STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE
SAN FRANCISCO

Bulletin No. 93-4A
February 7, 1994

TO: ALL INSURERS PROVIDING "HEALTH" COVERAGE

SUBJECT: Assembly Bills No. 1672 and 1768

This Bulletin updates Bulletin 93-4 of June 25, 1993, and reflects the 1993 amendments to the "all health insurance" (previously referred to as "all employer") sections of AB 1672 (Chapter 1128, Stats 1992). The 1993 substantive amendments were made by AB 1768 (Chapter 1052, Stats 1993) and are effective January 1, 1994. (Minor technical amendments were made by AB 1742.) As used herein, "all health insurance" means individual or group coverage which provides medical, hospital, and surgical benefits. General references to AB 1672 include all trailer legislation.

I. How AB 1672/AB 1768 Affect All Health Insurance.

A. Highlights of the New Legislation.

AB 1672 added §§ 10198.6 - 10198.9 to the California Insurance Code, applicable to employment-related individual or group health insurance programs covering three or more persons. With the enactment of AB 1768, the employment-related requirement and the "three or more" requirement were eliminated. As of January 1, 1994, Insurance Code §§ 10198.6 - 10198.8 apply to individual and group products which cover one or more persons, regardless of the setting in which the coverage was purchased.

Insurance Code §§ 10198.6 - 10198.9:

- Apply to essentially all types of health insurance providing benefits to Californians regardless of the situs of the contract or group master policyholder and regardless of the number of persons covered (Ins. C. §§ 10198.6(a) and 10198.8);

- Narrowly define what can be excluded as a "preexisting condition" (Ins. C. §§ 10198.6(c) and 10198.7(a));

- Establish maximum time limits for preexisting conditions exclusions imposed on newly eligible persons and on waiting periods imposed on "late enrollees" (Ins. C. § 10198.7);

- Require that insurers credit, toward the satisfaction of preexisting conditions exclusions or waiting periods, newly-insured persons with the time that they were covered under qualifying preceding health coverages in specified circumstances (Ins. C. § 10198.7(c));

- For health benefit plans that cover three or more persons, prohibit waivers, exclusions or special waiting periods for coverage applicable to specific persons (Ins. C. § 10198.7(a));

- For health benefit plans that cover one or two persons, prohibit waivers, exclusions or special waiting periods which exceed 12 months (Ins. C. § 10198.7(b) and (d)).

Parallel Health and Safety Code provisions in AB 1672 and AB 1768 apply to Health Care Service Plans. (Please refer to Bulletin 93-3A, of November 15, 1993, and Title 10, California Code of Regulations §§ 2233 - 2233.99 for guidance about AB 1672 as it applies to products covering employers of from 3 to 50 employees.)

B. Questions and Answers About The Provisions of AB 1672/AB 1768

Most of the questions below are from Bulletin 93-4, but the responses have been revised in accordance with the 1993 amendments to AB 1672. The comments reflect our understanding of the intended operation of AB 1672 and AB 1768 and are provided to assist you in your analysis of the law. These comments assume that the health benefit plans at issue ARE NOT subject to the "small employer" provisions of AB 1672, except as noted.

1. What plans are subject to AB 1672/AB 1768?

Any health benefit plan, either individual or group, covering one or more Californians is subject to the "all health insurance" provisions of AB 1672 and 1768, to wit, Ins. C. §§ 10198.6 - 10198.8. These provisions apply regardless of the presence or absence of an employment setting or sponsorship.

Note that plans covering employees of employers of between 3 and 50 employees may be subject to the "all health insurance" provisions of AB 1672/AB 1768 even if they are exempt from the "small employer" provisions of the law - for example, small employer plans which are paid for entirely by the employees. Ins. C. §§ 10198.7(a)(b) and (f).

2. Are "supplemental coverages" such as "cancer" or "long-term care" subject to AB 1672/AB 1768?

Yes and no. Insurance Code § 10198.6(a) specifically exempts certain types of products, such as Medicare supplement, long-term care and dental and vision products. All other products which provide medical, hospital, and surgical benefits, regardless of whether they are provided on an "indemnity" or expense-incurred basis, are subject to the law. Thus, dread disease and hospital indemnity products must comply with the law. Blanket policies providing medical, hospital and surgical benefits must also comply.

3. Must programs established before July 1, 1993 (AB 1672's effective date), provide a 30 day "open enrollment period" for previously-excluded employees and dependents, as required of such programs when they cover "small employers"?

No, unless the carrier wants to impose or has imposed a special limitation on coverage for "late enrollees", as defined in Ins. C. § 10198.6(b) and as discussed immediately below.

4. On its face, Ins. C. § 10198.7(f) forbids exclusion of late enrollees for more than 12 months. Must a health benefit plan accept all late enrollees after 12 months regardless of medical status?

We believe that the Section means that there may not be any special limitation, lasting more than 12 months, based on a person's being a late enrollee as defined in Ins. C. § 10198.6(b). Therefore, at the end of 12 months, the late enrollee should have the same rights as a new enrollee - if new entrants are not medically underwritten, then neither should "late enrollees" be, at the end of the 12 month waiting period. Similarly, a person who is not a late enrollee under 10198.6(b), because, for example, he or she has lost other group coverage, would have to be treated as a new enrollee upon application for coverage. In cases where new employees or dependents may be excluded for underwriting reasons, late enrollees may also be so excluded.

5. What preexisting conditions exclusions or waivers may be used as of January 1, 1994?

As of January 1, 1994, the effective date of AB 1768, Ins. C. § 10198.7 establishes two sets of rules for preexisting conditions and waivered conditions, depending on the number of persons covered by the particular policy.

If three or more persons are covered, a health benefit plan may not use a preexisting condition provision more stringent than a "six and six" provision, i.e., one that excludes for six months from the effective date those conditions for which the person received medical advice, etc. during the six months preceding the effective date. Waivers of coverage of a specific condition applicable to specific insureds are prohibited, but if no preexisting condition provision is imposed, a 60 day waiting period may be used.

If one or two persons are covered, the health benefit plan may not use a preexisting condition exclusion more stringent than a "12 and 12", i.e., one that excludes from the effective date those conditions for which the person received medical advice, etc. during the twelve months preceding the effective date. If the plan does not contain a preexisting conditions exclusion provision, then it may include a waiver of a specific illness for twelve months; the waivered condition must be one for which the insured received advice, etc. during the twelve months preceding the effective date. If neither a preexisting conditions exclusion or a waiver is used, a 60 day wait may be imposed.

[b? - prior to 2014 revisions?]

6. Insurance Code §§ 10198.6(c) and 10198.7(a) and (b) seem to limit definitions of "preexisting conditions" to those for which "medical advice, diagnosis, care, or treatment . . . was recommended or received . . ." within six months before the effective date of coverage. May an insurer also include

conditions for which a "reasonable" or "prudent" person would have sought advice or treatment within that six months? May the definition include conditions which became "manifest" within that period?

No. Only those conditions described in the cited Code Sections may be "preexisting conditions". An insurer may make the definition of "preexisting conditions" more precise, such as by defining "medical advice", etc., more specifically, but it may not expand the definition beyond the boundaries established by the Code Sections. A preexisting condition may not include a pregnancy which existed in the specified time period (6 or 12 months) before the effective date unless the insured had received medical advice, etc. within that time period.

7. When must a plan be brought into compliance with the new law?

The operative provisions (sub§§ (a) and (f) of Ins. C. § 10198.7) of AB 1672 apply to any product ". . . issued, renewed or written by any insurer . . . " on or after the effective date of the law - July 1, 1993. We understand that the intent of the word "written" was to make the law apply to all programs in force as of that date. Similarly, the amendments made by AB 1768 apply to any product in force as of January 1, 1994, the effective date of AB 1768.

8. Do the "waiting period" limitations of AB 1672 apply to employer-imposed rules postponing new employees' eligibility for fringe benefits until they have been at work for some period of time ("probationary periods")?

No. AB 1672 does not generally regulate employers' activities. However, such probationary periods are included in the term "any waiting period" as used in Ins. C. § 10198.7(e) - see Part II, below.

9. If a carrier wants to cover immediately a "late enrollee" who could be excluded entirely for one year, could it impose a waiver of coverage for a specified preexisting 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. We construe the "small employer" provisions of AB 1672 similarly. Ins. C. §§ 10198.6(b) and 10198.7(f).

10. Does AB 1672 apply to insured "Taft-Hartley" plans?

Insurance products issued to such plans must comply with AB 1672's "all health insurance" provisions pertaining to preexisting conditions limitations and late enrollees regardless of the size of the employers involved. Note that Title 10, California Code of Regulations § 2233.10(b) exempts some insured "Taft-Hartley" plans from the "small employer" provisions of AB 1672 but there is no similar exemption from the "all health insurance" provisions. Ins. C. § 10198.6(a).

11. Does AB 1672 apply to self-insured "large employer plans"?

"Self-insured" plans operated by state and local government entities (if not otherwise exempted) and religious organizations must comply with Ins. C. §§ 10198.6 - 10198.8. Such plans are not subject to ERISA and are thus not exempt from state regulation under that law's "preemption provision". Ins. C. § 10198.7(a)(b) and (f).

Lawful private single-employer or labor-management ("Taft-Hartley") fully self-insured plans which are otherwise legitimately exempt from state regulation under ERISA need not comply with the requirements of Ins. C. § 10198.7. (Note that "MEWAs" are illegal under California law.) However, sub§(g) of the Section prohibits carriers from providing "stop loss" coverages to such self-insured plans that have preexisting conditions or late enrollee provisions that are inconsistent with AB 1672/AB 1768.

12. What policy form filings are required as a result of the "all health insurance" provisions of AB 1672/AB 1768?

Due to the important changes in coverage made by the legislation, insurance companies should notify existing insureds of the changes as soon as possible. An existing policy affected by the legislation should be revised, via rider or a new policy or certificate, which forms must be filed or approved as otherwise required by law.

II. Determining Whether a New Plan Entrant Gets Credit for "Time Served" in a Prior Qualifying Plan.

We understand that the intent underlying the "credit for time served" concept is that, once someone has entered the private health care sector, he or she need "pay their dues" only once, unless that person leaves the sector for so long that his or her re-entry suggests an anti-selection motive. A new employee or dependent should not have to suffer new preexisting conditions exclusions because the employer or insurer imposes delays between the start of employment and eligibility for coverage which, when added to his or her time between employment periods or coverages, exceed the 30 or 90 day period applicable under the law.

Insurance Code § 10198.7(e) - pertaining to all health insurance - and § 10708(c) - pertaining to "small employer" health insurance - provide that a carrier shall ignore "any waiting period" in determining whether to give a new plan entrant "credit for time served" under qualifying prior coverage against any limitations in the carrier's plan applicable to new entrants. Similarly, the cited Sections require that time attributable to applying for coverage "within the applicable enrollment period" be ignored in determining whether to give a new plan entrant "credit for time served." We believe that the phrase "any waiting period", as used in the Sections, includes both employer-imposed "probationary periods" and carrier-imposed waiting periods for coverage. We also believe that the phrase "becomes eligible within 30 (or 90) days of termination of prior coverage" should be read as meaning "becomes employed or has a new health benefit plan take effect."

The credit for qualifying prior coverage provision found in Ins. C. § 10198.7(e) is not limited to employment related coverage. An individual shall be given credit for time served under a prior plan

whether or not the prior or new plan is employment related. The prior plan and the new plan need not be similar in coverage or contain similar exclusions and prior plans need not have contained a preexisting conditions exclusion.

Please note the broad definition of "qualifying prior coverage", which includes COBRA or other continuation coverage and public programs; exclusions are limited to those specified. Qualifying prior coverage is not limited to a single plan which preceded the new plan; if a continuous series of continuous plans preceded the new plan, all such plans would constitute qualifying prior coverage. Also, qualifying prior coverage need not be "accrued" or "earned" after July 1, 1993 or after January 1, 1994, the respective effective dates of AB 1672 and AB 1768.

III. INQUIRIES *about this Bulletin or AB 1672 as it applies to Department of Insurance licensees should be directed to:*

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