STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE
SAN FRANCISCO

Bulletin No. 93-3A

November 15, 1993

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

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

This Bulletin supersedes Bulletin 93-3 of April 15, 1993, and reflects the 1993 amendments to the "small employer" sections (Insurance Code §§10700 - 10718.6) of "AB 1672" (Chapter 1128, Stats 1992), as well as the Emergency Regulations effective October 29, 1993 (Title 10, Code of Regulations, §2233, et seq., File No RH-317A). The aforesaid amendments were made by ABs 1742 (Ch 113), 2059 (Ch 217) and 28 (Ch 1146) of 1993.

I. HIGHLIGHTS OF THE LEGISLATION. AB 1672 added §§10198.6 through 10198.9 (*currently* applicable to all employment-related health insurance - see Item IV, below) and §§10700 through 10749 (applicable to "small employer" health insurance) to the California Insurance Code, effective July 1, 1993. The latter sections fundamentally changed California law pertaining to health insurance for small employers. Parallel Health and Safety Code sections in the law apply to "health care service plans" - HMOs and the "Blues". Any entity or person providing, administering or marketing health insurance in California must become familiar with AB 1672.

SOME OF THE KEY PROVISIONS OF AB 1672 AS APPLIED TO SMALL EMPLOYERS AND GUARANTEED ASSOCIATIONS ARE:

- Guaranteed issue of all health insurance products sold to the following (Ins. C. §§10700(w), 10705(h) and 10707):

  Employers of 5 - 50 employees (4 - 50 employees, as of July 1, 1994);

  "Guaranteed associations";

  Members of guaranteed associations;

  Employers (regardless of size) purchasing coverage for their employees through guaranteed associations.

- Guaranteed renewal of all health insurance products sold to employers with 3 - 50 employees and to persons or entities with guaranteed issue rights, above. (Ins. C. §10713)

- "Rate bands" limiting the extent to which rates charged to employers with 3 - 50 employees and to persons or entities with guaranteed issue rights (above) can be varied at issue or increased on renewal to account for differences in health status and similar factors. (Ins. C. §10714)

- Standardized demographic rating factors. (Ins. C. §10700(v))

- Restrictions on the use of pre-existing conditions exclusions, waiting periods and "late enrollee" limitations. §§10708 and 10709.

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

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

II. FILINGS REQUIRED BY THE LAW. Please refer to this provision in Bulletin 93-3.

III. COMMENTS ON QUESTIONS SET FORTH IN BULLETIN 93-3 ABOUT AB1672. Most of the questions below are from Bulletin 93-3, but the responses have been revised in accordance with the 1993 amendments to AB 1672 and with the emergency regulations. Citations are to the California Insurance Code, as amended, except that citations to "RH-317A" are to emergency regulations in Title 10 of the California Code of Regulations. These comments are provided only to assist interested persons in their analysis of the law.

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(f) and "small employer" in §10700(w). Note that an employer that purchases coverage through a guaranteed association is a "small employer" regardless of its size.

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?*

Yes. §10700(b).

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

Yes. Such coverages are not exempted in §10700(j). However, they (and all other products) may otherwise be exempt if issued under conditions other than those in §10702. Note, however, that such coverages may be - and after January 1, 1994, will be - subject to §§10198.6 - 10198.8.

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

AB1672 does not require that a plan issued under that law to an association that "includes small employers" also cover individual members that are not employees of small employer members or cover employer-members that are not "small employers". However, AB1672 does apply to coverages of such individuals or employers who are "members of a guaranteed association" as defined in §10700(z). ("Guaranteed associations" are themselves defined in §10700(y).) Members of associations that have too few covered persons to be "guaranteed associations" may also have AB 1672 rights under §10705.1.

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?*

RH-317A, §2233.10(f), exempts existing plans covering such employers from AB 1672. However, that exemption does not extend to replacement coverage.

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

AB 1672 does not require a carrier to terminate a health benefit plan when the employer ceases to be a "small employer" as defined in §10700(w). Note that the cited provision suggests that AB 1672 continues to apply to such an employer until the next health benefit plan anniversary. Also, employer size is irrelevant for employers that purchase coverage through guaranteed associations.

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 became 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. RH-317A, §§2233.20 and 2233.50. Carriers withdrawing from the small employer market on or after July 1, 1993, must comply with §10713(d).

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 that include small employers, 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(e), 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 (g).

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

See RH-317A, §2233.20.

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

Yes. See RH-317A, §§2233.22. The relevant provision is now §10711(e) and "disenrolled" has been replaced by "terminated". Note the special treatment of terminating guaranteed association members (included within the definition of "eligible employee" in §10700(f)) who are covered through guaranteed associations

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 <u>all</u> 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. Accordingly, insurers that provide small employer products only through specific trusts or associations must ensure that <u>any</u> employer wishing to purchase such products has an unqualified right to join such trusts or associations.

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(i) 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?*

Yes. §10714(c) establishes standards for such rating plans. "Composite rates" must be used for no less than six and no more than twelve months. Note that composite rates must be computed on a per-employer basis - employers may not be grouped together for the purpose of computing composite rates.

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

Yes. See subparagraphs (A) and (B) of §10700(v)(3).

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(v), speak in terms of "small employers". Although §10700(v) 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?*

Yes to the first question. See §10700(v)(1). The second question is now moot.

5. *How does a carrier rate employees who enter an employer's plan after July 1, 1993, 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, LATE ENROLLEES AND MEDICAL UNDERWRITING

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, was effective July 1, 1993, because it refers to carrier actions rather than to health benefit plan provisions, which are usually changed at next renewal. (See the definition of "renewal" in RH-317A, §2233.20.) The other rules applicable to small employer products (§10708 and 10709) are less specific. However, corresponding provisions in §10198.7, which currently apply to virtually all employment-related health insurance - including "small employer" products - were effective July 1, 1993. (See Bulletin 93-4.) Thus, insurers should have implemented all the rules as of July 1, 1993.

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

See RH-317A, §2233.50. Previously-excluded (for whatever reason) employees or dependents should have been 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(l). Such persons may <u>not</u> be treated as "late enrollees" because they will come within the §10700(l)(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 <u>and</u> waiting periods, or just against the former?*

A small employer carrier must credit "time served" in preceding plans against both pre-existing conditions limitations and waiting periods, pursuant to §10708(c).

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. However, producers *must not* suggest that employers impose such rules or participate in determining the periods of ineligibility for insurance subject to AB1672. Otherwise, the insurers that they represent could be held to be imposing illegal waiting periods through their agents' acts.

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. §§10707 and 10709.

6. *In counting time served under prior qualifying coverage, does one look back to one plan, or to all the plans that covered the new plan member without gaps in coverage? For example, what would be the result where the new member was covered in 1992 by Plan A, switched to Plan B in March, 1993, and applied for coverage under Plan C on July 2, 1993, after the effective date of AB1672.*

We believe that time served in multiple preceding plans - including plans that ended *before* July 1, 1993 - should be counted so long as any gaps in coverage between plans were shorter than provided for in §10708(c). We see nothing in the law that would justify a carrier's limiting qualifying prior coverage to the most recently held coverage, at least unless there were gaps in coverage greater than that specified in the statute. Likewise, while the requirement that carriers give credit for prior qualifying coverage became effective July 1, 1993, there is nothing in the law that limits qualifying prior coverage to coverage held on or after that date. Note that there is no "retroactivity" problem with this interpretation, because no duties are imposed on anyone prior to the effective date of the new law.

7. *Is a small employer still eligible for guaranteed issue if it refuses to submit its employees to medical underwriting and offers to accept the maximum permissible risk adjustment factor instead?*

We believe so, since medical underwriting may be used only to determine a small employer's risk adjustment factor. The guaranteed issue requirements in AB 1672 are not conditioned on an employer's consent to submit its employees to medical underwriting. Indeed, medical underwriting is only implicitly authorized in the law's rating sections, which countenance different rates based on claims expectations.

Similarly, where there is medical underwriting and it is clear from the initial applications that an employer will be subject to the maximum risk adjustment factor, delaying the quotation of premium rates "pending the receipt of additional medical information" is improper. Such delay could be found to violate the 30-day effective date requirements of §10706.5 and the carrier's obligation to "fairly and affirmatively" market coverage under §10705(b). Even if the additional medical information is requested to determine whether the risk adjustment factor could be reduced, delay in its receipt should not delay the premium rate quotation (and the issuance of coverage), since risk adjustment factors may be *reduced* at any time.

Of course, a carrier can still require individual applications to identify prior qualifying coverage, Ins. C. §10700(v) risk categories and to verify eligibility.

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 - a carrier that has 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). Note that the amended law gives "guaranteed associations" and the members thereof many of the rights vis-a-vis carriers that small employers and their eligible employees have.

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

Such programs are not subject to the small employer provisions of 1672 unless they solicit coverage of employers that are not parties to the underlying collective bargaining agreement. Note also that benefit plan designs issued pursuant to Joint Powers Agreements entered into under certain California Government Code provisions are similarly exempt from the small employer provisions of AB 1672. RH-317A, §2233.10.

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 or members of guaranteed associations 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. RH-317A, §2233.10(g).

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?*

RH-317A, §2233.80, defines "participation requirements". Note that §10706 requires that participation requirements be uniform for all small employers and that minimum participation requirements may vary only by size and by whether the employer contributes 100% to the cost of coverage. The cited regulations require that participation requirements be the same regardless of plan and prohibit 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?*

RH-317A, §2233.80(b) requires a carrier to exclude persons who have waived coverage (under §10700(l)(1)(B)) because they have other coverage through another employer's plan before determining whether an employer has met the carrier's participation requirements. So also, guaranteed association members eligible for coverage but not electing it shall be excluded for the purpose of determining guaranteed association participation. (§10706) Of course, a carrier may also exclude additional classes of persons before determining participation, since that will make the requirements easier for employers to meet. However, participation requirements must still be applied "uniformly" to all small employers. Note that "eligible employees", as defined in §10700(f), includes out-of-state employees and members of guaranteed associations. Note

also that different rules apply for determining whether an employer is a "small employer" under §10700(w).

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

Section 10713(c) authorizes a carrier to nonrenew an employer's plan for failure to comply with the carrier's participation or employer contribution requirements at the time of renewal. Note that whether an employer is a "small employer" under §10700(w) is determined on the anniversary of the health benefit plan covering the employer.

4. *If a small employer fails 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 offer coverage to 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. Note that, under §10705(g), an employer offering coverage to less than all of its eligible employees could not demand guaranteed issue from a carrier. Also, §10705(f) 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 Managed (previously, "Major") Risk Medical Insurance Board (which administers 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 Article 4 is in the context of "rates", which must 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 and must be provided to all purchasers of that 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?*

RH-317A, §2233.90, exempts PPO-based plans from the statewide guaranteed-issue requirement if they comply with the requirements of that section.

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.

L. GUARANTEED ASSOCIATIONS

1. *What kinds of organizations can avail themselves of the rights granted to "guaranteed associations" under AB1672?*

"Guaranteed associations" are defined in §10700(y). Also, §10705.1 gives associations which comply with all the criteria of 10700(y) except that their health benefit plans cover less than 1000 persons, a "window" in which they may assert the rights of guaranteed associations.

2. *Historically, the word "member" has been strictly construed in group eligibility laws - persons who were not formal association members were ineligible for the association's group insurance coverage. Is that still the case under the "guaranteed association" amendments?*

No. Many categories of persons who are merely associated with guaranteed association members may be "members of a guaranteed association", pursuant to §10700(z), for the purposes of AB1672. Most of those categories are otherwise ineligible for health or life insurance "association coverage" under other provisions of law and remain so for non-AB1672 insurance products. (For example, compare paragraphs (3) and (4) of §10270.5(a).) Note also, that an association must elect in advance to make the non-member categories of covered persons eligible for coverage under its plan.

3. *Before the "guaranteed association" amendments, AB 1672 applied only to employees (and their dependents) of strictly-defined "small employers". Now, individuals and employees of very small employers may be eligible for AB1672 rights and protections under §10700(z). Do the amendments provide carriers with any additional defenses against the anti-selection which is thought to exist in the health insurance market for such persons?*

Yes. Section 10708(e) permits a carrier to impose an additional 60 day waiting period for coverage of applicants who would be ineligible for AB1672 coverage but for their relationship with a guaranteed association. This is in addition to the limitations relating to pre-existing conditions, late enrollees and participation otherwise authorized by AB 1672 for carriers of guaranteed associations.

4. *Can a guaranteed association plan treat certain persons as "late enrollees" in a manner similar to that permissible for a plan that covers just "small employers"?*

Yes. Sections 10700(l) and 10709 authorize limitations on late enrollees under guaranteed association plans that are similar, but not identical, to those permitted for "small employer" plans.

5. *Do the "guaranteed association" amendments impose any additional requirements on carriers or producers?*

Yes. §10705.1 requires that carriers which cover associations that would qualify as "guaranteed associations", but for their size, notify those associations of their rights under the Section.

M. PRIVATELY PROMOTED "HIPCs"

May a private organization, such as a group of producers, establish a "HIPC" similar to that established and operated by the Managed Risk Medical Insurance Board pursuant to Article 4 of Chapter 8?

We believe that the entity created by Article 4 is unique and that AB 1672 does not authorize the establishment of similar entities by private parties. Except for the HIPC, we believe that Article 4 does not supersede existing law defining the entities which are eligible master policyholders for group health insurance (Ins. C. §10270.5 et seq).

There is no magic in calling something a "HIPC". Private, insured multiple-employer purchasing arrangements have long been authorized by 10270.5(a)(1). (Note the criteria regarding the entities that may establish such arrangements.) All parties to such arrangements must follow all laws relating to group purchase of insurance, including Ins C. §§10700 - 10717 of AB 1672. Thus, such arrangements cannot be exclusive marketing vehicles for products subject to AB 1672, standard employee risk rates must be the same whether or not products are purchased through such arrangements (rates may vary only within the permissible rate bands), rating plans must comply with AB 1672 requirements for guarantee periods for standard employee risk rates and risk adjustment factors, and products must be fairly and affirmatively marketed throughout the state unless there are provider network limitations.

IV. AB1672'S APPLICATION TO ALL HEALTH INSURANCE.

See Bulletin 93-4, of June 25, 1993, for details of AB 1672's provisions (§§10198.6 through 10198.8) which apply to all "employment-related" health insurance through 1993. As of January 1, 1994, the provisions on pre-existing conditions (including "portability") will be amended *to apply to virtually all "health" insurance* marketed in California. (AB 1768, Chapter 1051, Statutes of 1993) We will issue shortly a new Bulletin 93-4A, to supersede Bulletin 93-4, reflecting these new amendments.

V. INQUIRIES:

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

Consumer Services Division
California Department of Insurance

300 South Spring Street
Los Angeles, CA 90013
Telephone 1-800-927-HELP
(Outside California: 213-897-8921)

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

Health Care Service Plans Division
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:*

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

JOHN GARAMENDI
Insurance Commissioner

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