



Home	Bill Information	California Law	Publications	Other Resources	My Subscriptions	My Favorites
------	------------------	----------------	--------------	-----------------	------------------	--------------

SB-910 Short-term limited duration health insurance. (2017-2018)

SHARE THIS:  

Date Published: 09/24/2018 09:00 PM

Senate Bill No. 910

CHAPTER 687

An act to amend Sections 1367.29 and 1368.016 of the Health and Safety Code, and to amend Sections 10113.9, 10123.7, 10123.81, 10123.865, 10123.866, 10123.198, 10123.199, 10123.202, 10273.6, and 12671 of, and to add Section 10123.61 to, the Insurance Code, relating to health insurance.

[Approved by Governor September 22, 2018. Filed with Secretary of State September 22, 2018.]

LEGISLATIVE COUNSEL'S DIGEST

SB 910, Hernandez. Short-term limited duration health insurance.

Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health insurer offering individual health insurance coverage from imposing any preexisting condition exclusion with respect to that coverage. Existing law prohibits a health insurer from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified, and authorizes health insurers to use only age, geographic region, and whether the plan or health insurer covers an individual or family for purposes of establishing rates for individual health benefit plans, as specified. Existing law requires an individual health insurance policy to include, at a minimum, coverage for essential health benefits, as defined. These health care coverage market reforms in the individual market do not apply to short-term limited duration health insurance policies offered by a health insurer.

This bill, commencing January 1, 2019, would prohibit a health insurer from issuing, selling, renewing, or offering a short-term limited duration health insurance policy, as defined, for health care coverage in this state. The bill would make conforming changes.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.29 of the Health and Safety Code is amended to read:

1367.29. (a) On and after July 1, 2011, in accordance with subdivision (b), a health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall issue an identification card to an enrollee in order to assist the enrollee with accessing health benefits coverage information, including, but not limited to, in-network provider access information, and claims processing purposes. The identification card, at a minimum, shall include all of the following information:

- (1) The name of the health care service plan issuing the identification card.
- (2) The enrollee's identification number.

(3) A telephone number that enrollees or providers may call for assistance with health benefits coverage information, in-network provider access information, and claims processing information, and if assessment services are provided by the health care service plan, access to assessment services for the purpose of referral to an appropriate level of care or an appropriate health care provider.

(4) The health care service plan's Internet Web site address.

(b) The identification card required by this section shall be issued by a health care service plan or a specialized health care service plan to an enrollee upon enrollment or upon a change in the enrollee's coverage that impacts the data content or format of the card.

(c) This section does not require a health care service plan to issue a separate identification card for professional mental health services coverage if the plan issues a card for health care coverage in general and the card provides the information required by this section.

(d) If a health care service plan or a specialized health care service plan, as described in subdivision (a), delegates responsibility for issuing the identification card to a contractor or an agent, the contractor or agent shall be required to comply with this section.

(e) This section does not prohibit a health care service plan or a specialized health care service plan from meeting the standards of the Workgroup for Electronic Data Interchange (WEDI) or other national uniform standards with respect to identification cards, and a health care service plan shall be deemed compliant with this section if the plan conforms with these standards, as long as the minimum requirements described in subdivision (a) have been met.

(f) For the purposes of this section, "identification card" includes other technology that performs substantially the same function as an identification card.

(g) (1) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health care service plans, except behavioral health-only plans.

(2) Notwithstanding paragraph (1), this section shall not apply to a behavioral health-only plan that provides coverage for professional mental health services pursuant to a contract with a health care service plan or insurer if that plan or insurer issues an identification card to its subscribers or insureds pursuant to this section or Section 10123.198 of the Insurance Code.

SEC. 2. Section 1368.016 of the Health and Safety Code is amended to read:

1368.016. (a) A health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall, pursuant to subdivision (f) of Section 1368.015, include on its Internet Web site, or provide a link to, the following information:

(1) A telephone number that the enrollee or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.

(2) A link to prescription drug formularies posted pursuant to Section 1367.205, or instructions on how to obtain the formulary, as described in Section 1367.20.

(3) A detailed summary that describes the process by which the plan reviews and authorizes or approves, modifies, or denies requests for health care services as described in Sections 1363.5 and 1367.01.

(4) Lists of providers or instructions on how to obtain the provider list, as required by Section 1367.27.

(5) A detailed summary of the enrollee grievance process as described in Sections 1368 and 1368.015.

(6) A detailed description of how an enrollee may request continuity of care pursuant to subdivisions (a) and (b) of Section 1373.95.

(7) Information concerning the right, and applicable procedure, of an enrollee to request an independent medical review pursuant to Section 1374.30.

(b) Any modified material described in subdivision (a) shall be updated at least quarterly.

(c) The information described in subdivision (a) may be made available through a secured Internet Web site that is only accessible to enrollees.

(d) The material described in subdivision (a) shall also be made available to enrollees in hard copy upon request.

(e) This article does not preclude a health care service plan from including additional information on its Internet Web site for applicants, enrollees or subscribers, or providers, including, but not limited to, the cost of procedures or services by health care providers in a plan's network.

(f) The department shall include on the department's Internet Web site a link to the Internet Web site of each health care service plan and specialized health care service plan described in subdivision (a).

(g) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health care service plans, except behavioral health-only plans.

(h) This section shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with this section or Section 10123.199 of the Insurance Code.

SEC. 3. Section 10113.9 of the Insurance Code is amended to read:

10113.9. (a) This section shall not apply to vision-only, dental-only, or CHAMPUS supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) (1) A change in the premium rate or coverage for an individual health insurance policy shall not become effective unless the insurer has provided a written notice of the change at least 10 days before the start of the annual enrollment period applicable to the policy or 60 days before the effective date of the policy renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be provided to the individual policyholder at his or her last address known to the insurer. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(c) (1) If the department determines that a rate is unreasonable or not justified consistent with Article 4.5 (commencing with Section 10181), the insurer shall notify the policyholder of this determination. This notification may be included in the notice required in subdivision (b). The notification to the policyholder shall be developed by the department. The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The notification to the policyholder shall include the following statements in 14-point type:

(A) The Department of Insurance has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the insurer.

(B) During the open enrollment period, the policyholder has the option to obtain other coverage from this insurer or another insurer, or to keep this coverage.

(C) The policyholder may want to contact Covered California at www.coveredca.com for help in understanding available options.

(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

(3) The insurer may include in the notification to the policyholder the Internet Web site address at which the insurer's final justification for implementing an increase that has been determined to be unreasonable by the commissioner may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(4) The notice shall also be provided to the agent of record for the policyholder, if any, so that the agent may assist the purchaser in finding other coverage.

(5) In developing the notification, the department shall take into consideration that this notice is required to be provided to an individual applicant pursuant to subdivision (g) of Section 10181.3.

(d) If an insurer rejects a dependent of a policyholder applying to be added to the policyholder's individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the insurer shall inform the applicant about the California Major Risk Medical Insurance Program (MRMIP) (Chapter 4 (commencing with Section 15870) of

Part 3.3 of Division 9 of the Welfare and Institutions Code) and about the new coverage options and the potential for subsidized coverage through Covered California. The insurer shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the insurer shall give the applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of personal or privileged information.

(f) For purposes of this section, the following definitions shall apply:

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and rules, regulations, or guidance issued pursuant to that law.

SEC. 4. Section 10123.61 is added to the Insurance Code, to read:

10123.61. (a) Commencing January 1, 2019, a health insurer shall not issue, amend, sell, renew, or offer a policy of short-term limited duration health insurance in this state.

(b) For purposes of this section, "short-term limited duration health insurance" means health insurance coverage provided pursuant to a health insurance policy that has an expiration date specified in the policy that is less than 12 months after the original effective date of the coverage.

SEC. 5. Section 10123.7 of the Insurance Code is amended to read:

10123.7. (a) On or after January 1, 1986, an insurer issuing group health insurance shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group policyholder and the insurer. An insurer shall communicate the availability of that coverage to all group policyholders and to all prospective group policyholders with whom the insurer is negotiating. Coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. Coverage for orthotic devices shall provide for coverage if the device, including original and replacement devices, is prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license. An insurer shall have the right to conduct a utilization review to determine medical necessity before authorizing these services.

(b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to all benefits in the policy. A copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and prosthetic devices and services shall be no more than the most common amounts contained in the policy.

(c) This section shall not apply to Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

SEC. 6. Section 10123.81 of the Insurance Code is amended to read:

10123.81. (a) An individual or group policy of disability insurance or self-insured employee welfare benefit plan shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon the referral of a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(b) This section does not prevent the application of copayment or deductible provisions in a policy, nor does this section require that a policy be extended to cover any other procedures under an individual or a group policy. This section does not authorize a policyholder to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the policyholder is referred to that provider by a participating physician, nurse practitioner, or certified nurse-midwife providing care.

(c) This section shall not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

SEC. 7. Section 10123.865 of the Insurance Code is amended to read:

10123.865. (a) Commencing no later than July 1, 2012, an individual health insurance policy shall provide coverage for maternity services for all insureds covered under the policy.

(b) For purposes of this section, "maternity services" include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care. This definition of "maternity services" shall remain in effect until the time as federal regulations and guidance issued pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148) define the scope of benefits to be provided under the maternity benefit requirement of that act, after which time the definition of that term under the federal act and associated regulations and guidance shall apply for purposes of this section.

(c) This section shall not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

SEC. 8. Section 10123.866 of the Insurance Code is amended to read:

10123.866. (a) Commencing no later than July 1, 2012, a group health insurance policy shall provide coverage for maternity services for all insureds covered under the policy.

(b) For purposes of this section, "maternity services" include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care. This definition of "maternity services" shall remain in effect until the time as federal regulations and guidance issued pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148) define the scope of benefits to be provided under the maternity benefit requirement of that act, after which time the definition of that term under the federal act and associated regulations and guidance shall apply for purposes of this section.

(c) This section shall not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

SEC. 9. Section 10123.198 of the Insurance Code is amended to read:

10123.198. (a) On and after July 1, 2011, in accordance with the requirements of subdivision (b), a health insurer that provides coverage for professional mental health services shall issue an identification card to an insured in order to assist the insured with accessing health benefits coverage information, including, but not limited to, in-network provider access information, and claims processing purposes. The identification card, at a minimum, shall include all of the following information:

(1) The name of the health insurer issuing the identification card.

(2) The insured's identification number.

(3) A telephone number that insureds or providers may call for assistance with health benefits coverage information, in-network provider access information, and claims processing information, and if assessment services are provided by the health insurer, access to assessment services for the purpose of referral to an appropriate level of care or an appropriate health care provider.

(4) The health insurer's Internet Web site address.

(b) The identification card required by this section shall be issued by a health insurer to an insured upon commencement of coverage or upon a change in the insured's coverage that impacts the data content or format of the card.

(c) This section does not require a health insurer to issue a separate identification card for professional mental health coverage if the insurer issues a card for health care coverage in general and the card provides the information required by this section.

(d) If a health insurer, as described in subdivision (a), delegates responsibility for issuing the card to a contractor or agent, the contractor or agent shall be required to comply with this section.

(e) This section does not prohibit a health insurer from meeting the standards of the Workgroup for Electronic Data Interchange (WEDI) or other national uniform standards with respect to identification cards, and a health insurer shall be deemed compliant with this section if the insurer conforms with these standards, as long as the minimum requirements described in subdivision (a) have been met.

(f) For the purposes of this section, "identification card" includes other technology that performs substantially the same function as an identification card.

(g) (1) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health insurance policies, except behavioral health-only policies.

(2) Notwithstanding paragraph (1), this section shall not apply to a behavioral health-only policy that provides coverage for professional mental health services pursuant to a contract with a health care service plan or insurer if that plan or insurer issues an identification card to its subscribers or insureds pursuant to this section or Section 1367.29 of the Health and Safety Code.

SEC. 10. Section 10123.199 of the Insurance Code is amended to read:

10123.199. (a) A health insurer that provides coverage for professional mental health services shall establish an Internet Web site. Each Internet Web site shall include, or provide a link to, the following information:

(1) A telephone number that the insured or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.

(2) A link to prescription drug formularies posted pursuant to Section 10123.192, or instructions on how to obtain formulary information.

(3) A detailed summary description of the process by which the insurer reviews and approves, modifies, or denies requests for health care services as described in Section 10123.135.

(4) Lists of providers or instructions on how to obtain a provider list as required by Section 10133.1.

(5) A detailed summary of the health insurer's grievance process.

(6) A detailed description of how the insured may request continuity of care as described in Section 10133.55.

(7) Information concerning the right, and applicable procedure, of the insured to request an independent medical review pursuant to Section 10169.

(b) Except as otherwise specified, the material described in subdivision (a) shall be updated at least quarterly.

(c) The information described in subdivision (a) may be made available through a secured Internet Web site that is only accessible to the insured.

(d) The material described in subdivision (a) shall also be made available to insureds in hard copy upon request.

(e) This article does not preclude an insurer from including additional information on its Internet Web site for applicants or insureds, including, but not limited to, the cost of procedures or services by health care providers in an insurer's network.

(f) The department shall include on the department's Internet Web site, a link to the Internet Web site of each health insurer described in subdivision (a).

(g) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health insurance policies, except behavioral health-only policies.

(h) This section shall not apply to a health insurer that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its insureds, provided that the health insurer provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with this section or Section 1368.016 of the Health and Safety Code.

SEC. 11. Section 10123.202 of the Insurance Code is amended to read:

10123.202. (a) A health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, excluding specialized health insurance policies, shall be prohibited from requiring an insured to receive a referral before receiving coverage or services for reproductive and sexual health care.

(b) (1) For the purposes of this section, "reproductive and sexual health care services" are all reproductive and sexual health services described in Sections 6925, 6926, 6927, and 6928 of the Family Code, or Section 121020 of the Health and Safety Code, obtained by a patient.

(2) This section applies whether or not the patient is a minor.

(c) In implementing this section, a health insurer may establish reasonable provisions governing utilization protocols for obtaining reproductive and sexual health care services, as provided for in subdivision (a), if these provisions are consistent with the intent of this section and are those customarily applied to other health care providers, such as primary care physicians and surgeons, to whom the insured has direct access, and are not more restrictive for reproductive and sexual health care services. An insured shall not be required to obtain prior approval from another physician, another provider, or the insurer before obtaining direct access to reproductive and sexual health care services. An insurer may establish reasonable provisions governing communication with the insured's primary care physician and surgeon regarding the insured's condition, treatment, and a need for followup care.

(d) This section shall not apply to a health insurance policy that does not require insureds to obtain a referral from their primary care physician before seeking covered health care services from a specialist.

(e) A health insurer shall not impose utilization protocols related to contraceptive drugs, supplies, and devices beyond those in Section 10123.196.

(f) This section shall not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRICARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

SEC. 12. Section 10273.6 of the Insurance Code is amended to read:

10273.6. All individual health benefit plans shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) (1) For nonpayment of the required premiums by the individual if the individual has been duly notified and billed for the premium and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and subsequent rules or regulations has elapsed.

(2) Pursuant to paragraph (1), the disability insurer shall continue to provide coverage as required by the policyholder's, certificate holder's, or other insured's policy during the period described in paragraph (1).

(b) The insurer demonstrates fraud or intentional misrepresentation of material fact under the terms of the policy by the individual.

(c) Movement of the individual contractholder outside the service area, but only if coverage is terminated uniformly without regard to a health status-related factor of covered individuals.

(d) If the disability insurer ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state, as long as the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the individual policy or contractholder at least 180 days before discontinuation of that coverage.

(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a disability insurer that remains in force, a disability insurer that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) A disability insurer that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.

(e) If the disability insurer withdraws an individual health benefit plan from the market, as long as the disability insurer notifies all affected individuals and the commissioner at least 90 days before the discontinuation of these plans, and the disability insurer makes available to the individual all health benefit plans that it makes available to new individual businesses without regard to a health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(f) If coverage is made available in the individual market through a bona fide association, and the membership of the individual in the association on the basis of which the coverage is provided ceases, but only if that coverage is terminated under this subdivision uniformly without regard to a health status-related factor of covered individuals.

SEC. 13. Section 12671 of the Insurance Code is amended to read:

12671. As used in this part, the following terms have the following meanings:

(a) "Group policy" means a group health insurance policy providing medical, hospital, surgical, major medical, or comprehensive medical coverage issued by an insurer, a group contract issued by a hospital service corporation, or medical, hospital, surgical, major medical, or comprehensive medical coverage otherwise provided by a policyholder to its employees or members, except for self-insurance programs provided by employers that are not exempt from the federal Employee Retirement Income Security Act of 1974 (ERISA), as specified in subdivision (i). For the purposes of this part, a group policy not having an established annual renewal date shall be considered renewed on each anniversary of its effective date.

(b) "Conversion coverage" means health insurance benefits providing hospital, surgical, major medical, or comprehensive medical coverage issued to an individual under a converted policy.

(c) "Converted policy" means a policy or contract providing conversion coverage issued by an insurance company or by a hospital service corporation, or individual hospital, surgical, major medical, or comprehensive medical coverage otherwise provided by a policyholder to its employees or members.

(d) "Insurer" means the entity issuing a group policy, an individual or converted policy, a hospital service contract or an employer or employee organization otherwise providing medical, hospital, surgical, major medical, or comprehensive medical coverage to its employees or members.

(e) "Insurance" refers to health insurance, major medical, or comprehensive coverage paid by premium or contribution under a group policy, a hospital service contract, or as otherwise provided by a policyholder to its employees or members other than by self-insuring except in the case of a plan that is exempt from ERISA, but does include an employer plan that is exempt from ERISA as specified in subdivision (i). "Insurance" does not include any of the following:

(1) Coverage provided solely as an accrued liability or by reason of a disability extension.

(2) Medicare supplement insurance.

(3) Vision-only insurance.

(4) Dental-only insurance.

(5) CHAMPUS supplement insurance.

(6) Hospital indemnity insurance.

(7) Accident-only insurance.

(8) Short-term limited duration health insurance. "Short-term limited duration health insurance" means health insurance coverage provided pursuant to a health insurance policy that has an expiration date specified in the policy that is less than 12 months after the original effective date of the coverage.

(9) Specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(f) "Policyholder" means the holder of a group policy issued by an insurer, a holder of a group contract issued by a hospital service corporation or an employer, employee association, or other entity otherwise providing medical, hospital, surgical, major medical, or comprehensive medical coverage on a group basis to its employees or members.

(g) "Premium" means contribution or other consideration paid or payable for coverage under a group policy or converted policy.

(h) "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(i) "Employer plan that is exempt from ERISA" means an employer plan that, pursuant to Section 1003 of Title 29 of the United States Code, is not covered by or that is exempt from Subchapter I (commencing with Section 1001) of Chapter 18 of Title 29 of the United States Code, except that, in the case of a governmental plan, it only includes a self-insured governmental plan as defined in subdivision (j).

(j) "Self-insured governmental plan" means a self-insured plan established or maintained for its employees by a public entity, as defined in Section 811.2 of the Government Code, that is a governmental plan as defined in subdivision (32) of Section 1002 of Title 29 of the United States Code.