region" there is merely a general reference to the risk categories.

4. *As coverage for Medicare eligible persons is primary or secondary to Medicare depending on the size of the employer (over or under 20) - can different standard employee risk rates be charged depending on whether Medicare is primary or will there have to be different benefit plan designs to reflect this factor?*

We would not object to carriers designating "Medicare-primary" and "Medicare-secondary" rates for their over-65 populations. AB1672 requires that all of a carrier's benefit plan designs be made available to all "small employers". Thus, there may not be different "benefit plan designs", as used in the law, for over-20 and under-20 employers.

5. *How does a carrier rate employees who enter an employer's plan after July 1, but before the first renewal date under the law?*

The carrier would have to rate the new employee consistent with the provisions of the existing program, including any previously guaranteed rates.

E. Preexisting Conditions, Waiting Periods and Late Enrollees

1. *What are the effective dates for the new rules relating to pre-existing conditions, exclusion of individual employees, and late enrollees?*

We believe that §10707, forbidding the exclusion of individual employees, is effective July 1, 1993, because it refers to carrier actions rather than to health benefit plan provisions, which are usually changed at next renewal. However, the other rules (§§10708 and 10709) are less specific, and we would encourage carriers to impose all the rules simultaneously in the interest of simplicity. We understand that many carriers intend to do so.

2. *What happens to previously-excluded employees or dependents on July 1, 1993?*

Previously-excluded (for whatever reason) employees or dependents should be given a 30 day open enrollment period as of July 1, 1993, in which to elect coverage or to waive it under the procedure set forth in §10700(m). Such persons may <u>not</u> be treated as "late enrollees" because

they will come within the §10700(m)(4) exception in the definition of late enrollees. Even if written waivers of coverage were taken before the effective date of AB 1672, they would be invalid because they would not have been given in the context of guaranteed coverage and after the warnings required by the cited Subdivision.

3. *Does a small employer carrier have to credit "time served" in preceding plans against pre-existing conditions limitations and waiting periods, or just against the former?*

AB 1672's provisions pertaining to all employment-related health insurance specify that credit be given against both pre-existing conditions limitations and waiting periods where there has been previous qualifying coverage. AB 1672's provisions pertaining to small employers are silent about waiting periods. We believe that the former provisions state the general rule which should be applied in all instances.

4. *Do the "waiting period" restrictions of AB1672 apply to employer-imposed rules postponing new employees' eligibility for fringe benefits until they have been at work for some period of time?*

No. AB1672 does not regulate employers' activities.

5 *If a carrier wants to cover immediately a "late enrollee" who could be excluded entirely for one year under the new law, can it impose a waiver of coverage for a specified pre-existing condition for that year?*

Yes. It would appear to be consistent with the law to allow carriers to impose individual "waiver" riders on late enrollees in lieu of totally excluding them from coverage, for the period of time that the late enrollee could be excluded entirely. §§10198.7(a), 10198.7(d), 10707 and 10709.

F. Associations and Trusts (See also, I. Tied Products, below.)

1. *May a carrier (an insurer or an administrator) limit the availability of a small employer health insurance product to members of a specified association?*

No. "Association-specific" products are prohibited except for the §10705(b)(2) exemption - carriers that have sold health products solely through one association for 20 years. If any other carrier sells a product to any small employer or to any association that includes a small employer, then AB 1672's guaranteed issue requirements apply and the carrier must market that product to the entire small employer market. §10705(c).

2. *How does AB 1672 affect insured "Taft-Hartley" plans?*

Products issued to such plans must comply with AB 1672's provisions pertaining to pre-existing conditions limitations and late enrollees which apply to all employment-related health insurance. §§10198.6 through 10198.8. However, such products do not have to comply with the "small employer" provisions commencing with §10700 because they are not benefit plan designs issued ". . . to small employers or to trustees of associations that include small employers." §10700(c).

3. *At what date should a carrier selling a trust or association product comply with the rules concerning premiums - on the date coverage is sold to or renewed for a specific small employer or only on the renewal date of the policy issued to the trust or association?*

Any time coverage is sold or renewed to any small employer, the rules concerning rate bands and limitations on renewal premiums apply. Note that the rate bands for a given product must be observed both within the trust or association and as to all other small employers who are entitled to purchase the product under the guaranteed issue sections of the law. §10714.

G. Stop Loss

Does a carrier have to comply with AB 1672 if it provides "stop-loss" coverage for small employers or for associations which "self-insure" and which would otherwise be clearly within the law if they were "insured"?

Yes. A stop loss product (including "minimum premium" plans) sold in conjunction with a "self-insured" small-employer-based health plan is itself a "health benefit plan" under §10700(k) and therefore all of the small employer provisions - guaranteed issue, guaranteed renewal, rate bands, etc. - apply. We have long regarded such products to be "group health policies" - they are not reinsurance because there is no "insurer" to reinsure, and they are not casualty policies - if they were, life carriers could not sell them under their certificates of authority. Finally, regardless of their form, as sold in a package with "administrative services", they are plainly marketed as an alternative to traditional employer group health insurance.

Note that "associations" cannot "self-insure" their members or their members' employees under current California law nor are such arrangements exempt from state law under ERISA.

We are aware of the conventional wisdom that stop loss arrangements are unique to specific employers, but we believe that the stop loss and minimum premium arrangements currently available in the under-50 market are nonetheless fairly standardized or would soon become so even in the absence of AB 1672. Applying the Bill's strictures to such arrangements was seen by its drafters as the only way to avoid the "gaming" which would otherwise undercut the pooling of risks anticipated by AB 1672. §§10700(c), 10708(d), 10709(b) and 10198.7(e).

H. PARTICIPATION

1. *What are "participation requirements" as used in the law?*

There is no apparent basis for interpreting the phrase "participation requirements" to mean anything other than the generally-accepted meaning of the phrase in the industry - standards set by a carrier requiring that a stipulated minimum percentage of an employer's employees must be enrolled as a condition of sale. Note that §10706 requires that participation requirements be uniform for all small employers regardless of plan and that minimum participation requirements may vary only by size. So also, the cited Code Section does not contemplate that carriers can impose requirements that individual employees or small employers qualify for or purchase "non-health" products before they are eligible for guaranteed issue.

2. *What employees may be excluded for the purposes of determining whether the carrier's participation requirements have been met under AB 1672?*

Section 10705(h) suggests that a carrier must exclude persons who have waived coverage (under §10700(m)(1)(B)) because they have other coverage through another employer's plan before determining whether an employer has met the carrier's participation requirements. Note that "eligible employees", as defined in §10700(g), includes out-of-state employees. cf. §10700(x) Of course, a carrier may also exclude additional classes of persons before determining participation. Note that the rules for determining whether an employer is a "small employer" under §10700(x) are different.

3. *Can a carrier require compliance with participation requirements as a condition of renewal?*

We believe that carriers should observe the same rule for periodically determining satisfaction of participation requirements that applies to determining that an employer is a "small employer" - on the anniversary of the health benefit plan covering the employer. §10700(x). Note that if an employer's failure to comply with participation requirements amounted to misrepresentation or fraud, a carrier could non-renew pursuant to §10713(b).

4. *If a small employer falls a carrier's participation or contribution requirements, can the carrier sell a product which does not comply with AB 1672 to that employer?*

No. All "health" products sold to employers of 3 to 50 employees are subject to AB 1672.

5. *May a carrier insure a small employer who chooses to cover less than all of its eligible employees?*

Yes, but only if the distinction between who is and who is not offered coverage is ". . . determined by conditions related to employment . . .". §10270.5(a)(1). Thus, an employer could choose to cover only its salaried employees, even though it might also have permanent, full-time hourly employees. However, an employer could not choose to cover just "favorite" employees. An employer covering less than all of its eligible employees could not demand coverage from a carrier under §10705(h). Also, §10705(g) prohibits producers from inducing or encouraging small employers to separate out otherwise-eligible employees.

6. *Does a carrier which is marketing coverage in the open marketplace and also through the Voluntary Alliance Uniting Employers Purchasing Program ("Health Insurance Plan of California") have to use the same geographical regions and participation and employer contribution standards (i.e., those of the Program) in both segments of its business?*

We believe not. Article 4 (starting with §10730) grants very broad authority to the Major Risk Major Medical Insurance Board (which will initially administer the Program) to define the features of the products which it will make available to small employers. The only linkage with the "open" small employer market specifically recognized in the Article is in the context of "rates", which are required to be "consistent" with the rates participating carriers use in the open market under §10746. We do not see any intent in the legislation to require that pool carriers use the same standards in both markets nor do we see any strong policy reasons for suggesting that they should.

I. TIED PRODUCTS

1. *May a carrier add "frills," such as glossy newsletters, free infant car seats, health classes, etc., to employers' plans within an association but not to the plans available to employers purchasing outside the association?*

No. These frills are part of what an association small employer receives for his premium and are thus part of the benefit plan design.

2. *Would a carrier that is willing to guarantee-issue some health-only products also be permitted to offer a "tied product" which contains health and life?*

No. All benefit plan designs must be guaranteed issue to all small employers. Even if the "tied product" were guaranteed issue, the life insurance premium would be subject to the rate bands because it would have to be paid to obtain the health coverage.

J. PPOs

1. *Can a PPO-based plan be guaranteed issue only within its network area or must it be guaranteed issue statewide even though its out-of-network coverage is inadequate?*

It would seem illogical not to permit such a plan to restrict guaranteed issue to its network area. However, this Department is very concerned that PPOs do not draw their boundaries to exclude undesirable areas. We would regard obviously-gerrymandered network areas to be violations of a carrier's obligation to "fairly and affirmatively market" its products under §10705(b).

2. *Are multiple option plans - "point of service" or HMO/indemnity packages - where health coverages are provided by different carriers but which are offered to employees together, permitted under AB 1672?*

Yes. We view a plan's "linkage" with another plan as a component of the plan. We think that AB 1672 does not require that plans with such linkages be separately marketed, etc., without the linkages. However, since they are still separate plans, it would be inappropriate to limit participation in one of the linked plans to a certain percentage or number of covered persons and require that the remainder participate in the other linked plan.

K. Disclosure and Solicitation

For disclosure purposes, can standard employee risk rates be expressed, and can differences among benefit plan designs be described, as variations from a basic plan design with accompanying rate supplements or factors for the effect of each variation?

Yes. Standard employee risk rates for multiple benefit plan designs which are comprised of a common benefit package with various "add-on" benefits may be displayed as a matrix showing the rates for the common benefit package and supplemental rates for the risk categories and the "add-on" benefits.

IV. AB1672's Application to ALL Employment-Related Health Insurance.

AB 1672 makes significant changes, not limited to the small employer market, in the laws governing pre-existing conditions exclusions, waiting periods and "late enrollee" limitations in all employment-related individual or group insurance programs covering three or more persons. It establishes maximum time limits on pre-existing conditions exclusions and waiting periods for coverage. It also requires that insurers credit, toward the satisfaction of such exclusions and waiting periods, newly-insured persons with the time that they have been covered under qualifying preceding health benefit plans in specified circumstances. (Note that these

provisions apply regardless of whether the employer contributes to the premium.) §§10198.6 through 10198.8.

V. INQUIRIES:

- *About this Bulletin or AB 1672 as it applies to Department of Insurance licensees should be directed to:*

Policy Approval Bureau, Legal Division
California Department of Insurance
45 Fremont Street
San Francisco, CA 94105
Telephone (415) 904-~~3671~~ 5722

- *About AB1672 as it applies to "health care service plans" should be directed to:*

Division of Health Care Service Plans
California Department of Corporations
1115 11th Street
Sacramento, CA 95814
Telephone (916) 324-9013

- *About the publicly-sponsored small employer purchasing pool ("Health Insurance Plan of California") should be directed to:*

Major Risk Medical Insurance Board
818 K Street, Second Floor
Sacramento, CA 95814
(916) 324-4695

JOHN GARAMENDI
Insurance Commissioner