AMENDED IN ASSEMBLY MARCH 19, 2009

AMENDED IN ASSEMBLY FEBRUARY 23, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 23

Introduced by Assembly ~~Member Jones~~ *Members Jones and Fletcher*
(Principal coauthor: Senator Alquist)

December 1, 2008

~~An act to amend Section 14011.16 of, to amend and repeal Section 14005.25 of, and to repeal Section 14011.18 of, the Welfare and Institutions Code, relating to Medi-Cal.~~ *An act to amend Sections 1366.20, 1366.21, 1366.22, 1366.24, and 1366.25 of the Health and Safety Code, and to amend Sections 10128.50, 10128.51, 10128.52, 10128.54, and 10128.55 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 23, as amended, Jones. ~~Medi-Cal: continuous eligibility.~~ *Cal-COBRA: premium assistance.*

Existing federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires group health plans providing coverage to employers of 20 or more employees to provide former employees with continuation of benefits, as specified. Existing federal law, the American Recovery and Reinvestment Act of 2009, provides specified premium assistance under COBRA and state programs that provide comparable continuation coverage for certain assistance eligible individuals, as defined.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans

by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for regulation of health insurers by the Department of Insurance. Existing law, the California Continuation Benefits Replacement Act (Cal-COBRA), requires health care service plans and health insurers providing group coverage to employers of 2 to 19 employees to offer continuation of that coverage for a specified period of time to persons who become ineligible for that coverage, as specified.

This bill would require health care service plans and health insurers, among others, to provide notice of the availability of premium assistance under the federal American Recovery and Reinvestment Act of 2009 to individuals eligible for that assistance, as specified, and would make other conforming changes to allow those individuals to receive Cal-COBRA coverage with that premium assistance. The bill would authorize the Director of Managed Health Care and the Insurance Commissioner to adopt emergency regulations in the event that any federal assistance is or becomes available to persons eligible for Cal-COBRA.

Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is partially governed and funded under federal Medicaid provisions.~~

~~Existing law, until January 1, 2012, requires the department, subject to the availability of federal financial participation, to exercise a federal option to expand continuous eligibility to children 19 years of age and younger for 6 months, after which date the continuous eligibility period shall be from the date of a determination of eligibility to the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age.~~

~~This bill would eliminate the provisions limiting continuous eligibility to 6 months, would make those provisions that become operative on~~

~~January 1, 2012, applicable commencing January 1, 2010, and would make conforming changes.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Section 1366.20 of the Health and Safety Code is amended to read:

1366.20. (a) This article shall be known as the California Continuation Benefits Replacement Act, or "Cal-COBRA."

(b) It is the intent of the Legislature that continued access to health insurance coverage is provided to employees, and their dependents, of employers with 2 to 19 eligible employees who are not currently offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

(c) It is the intent of the Legislature that any federal assistance that is or may become available to qualified beneficiaries under this article be effectively and promptly implemented by the department.

(d) The director may adopt emergency regulations to implement this article in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code by making a finding of emergency and demonstrating the need for immediate action in the event that any federal assistance is or becomes available to qualified beneficiaries under this article. The adoption of these regulations shall be considered by the Office of Administrative Law to be necessary to avoid serious harm to the public peace, health, safety, or general welfare.

SEC. 2. Section 1366.21 of the Health and Safety Code is amended to read:

1366.21. The definitions contained in this section govern the construction of this article.

(a) "Continuation coverage" means extended coverage under the group benefit plan in which an eligible employee or eligible dependent is currently enrolled, or, in the case of a termination of the group benefit plan or an employer open enrollment period, extended coverage under the group benefit plan currently offered by the employer.

(b) "Group benefit plan" means any health care service plan contract provided pursuant to Article 3.1 (commencing with Section 1357) to an employer with 2 to 19 eligible employees, as defined in Section 1357, as well as a specialized health care service plan contract provided to an employer with 2 to 19 eligible employees, as defined in Section 1357.

(c) "Qualified beneficiary" means any individual who, on the day before the qualifying event, is an enrollee in a group benefit plan offered by a health care service plan pursuant to Article 3.1 (commencing with Section 1357) and has a qualifying event, as defined in subdivision (d). *For purposes of eligibility for the premium assistance under paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), a "qualified beneficiary" also includes any individual who was or is eligible for continuation coverage as a result of the involuntary termination of the covered employee's employment during the period that begins with September 1, 2008, and ends with December 31, 2009, elects continuation coverage, and meets the definition of "qualified beneficiary" set forth in paragraph (3) of Section 1167 of Title 29 of the United States Code, as used in subparagraph (E) of paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).*

(d) "Qualifying event" means any of the following events that, but for the election of continuation coverage under this article, would result in a loss of coverage under the group benefit plan to a qualified beneficiary:

(1) The death of the covered employee.

(2) The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.

(3) The divorce or legal separation of the covered employee from the covered employee's spouse.

(4) The loss of dependent status by a dependent enrolled in the group benefit plan.

(5) With respect to a covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

(e) "Employer" means any employer that meets the definition of "small employer" as set forth in Section 1357 and (1) employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar year, or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter, (2) has contracted for health care coverage through a group benefit plan offered by a health care service plan, and (3) is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

(f) "Core coverage" means coverage of basic health care services, as defined in subdivision (b) of Section 1345, and other hospital, medical, or surgical benefits provided by the group benefit plan that a qualified beneficiary was receiving immediately prior to the qualifying event, other than noncore coverage.

(g) "Noncore coverage" means coverage for vision and dental care.

SEC. 3. Section 1366.22 of the Health and Safety Code is amended to read:

1366.22. The continuation coverage requirements of this article do not apply to the following individuals:

(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

(b) Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 1357 and 1357.06. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.

(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq.

(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 1366.24 regarding notification of a qualifying event or election of continuation coverage within the specified time limits, *except as provided in subdivision (g) of Section 1366.24.*

(f) Qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 1366.24 and Section 1366.26, in accordance with the terms and conditions of the plan contract, or fail to satisfy other terms and conditions of the plan contract.

SEC. 4. Section 1366.24 of the Health and Safety Code is amended to read:

1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to perform the administrative services as provided for in Section 1366.25, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60 days of the date of the qualifying event. This disclosure shall inform enrollees that failure to make the notification to the health care service plan, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state

that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of (1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the health care service plan, in accordance with the terms and conditions of the plan contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 1366.25, the amount of the required premium payment, as set forth in Section 1366.26. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the employer has contracted with the plan to perform the administrative services pursuant to subdivision (d) of Section 1366.25, within 45 days of the date the qualified beneficiary provided written notice to the health care service plan or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to subdivision

(b) of Section 1366.27 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every health care service plan shall provide to all covered employees of employers subject to this article a written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this section a new or amended evidence of coverage that includes the disclosures required by this section. Any specialized health care service plan that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchasers of benefits.

(e) Every plan disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an enrollee may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.

(f) Every disclosure issued, amended, or renewed on and after July 1, 2006, for a group benefit plan subject to this article shall include the following notice:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(g) Notwithstanding subdivision (b), a qualified beneficiary may notify the health care service plan, or the employer if the plan has contracted with the employer for administrative services pursuant

to subdivision (d) of Section 1366.25, of the qualified beneficiary's election to continue coverage no later than 60 days after receipt of the notice required under subdivision (g) of Section 1366.25 if the qualified beneficiary meets all of the following requirements:

(1) Receives a notice pursuant to subdivision (g) of Section 1366.25.

(2) Became eligible for continuation coverage prior to the effective date of this subdivision.

(3) Is eligible for premium assistance under paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

(4) Failed to notify the health care service plan, or the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of the following:

(A) The date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event.

(B) The date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan.

(h) With respect to a qualified beneficiary who elects to continue coverage pursuant to subdivision (g), the period beginning on the date of the qualifying event and ending on the effective date of the continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (c) of Section 1357.06 or subdivision (e) of Section 1357.51.

SEC. 5. Section 1366.25 of the Health and Safety Code is amended to read:

1366.25. (a) Every group contract between a health care service plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the plan, in writing, of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 1366.21, within 30 days of the qualifying event. The group contract shall also require the employer to notify the plan, in writing, within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue

Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

(b) Every group contract between a plan and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 1366.27, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

Every health care service plan and specialized health care service plan shall provide to the employer replacing a health care service plan contract issued by the plan, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the plan reasonably required to administer the notification requirements of this subdivision and subdivision (c).

(c) Notwithstanding subdivision (a), the group contract between the health care service plan and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 1366.24 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified, pursuant to Section 1366.24, of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or disability insurer currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to

provide this information to qualified beneficiaries if the employer or prior plan or insurer fails to comply with this section.

(d) A health care service plan may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the health care service plan. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit a plan to require an employer to perform the administrative obligations of the plan as required by this article as a condition of the issuance or renewal of coverage.

(e) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary benefits information, premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(f) Every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 1366.27, notify a qualified beneficiary who has elected continuation coverage pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the plan and the employer is being terminated.

(g) For every qualified beneficiary eligible for premium assistance under paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), every health care service plan, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall provide notice to the qualified beneficiary of the

qualified beneficiary's ability to elect continuation coverage no later than 60 days after receipt of that notice. This notice shall be provided within 14 days of the effective date of this subdivision and shall inform the qualified beneficiary of the availability of premium assistance in the amount of 65 percent of the premium under subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and the duration of the premium assistance as provided by paragraph (2) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5). The notice shall use language that adequately informs a reasonable person that changes in federal law permit employees involuntarily terminated between September 1, 2008, and December 31, 2009, to qualify for a 65 percent subsidy of Cal-COBRA premiums for up to nine months, and that any eligible employee who had previously rejected Cal-COBRA has the right under California law to withdraw that rejection and accept the coverage with the new subsidy. The notice shall also provide the qualified beneficiary with all necessary premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1366.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(h) A health care service plan that receives an election notice from a qualified beneficiary eligible for premium assistance under paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

SEC. 6. Section 10128.50 of the Insurance Code is amended to read:

10128.50. (a) This article shall be known as the California Continuation Benefits Replacement Act, or "Cal-COBRA."

(b) It is the intent of the Legislature that continued access to health insurance coverage is provided to employees, and their dependents, of employers with 2 to 19 eligible employees who are

not currently offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

(c) It is the intent of the Legislature that any federal assistance that is or may become available to qualified beneficiaries under this article be effectively and promptly implemented by the department.

(d) The commissioner may adopt emergency regulations to implement this article in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code by making a finding of emergency and demonstrating the need for immediate action in the event that any federal assistance is or becomes available to qualified beneficiaries under this article. The adoption of these regulations shall be considered by the Office of Administrative Law to be necessary to avoid serious harm to the public peace, health, safety, or general welfare.

SEC. 7. Section 10128.51 of the Insurance Code is amended to read:

10128.51. (a) "Continuation coverage" means extended coverage under the group benefit plan under which an eligible employee or eligible dependent is currently covered, or, in the case of a termination of the group benefit plan or an employer open enrollment period, extended coverage under the group benefit plan currently offered by the employer.

(b) "Group benefit plan" has the same meaning as "health benefit plan" defined in Section 10700, including group policies of vision-only and dental-only coverage, provided pursuant to Chapter 8 (commencing with Section 10700) to an employer with 2 to 19 eligible employees, as defined in Section 10700.

(c) "Qualified beneficiary" means any individual who, on the day before the qualifying event, is covered under a group benefit plan offered by a disability insurer pursuant to Article 1 (commencing with Section 10700) of Chapter 8, and has a qualifying event, as defined in subdivision (d). *For purposes of eligibility for the premium assistance under paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), a "qualified beneficiary" also includes any individual who was or is eligible for continuation coverage as a result of the involuntary termination of the covered employee's employment*

during the period that begins with September 1, 2008, and ends with December 31, 2009, elects continuation coverage, and meets the definition of "qualified beneficiary" set forth in paragraph (3) of Section 1167 of Title 29 of the United States Code, as used in subparagraph (E) of paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

(d) "Qualifying event" means any of the following events that, but for the election of continuation coverage under this article, would result in a loss of coverage under the group benefit plan to a qualified beneficiary:

(1) The death of the covered employee.

(2) The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event.

(3) The divorce or legal separation of the covered employee from the covered employee's spouse.

(4) The loss of dependent status by a dependent enrolled in the group benefit plan.

(5) With respect to a covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

(e) "Employer" means any employer that meets the definition of "small employer" as set forth in Section 10700 and (1) employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar year, or, if the employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter, (2) has contracted for health care coverage through a group benefit plan offered by a disability insurer, and (3) is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

(f) "Core coverage" means coverage for hospital, medical, or surgical benefits provided under the group benefit plan that a qualified beneficiary was receiving immediately prior to the qualifying event, other than noncore coverage.

(g) "Noncore coverage" means coverage for vision and dental care.

SEC. 8. Section 10128.52 of the Insurance Code is amended to read:

10128.52. The continuation coverage requirements of this article do not apply to the following individuals:

(a) Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.

(b) Individuals who have other hospital, medical, or surgical coverage, or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 10198.6 and 10198.7. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.

(c) Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.

(d) Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq.

(e) Qualified beneficiaries who fail to meet the requirements of subdivision (b) of Section 10128.55 regarding notification of a qualifying event or election of continuation coverage within the specified time limits, *except as provided in subdivision (g) of Section 10128.54*.

(f) Qualified beneficiaries who fail to submit the correct premium amount required by subdivision (b) of Section 10128.55 and Section 10128.57, in accordance with the terms and conditions of the policy or contract, or fail to satisfy other terms and conditions of the policy or contract.

SEC. 9. Section 10128.54 of the Insurance Code is amended to read:

10128.54. (a) Every insurer's evidence of coverage for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all insureds who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 10128.51, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the insurer, or the employer if the employer contracts to perform the administrative services as provided for in Section 10128.55, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 10128.51 within 60 days of the date of the qualifying event. This disclosure shall inform insureds that failure to make the notification to the insurer, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 10128.55, within the 60-day period following the later of (1) the date that the insured's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the insured was sent notice pursuant to subdivision (e) of Section 10128.55 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the disability insurer, in accordance with the terms and conditions of the policy or contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 10128.55, the amount of the required premium payment, as set forth in Section 10128.56. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium

payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the employer has contracted with the insurer to perform the administrative services pursuant to subdivision (d) of Section 10128.55, within 45 days of the date the qualified beneficiary provided written notice to the insurer or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay all required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to Section 10128.57 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every insurer shall provide to all covered employees of employers subject to this article written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this article a new or amended evidence of coverage that includes the disclosures required by this section. Any insurer that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits, and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchases of benefits.

(e) Every disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an insured may be

entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the evidence of coverage.

(f) Every disclosure form issued, amended, or renewed on and after July 1, 2006, for a group benefit plan subject to this article shall include the following notice:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(g) Notwithstanding subdivision (b), a qualified beneficiary may notify the insurer, or the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 10128.55, of the qualified beneficiary's election to continue coverage no later than 60 days after receipt of the notice required under subdivision (g) of Section 10128.55 if the qualified beneficiary meets all of the following requirements:

(1) Receives a notice pursuant to subdivision (g) of Section 10128.55.

(2) Became eligible for continuation coverage prior to the effective date of this subdivision.

(3) Is eligible for premium assistance under paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

(4) Failed to notify the insurer, or the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 10128.55, within the 60-day period following the later of the following:

(A) The date that the insured's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event.

(B) The date the insured was sent notice pursuant to subdivision (e) of Section 10128.55 of the ability to continue coverage under the group benefit plan.

(h) With respect to a qualified beneficiary who elects to continue coverage pursuant to subdivision (g), the period beginning on the date of the qualifying event and ending on the effective date of the

continuation coverage shall be disregarded for purposes of calculating a break in coverage in determining whether a preexisting condition provision applies under subdivision (e) of Section 10198.7 or subdivision (c) of Section 10708.

SEC. 10. Section 10128.55 of the Insurance Code is amended to read:

10128.55. (a) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed on or after July 1, 1998, shall require the employer to notify the insurer in writing of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 10128.51, within 30 days of the qualifying event. The group contract shall also require the employer to notify the insurer, in writing, within 30 days of the date when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

(b) Every group benefit plan contract between a disability insurer and an employer subject to this article that is issued, amended, or renewed after July 1, 1998, shall require the employer to notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, as specified in Section 10128.57, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

Every disability insurer shall provide to the employer replacing a group benefit plan policy issued by the insurer, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the insurer reasonably required to administer the notification requirements of this subdivision and subdivision (c).

(c) Notwithstanding subdivision (a), the group benefit plan contract between the insurer and the employer shall require the employer to notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the

successor plan, or contracting employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 10128.54 and subdivision (e) of this section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the group benefit plan and those qualified beneficiaries who have been notified, pursuant to Section 10128.54 of their ability to continue their coverage and may still elect coverage within the specified 60-day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the employer by the health care service plan or, disability insurer currently providing continuation coverage to the qualified beneficiary. The successor insurer shall not be obligated to provide this information to qualified beneficiaries if the employer or prior insurer or health care service plan fails to comply with this section.

(d) A disability insurer may contract with an employer, or an administrator, to perform the administrative obligations of the plan as required by this article, including required notifications and collecting and forwarding premiums to the insurer. Except for the requirements of subdivisions (a), (b), and (c), this subdivision shall not be construed to permit an insurer to require an employer to perform the administrative obligations of the insurer as required by this article as a condition of the issuance or renewal of coverage.

(e) Every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, within 14 days of receiving a notice of a qualifying event, provide to the qualified beneficiary the necessary premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 10128.54 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(f) Every insurer, *or* employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall, during the 180-day period ending on the date that continuation coverage is terminated pursuant to paragraphs (1), (3), and (5) of subdivision (a) of Section 10128.57, notify a qualified beneficiary who has elected continuation coverage

pursuant to this article of the date that his or her coverage will terminate, and shall notify the qualified beneficiary of any conversion coverage available to that qualified beneficiary. This requirement shall not apply when the continuation coverage is terminated because the group contract between the insurer and the employer is being terminated.

(g) For every qualified beneficiary eligible for premium assistance under paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), every insurer, or employer or administrator that contracts to perform the notice and administrative services pursuant to this section, shall provide notice to the qualified beneficiary of the qualified beneficiary's ability to elect continuation coverage no later than 60 days after receipt of that notice. This notice shall be provided within 14 days of the effective date of this subdivision and shall inform the qualified beneficiary of the availability of premium assistance in the amount of 65 percent of the premium under subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and the duration of the premium assistance as provided by paragraph (2) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5). The notice shall use language that adequately informs a reasonable person that changes in federal law permit employees involuntarily terminated between September 1, 2008, and December 31, 2009, to qualify for a 65 percent subsidy of Cal-COBRA premiums for up to nine months, and that any eligible employee who had previously rejected Cal-COBRA has the right under California law to withdraw that rejection and accept the coverage with the new subsidy. The notice shall also provide the qualified beneficiary with all necessary premium information, enrollment forms, and disclosures consistent with the notice requirements contained in subdivisions (b) and (c) of Section 10128.54 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

(h) An insurer that receives an election notice from a qualified beneficiary eligible for premium assistance under paragraph (1) of subdivision (a) of Section 3001 of Title III of Division B of the

American Recovery and Reinvestment Act of 2009 (Public Law 111-5) shall be considered a person entitled to reimbursement, as defined in Section 6432(b)(3) of the Internal Revenue Code, as amended by paragraph (12) of subdivision (a) of Section 3001 of Title III of Division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

SEC. 11. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. Section 14005.25 of the Welfare and Institutions Code, as amended by Section 27 of Chapter 758 of the Statutes of 2008, is amended to read:~~

~~14005.25. (a) To the extent federal financial participation is available, the department shall exercise the option under Section 1902(e)(12) of the federal Social Security Act (42 U.S.C. Sec. 1396a(e)(12)) to extend continuous eligibility to children 19 years of age and younger. A child shall remain eligible pursuant to this subdivision from the date of a determination of eligibility for Medi-Cal benefits until the earlier of either:~~

~~(1) The end of a 12-month period following the eligibility determination.~~

~~(2) The date the individual exceeds the age of 19 years.~~

~~(b) This section shall be implemented only if, and to the extent that, federal financial participation is available.~~

~~(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall, without taking regulatory action, implement this section by means of all county letters or similar instructions. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~SEC. 2. Section 14005.25 of the Welfare and Institutions Code, as added by Section 28 of Chapter 758 of the Statutes of 2008, is repealed.~~

~~SEC. 3. Section 14011.16 of the Welfare and Institutions Code is amended to read:~~

~~14011.16. (a) Commencing August 1, 2003, the department shall implement a requirement for beneficiaries to file semiannual status reports as part of the department's procedures to ensure that beneficiaries make timely and accurate reports of any change in circumstance that may affect their eligibility. The department shall develop a simplified form to be used for this purpose. The department shall explore the feasibility of using a form that allows a beneficiary who has not had any changes to so indicate by checking a box and signing and returning the form.~~

~~(b) Beneficiaries who have been granted continuous eligibility under Section 14005.25 shall not be required to submit semiannual status reports. To the extent federal financial participation is available, all children under 19 years of age shall be exempt from the requirement to submit semiannual status reports.~~

~~(c) Beneficiaries whose eligibility is based on a determination of disability or on their status as aged or blind shall be exempt from the semiannual status report requirement described in subdivision (a). The department may exempt other groups from the semiannual status report requirement as necessary for simplicity of administration.~~

~~(d) When a beneficiary has completed, signed, and filed a semiannual status report that indicated a change in circumstance, eligibility shall be redetermined.~~

~~(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all county letters or similar instructions without taking regulatory action. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~(f) This section shall be implemented only if and to the extent federal financial participation is available.~~

~~SEC. 4. Section 14011.18 of the Welfare and Institutions Code is repealed.~~

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