

AMENDED IN ASSEMBLY APRIL 16, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1180**

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**Introduced by Assembly Member Pan**

February 22, 2013

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An act to ~~repeal and add Sections 1399.805 and 1399.811~~ amend Sections 1373.621 and 1389.5 of, to add and repeal Section 1363.08 of, to repeal Section 1399.816 of, and to repeal, add, and repeal Section 1399.818 of, the Health and Safety Code, and to ~~repeal and add Sections 10901.3 and 10901.9~~ amend Sections 10116.5, 10119.1, 10127.14, 10127.18, and 12672 of, to repeal Section 10902.4 of, and to repeal, add, and repeal Section 10902.6 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1180, as amended, Pan. Health care coverage: ~~HPAA rates.~~ *federally eligible defined individuals: conversion or continuation of coverage.*

**Existing**

(1) 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 the act a crime. Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual insurance policies to fairly and affirmatively offer, market, and sell certain individual contracts and policies to all

federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. Existing law prohibits the premium for those policies and contracts from exceeding the premium paid by a subscriber of the California Major Risk Medical Insurance Program who is of the same age and resides in the same geographic region as the federally eligible defined individual, as specified.

~~This bill would instead prohibit the premium for those policies and contracts from exceeding the premium for a specified plan offered in the individual market through the California Health Benefit Exchange in the rating area in which the individual resides. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. make these provisions of law applicable only to grandfathered individual health plan contracts or insurance policies, as defined, previously issued to federally eligible defined individuals, unless and until specified provisions of the federal Patient Protection and Affordable Care Act (PPACA) are amended or repealed, as specified.~~

~~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:~~

~~(2) Existing law requires a health care service plan or health insurer to offer continuation or conversion of individual or group coverage for a specified period of time and under certain circumstances.~~

~~The bill would make those provisions inoperative, unless and until specified provisions of PPACA are amended or repealed, as specified, and would make conforming changes.~~

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

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

- 1 SECTION 1. Section 1363.08 is added to the Health and Safety
- 2 Code, to read:
- 3 1363.08. (a) Sections 1363.06 and 1363.07 shall be inoperative
- 4 on January 1, 2014.
- 5 (b) If Section 5000A of the Internal Revenue Code, as added by
- 6 Section 1501 of PPACA, is repealed or amended to no longer apply

1 to the individual market, as defined in Section 2791 of the federal  
2 Public Health Service Act (42 U.S.C. Sec. 300gg-04), this section  
3 shall become inoperative and shall be repealed on January 1  
4 following the date that it becomes inoperative.

5 (c) For purposes of this section, "PPACA" means the federal  
6 Patient Protection and Affordable Care Act (Public Law 111-148),  
7 as amended by the federal Health Care and Education  
8 Reconciliation Act of 2010 (Public Law 111-152), and any rules,  
9 regulations, or guidance issued pursuant to that law.

10 SEC. 2. Section 1373.621 of the Health and Safety Code is  
11 amended to read:

12 1373.621. (a) Except for a specialized health care service plan,  
13 every health care service plan contract that is issued, amended,  
14 delivered, or renewed in this state on or after January 1, 1999, that  
15 provides hospital, medical, or surgical expense coverage under an  
16 employer-sponsored group plan for an employer subject to  
17 COBRA, as defined in subdivision (e), or an employer group for  
18 which the plan is required to offer Cal-COBRA coverage, as  
19 defined in subdivision (f), including a carrier providing replacement  
20 coverage under Section 1399.63, shall further offer the former  
21 employee the opportunity to continue benefits as required under  
22 subdivision (b), and shall further offer the former spouse of an  
23 employee or former employee the opportunity to continue benefits  
24 as required under subdivision (c).

25 (b) (1) In the event a former employee who worked for the  
26 employer for at least five years prior to the date of termination of  
27 employment and who is 60 years of age or older on the date  
28 employment ends is entitled to and so elects to continue benefits  
29 under COBRA or Cal-COBRA for himself or herself and for any  
30 spouse, the employee or spouse may further continue benefits  
31 beyond the date coverage under COBRA or Cal-COBRA ends, as  
32 set forth in paragraph (2). Except as otherwise specified,  
33 continuation coverage shall be under the same benefit terms and  
34 conditions as if the continuation coverage under COBRA or  
35 Cal-COBRA had remained in force. For the employee or spouse,  
36 continuation coverage following the end of COBRA or  
37 Cal-COBRA is subject to payment of premiums to the health care  
38 service plan. Individuals ineligible for COBRA or Cal-COBRA,  
39 or who are eligible but have not elected or exhausted continuation  
40 coverage under federal COBRA or Cal-COBRA, are not entitled

1 to continuation coverage under this section. Premiums for  
2 continuation coverage under this section shall be billed by, and  
3 remitted to, the health care service plan in accordance with  
4 subdivision (d). Failure to pay the requisite premiums may result  
5 in termination of the continuation coverage in accordance with the  
6 applicable provisions in the plan's group subscriber agreement  
7 with the former employer.

8 (2) The employer shall notify the former employee or spouse  
9 or both, or the former spouse of the employee or former employee,  
10 of the availability of the continuation benefits under this section  
11 in accordance with Section 2800.2 of the Labor Code. To continue  
12 health care coverage pursuant to this section, the individual shall  
13 elect to do so by notifying the plan in writing within 30 calendar  
14 days prior to the date continuation coverage under COBRA or  
15 Cal-COBRA is scheduled to end. Every health care service plan  
16 and specialized health care service plan shall provide to the  
17 employer replacing a health care service plan contract issued by  
18 the plan, or to the employer's agent or broker representative, within  
19 15 days of any written request, information in possession of the  
20 plan reasonably required to administer the requirements of Section  
21 2800.2 of the Labor Code.

22 (3) The continuation coverage shall end automatically on the  
23 earlier of (A) the date the individual reaches age 65, (B) the date  
24 the individual is covered under any group health plan not  
25 maintained by the employer or any other health plan, regardless  
26 of whether that coverage is less valuable, (C) the date the individual  
27 becomes entitled to Medicare under Title XVIII of the Social  
28 Security Act, (D) for a spouse, five years from the date on which  
29 continuation coverage under COBRA or Cal-COBRA was  
30 scheduled to end for the spouse, or (E) the date on which the  
31 employer terminates its group subscriber agreement with the health  
32 care service plan and ceases to provide coverage for any active  
33 employees through that plan, in which case the health care service  
34 plan shall notify the former employee or spouse or both of the right  
35 to a conversion plan in accordance with Section 1373.6.

36 (c) (1) If a former spouse of an employee or former employee  
37 was covered as a qualified beneficiary under COBRA or  
38 Cal-COBRA, the former spouse may further continue benefits  
39 beyond the date coverage under COBRA or Cal-COBRA ends, as  
40 set forth in paragraph (2) of subdivision (b). Except as otherwise

1 specified in this section, continuation coverage shall be under the  
2 same benefit terms and conditions as if the continuation coverage  
3 under COBRA or Cal-COBRA had remained in force. Continuation  
4 coverage following the end of COBRA or Cal-COBRA is subject  
5 to payment of premiums to the health care service plan. Premiums  
6 for continuation coverage under this section shall be billed by, and  
7 remitted to, the health care service plan in accordance with  
8 subdivision (d). Failure to pay the requisite premiums may result  
9 in termination of the continuation coverage in accordance with the  
10 applicable provisions in the plan's group subscriber agreement  
11 with the employer or former employer.

12 (2) The continuation coverage for the former spouse shall end  
13 automatically on the earlier of (A) the date the individual reaches  
14 65 years of age, (B) the date the individual is covered under any  
15 group health plan not maintained by the employer or any other  
16 health plan, regardless of whether that coverage is less valuable,  
17 (C) the date the individual becomes entitled to Medicare under  
18 Title XVIII of the Social Security Act, (D) five years from the date  
19 on which continuation coverage under COBRA or Cal-COBRA  
20 was scheduled to end for the former spouse, or (E) the date on  
21 which the employer or former employer terminates its group  
22 subscriber agreement with the health care service plan and ceases  
23 to provide coverage for any active employees through that plan;  
24 ~~in which case the health care service plan shall notify the former~~  
25 ~~spouse of the right to a conversion plan in accordance with Section~~  
26 ~~1373.6.~~

27 (d) (1) If the premium charged to the employer for a specific  
28 employee or dependent eligible under this section is adjusted for  
29 the age of the specific employee, or eligible dependent, on other  
30 than a composite basis, the rate for continuation coverage under  
31 this section shall not exceed 102 percent of the premium charged  
32 by the plan to the employer for an employee of the same age as  
33 the former employee electing continuation coverage in the case of  
34 an individual who was eligible for COBRA, and 110 percent in  
35 the case of an individual who was eligible for Cal-COBRA. If the  
36 coverage continued is that of a former spouse, the premium charged  
37 shall not exceed 102 percent of the premium charged by the plan  
38 to the employer for an employee of the same age as the former  
39 spouse selecting continuation coverage in the case of an individual

1 who was eligible for COBRA, and 110 percent in the case of an  
2 individual who was eligible for Cal-COBRA.

3 (2) If the premium charged to the employer for a specific  
4 employee or dependent eligible under this section is not adjusted  
5 for age of the specific employee, or eligible dependent, then the  
6 rate for continuation coverage under this section shall not exceed  
7 213 percent of the applicable current group rate. For purposes of  
8 this section, the “applicable current group rate” means the total  
9 premiums charged by the health care service plan for coverage for  
10 the group, divided by the relevant number of covered persons.

11 (3) However, in computing the premiums charged to the specific  
12 employer group, the health care service plan shall not include  
13 consideration of the specific medical care expenditures for  
14 beneficiaries receiving continuation coverage pursuant to this  
15 section.

16 (e) For purposes of this section, “COBRA” means Section  
17 4980B of Title 26 of the United States Code, Section 1161 et seq.  
18 of Title 29 of the United States Code, and Section 300bb of Title  
19 42 of the United States Code, as added by the Consolidated  
20 Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272),  
21 and as amended.

22 (f) For purposes of this section, “Cal-COBRA” means the  
23 continuation coverage that must be offered pursuant to Article 4.5  
24 (commencing with Section 1366.20), or Article 1.7 (commencing  
25 with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the  
26 Insurance Code.

27 (g) For the purposes of this section, “former spouse” means  
28 either an individual who is divorced from an employee or former  
29 employee or an individual who was married to an employee or  
30 former employee at the time of the death of the employee or former  
31 employee.

32 (h) Every plan evidence of coverage that is issued, amended,  
33 or renewed after July 1, 1999, shall contain a description of the  
34 provisions and eligibility requirements for the continuation  
35 coverage offered pursuant to this section.

36 ~~(i) This section shall take effect on January 1, 1999.~~

37 ~~(j)~~

38 (i) This section does not apply to any individual who is not  
39 eligible for its continuation coverage prior to January 1, 2005.

1     *SEC. 3. Section 1389.5 of the Health and Safety Code is*  
2 *amended to read:*

3     1389.5. (a) This section shall apply to a health care service  
4 plan that provides coverage under an individual plan contract that  
5 is issued, amended, delivered, or renewed on or after January 1,  
6 2007.

7     (b) At least once each year, the health care service plan shall  
8 permit an individual who has been covered for at least 18 months  
9 under an individual plan contract to transfer, without medical  
10 underwriting, to any other individual plan contract offered by that  
11 same health care service plan that provides equal or lesser benefits,  
12 as determined by the plan.

13     “Without medical underwriting” means that the health care  
14 service plan shall not decline to offer coverage to, or deny  
15 enrollment of, the individual or impose any preexisting condition  
16 exclusion on the individual who transfers to another individual  
17 plan contract pursuant to this section.

18     (c) The plan shall establish, for the purposes of subdivision (b),  
19 a ranking of the individual plan contracts it offers to individual  
20 purchasers and post the ranking on its Internet Web site or make  
21 the ranking available upon request. The plan shall update the  
22 ranking whenever a new benefit design for individual purchasers  
23 is approved.

24     (d) The plan shall notify in writing all enrollees of the right to  
25 transfer to another individual plan contract pursuant to this section,  
26 at a minimum, when the plan changes the enrollee’s premium rate.  
27 Posting this information on the plan’s Internet Web site shall not  
28 constitute notice for purposes of this subdivision. The notice shall  
29 adequately inform enrollees of the transfer rights provided under  
30 this section, including information on the process to obtain details  
31 about the individual plan contracts available to that enrollee and  
32 advising that the enrollee may be unable to return to his or her  
33 current individual plan contract if the enrollee transfers to another  
34 individual plan contract.

35     (e) The requirements of this section shall not apply to the  
36 following:

37     (1) A federally eligible defined individual, as defined in  
38 subdivision (c) of Section 1399.801, who is enrolled in an  
39 individual health benefit plan contract offered pursuant to Section  
40 1366.35.

1 (2) An individual offered conversion coverage pursuant to  
2 Section 1373.6.

3 (3) Individual coverage under a specialized health care service  
4 plan contract.

5 (4) An individual enrolled in the Medi-Cal program pursuant  
6 to Chapter 7 (commencing with Section 14000) of Division 9 of  
7 Part 3 of the Welfare and Institutions Code.

8 (5) An individual enrolled in the Access for Infants and Mothers  
9 Program pursuant to Part 6.3 (commencing with Section 12695)  
10 of Division 2 of the Insurance Code.

11 (6) An individual enrolled in the Healthy Families Program  
12 pursuant to Part 6.2 (commencing with Section 12693) of Division  
13 2 of the Insurance Code.

14 (f) It is the intent of the Legislature that individuals shall have  
15 more choice in their health coverage when health care service plans  
16 guarantee the right of an individual to transfer to another product  
17 based on the plan's own ranking system. The Legislature does not  
18 intend for the department to review or verify the plan's ranking  
19 for actuarial or other purposes.

20 (g) (1) *This section shall be inoperative on January 1, 2014.*

21 (2) *If Section 5000A of the Internal Revenue Code, as added by*  
22 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
23 *to the individual market, as defined in Section 2791 of the federal*  
24 *Public Health Service Act (42 U.S.C. Sec. 300gg-04), this section*  
25 *shall become operative on the date of that repeal or amendment.*

26 (3) *For purposes of this subdivision, "PPACA" means the*  
27 *federal Patient Protection and Affordable Care Act (Public Law*  
28 *111-148), as amended by the federal Health Care and Education*  
29 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*  
30 *regulations, or guidance issued pursuant to that law.*

31 *SEC. 4. Section 1399.816 of the Health and Safety Code is*  
32 *repealed.*

33 ~~1399.816. Carriers and health care service plans that offer~~  
34 ~~contracts to individuals may elect to establish a mechanism or~~  
35 ~~method to share in the financing of high-risk individuals. This~~  
36 ~~mechanism or method shall be established through a committee~~  
37 ~~of all carriers and health care service plans offering coverage to~~  
38 ~~individuals by July 1, 2002, and shall be implemented by January~~  
39 ~~1, 2003. If carriers and health care service plans wish to establish~~  
40 ~~a risk-sharing mechanism but cannot agree on the terms and~~

1 conditions of such an agreement, the Managed Risk Medical  
2 Insurance Board shall develop a risk-sharing mechanism or method  
3 by January 1, 2003, and it shall be implemented by July 1, 2003.

4 *SEC. 5. Section 1399.818 of the Health and Safety Code is*  
5 *repealed.*

6 ~~1399.818. This article shall apply to health care service plan~~  
7 ~~contracts offered, delivered, amended, or renewed on or after~~  
8 ~~January 1, 2001.~~

9 *SEC. 6. Section 1399.818 is added to the Health and Safety*  
10 *Code, to read:*

11 *1399.818. (a) On and after January 1, 2014, this article and*  
12 *Sections 1366.35 and 1373.6 shall apply only to grandfathered*  
13 *individual health plan contracts previously issued to federally*  
14 *eligible defined individuals.*

15 *(b) If Section 5000A of the Internal Revenue Code, as added by*  
16 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
17 *to the individual market, as defined in Section 2791 of the federal*  
18 *Public Health Service Act (42 U.S.C. Sec. 300gg-04), this section*  
19 *shall become inoperative and shall be repealed on January 1*  
20 *following the date that it becomes inoperative.*

21 *(c) For purposes of this section, the following definitions apply:*

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

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

29 *SEC. 7. Section 10116.5 of the Insurance Code is amended to*  
30 *read:*

31 *10116.5. (a) Every policy of disability insurance that is issued,*  
32 *amended, delivered, or renewed in this state on or after January*  
33 *1, 1999, that provides hospital, medical, or surgical expense*  
34 *coverage under an employer-sponsored group plan for an employer*  
35 *subject to COBRA, as defined in subdivision (e), or an employer*  
36 *group for which the disability insurer is required to offer*  
37 *Cal-COBRA coverage, as defined in subdivision (f), including a*  
38 *carrier providing replacement coverage under Section 10128.3,*  
39 *shall further offer the former employee the opportunity to continue*  
40 *benefits as required under subdivision (b), and shall further offer*

1 the former spouse of an employee or former employee the  
2 opportunity to continue benefits as required under subdivision (c).

3 (b) (1) If a former employee worked for the employer for at  
4 least five years prior to the date of termination of employment and  
5 is 60 years of age or older on the date employment ends is entitled  
6 to and so elects to continue benefits under COBRA or Cal-COBRA  
7 for himself or herself and for any spouse, the employee or spouse  
8 may further continue benefits beyond the date coverage under  
9 COBRA or Cal-COBRA ends, as set forth in paragraph (2). Except  
10 as otherwise specified in this section, continuation coverage shall  
11 be under the same benefit terms and conditions as if the  
12 continuation coverage under COBRA or Cal-COBRA had remained  
13 in force. For the employee or spouse, continuation coverage  
14 following the end of COBRA or Cal-COBRA is subject to payment  
15 of premiums to the insurer. Individuals ineligible for COBRA or  
16 Cal-COBRA or who are eligible but have not elected or exhausted  
17 continuation coverage under federal COBRA or Cal-COBRA are  
18 not entitled to continuation coverage under this section. Premiums  
19 for continuation coverage under this section shall be billed by, and  
20 remitted to, the insurer in accordance with subdivision (d). Failure  
21 to pay the requisite premiums may result in termination of the  
22 continuation coverage in accordance with the applicable provisions  
23 in the insurer's group contract with the employer.

24 (2) The employer shall notify the former employee or spouse  
25 or both, or the former spouse of the employee or former employee,  
26 of the availability of the continuation benefits under this section  
27 in accordance with Section 2800.2 of the Labor Code. To continue  
28 health care coverage pursuant to this section, the individual shall  
29 elect to do so by notifying the insurer in writing within 30 calendar  
30 days prior to the date continuation coverage under COBRA or  
31 Cal-COBRA is scheduled to end. Every disability insurer shall  
32 provide to the employer replacing a group benefit plan policy  
33 issued by the insurer, or to the employer's agent or broker  
34 representative, within 15 days of any written request, information  
35 in possession of the insurer reasonably required to administer the  
36 requirements of Section 2800.2 of the Labor Code.

37 (3) The continuation coverage shall end automatically on the  
38 earlier of (A) the date the individual reaches age 65, (B) the date  
39 the individual is covered under any group health plan not  
40 maintained by the employer or any other insurer or health care

1 service plan, regardless of whether that coverage is less valuable,  
2 (C) the date the individual becomes entitled to Medicare under  
3 Title XVIII of the Social Security Act, (D) for a spouse, five years  
4 from the date on which continuation coverage under COBRA or  
5 Cal-COBRA was scheduled to end for the spouse, or (E) the date  
6 on which the employer terminates its group contract with the  
7 insurer and ceases to provide coverage for any active employees  
8 through that insurer, in which case the insurer shall notify the  
9 former employee or spouse, or both, of the right to a conversion  
10 policy.

11 (c) (1) If a former spouse of an employee or former employee  
12 was covered as a qualified beneficiary under COBRA or  
13 Cal-COBRA, the former spouse may further continue benefits  
14 beyond the date coverage under COBRA or Cal-COBRA ends, as  
15 set forth in paragraph (2) of subdivision (b). Except as otherwise  
16 specified in this section, continuation coverage shall be under the  
17 same benefit terms and conditions as if the continuation coverage  
18 under COBRA or Cal-COBRA had remained in force. Continuation  
19 coverage following the end of COBRA or Cal-COBRA is subject  
20 to payment of premiums to the insurer. Premiums for continuation  
21 coverage under this section shall be billed by, and remitted to, the  
22 insurer in accordance with subdivision (d). Failure to pay the  
23 requisite premiums may result in termination of the continuation  
24 coverage in accordance with the applicable provisions in the  
25 insurer's group contract with the employer or former employer.

26 (2) The continuation coverage for the former spouse shall end  
27 automatically on the earlier of (A) the date the individual reaches  
28 65 years of age, (B) the date the individual is covered under any  
29 group health plan not maintained by the employer or any other  
30 health care service plan or insurer, regardless of whether that  
31 coverage is less valuable, (C) the date the individual becomes  
32 entitled to Medicare under Title XVIII of the Social Security Act,  
33 (D) five years from the date on which continuation coverage under  
34 COBRA or Cal-COBRA was scheduled to end for the former  
35 spouse, or (E) the date on which the employer or former employer  
36 terminates its group contract with the insurer and ceases to provide  
37 coverage for any active employees through that insurer, ~~in which~~  
38 ~~case the insurer shall notify the former spouse of the right to a~~  
39 ~~conversion policy.~~

1 (d) (1) If the premium charged to the employer for a specific  
2 employee or dependent eligible under this section is adjusted for  
3 the age of the specific employee, or eligible dependent, on other  
4 than a composite basis, the rate for continuation coverage under  
5 this section shall not exceed 102 percent of the premium charged  
6 by the insurer to the employer for an employee of the same age as  
7 the former employee electing continuation coverage in the case of  
8 an individual who was eligible for COBRA, and 110 percent in  
9 the case of an individual who was eligible for Cal-COBRA. If the  
10 coverage continued is that of a former spouse, the premium charged  
11 shall not exceed 102 percent of the premium charged by the plan  
12 to the employer for an employee of the same age as the former  
13 spouse selecting continuation coverage in the case of an individual  
14 who was eligible for COBRA, and 110 percent in the case of an  
15 individual who was eligible for Cal-COBRA.

16 (2) If the premium charged to the employer for a specific  
17 employee or dependent eligible under this section is not adjusted  
18 for age of the specific employee, or eligible dependent, then the  
19 rate for continuation coverage under this section shall not exceed  
20 213 percent of the applicable current group rate. For purposes of  
21 this section, the “applicable current group rate” means the total  
22 premiums charged by the insurer for coverage for the group,  
23 divided by the relevant number of covered persons.

24 (3) However, in computing the premiums charged to the specific  
25 employer group, the insurer shall not include consideration of the  
26 specific medical care expenditures for beneficiaries receiving  
27 continuation coverage pursuant to this section.

28 (e) For purposes of this section, “COBRA” means Section  
29 4980B of Title 26, Section 1161 and following of Title 29, and  
30 Section 300bb of Title 42 of the United States Code, as added by  
31 the Consolidated Omnibus Budget Reconciliation Act of 1985  
32 (P.L. 99-272), and as amended.

33 (f) For purposes of this section, “Cal-COBRA” means the  
34 continuation coverage that must be offered pursuant to Article 1.7  
35 (commencing with Section 10128.50), or Article 4.5 (commencing  
36 with Section 1366.20) of Chapter 2.2 of Division 2 of the Health  
37 and Safety Code.

38 (g) For the purposes of this section, “former spouse” means  
39 either an individual who is divorced from an employee or former  
40 employee or an individual who was married to an employee or

1 former employee at the time of the death of the employee or former  
2 employee.

3 (h) Every group benefit plan evidence of coverage that is issued,  
4 amended, or renewed after January 1, 1999, shall contain a  
5 description of the provisions and eligibility requirements for the  
6 continuation coverage offered pursuant to this section.

7 ~~(i) This section shall take effect on January 1, 1999.~~

8 ~~(j)~~

9 (i) This section does not apply to any individual who is not  
10 eligible for its continuation coverage prior to January 1, 2005.

11 *SEC. 8. Section 10119.1 of the Insurance Code is amended to*  
12 *read:*

13 10119.1. (a) This section shall apply to a health insurer that  
14 covers hospital, medical, or surgical expenses under an individual  
15 health benefit plan, as defined in subdivision (a) of Section  
16 10198.6, that is issued, amended, renewed, or delivered on or after  
17 January 1, 2007.

18 (b) At least once each year, a health insurer shall permit an  
19 individual who has been covered for at least 18 months under an  
20 individual health benefit plan to transfer, without medical  
21 underwriting, to any other individual health benefit plan offered  
22 by that same health insurer that provides equal or lesser benefits  
23 as determined by the insurer.

24 “Without medical underwriting” means that the health insurer  
25 shall not decline to offer coverage to, or deny enrollment of, the  
26 individual or impose any preexisting condition exclusion on the  
27 individual who transfers to another individual health benefit plan  
28 pursuant to this section.

29 (c) The insurer shall establish, for the purposes of subdivision  
30 (b), a ranking of the individual health benefit plans it offers to  
31 individual purchasers and post the ranking on its Internet Web site  
32 or make the ranking available upon request. The insurer shall  
33 update the ranking whenever a new benefit design for individual  
34 purchasers is approved.

35 (d) The insurer shall notify in writing all insureds of the right  
36 to transfer to another individual health benefit plan pursuant to  
37 this section, at a minimum, when the insurer changes the insured’s  
38 premium rate. Posting this information on the insurer’s Internet  
39 Web site shall not constitute notice for purposes of this subdivision.  
40 The notice shall adequately inform insureds of the transfer rights

1 provided under this section including information on the process  
 2 to obtain details about the individual health benefit plans available  
 3 to that insured and advising that the insured may be unable to  
 4 return to his or her current individual health benefit plan if the  
 5 insured transfers to another individual health benefit plan.

6 (e) The requirements of this section shall not apply to the  
 7 following:

8 (1) A federally eligible defined individual, as defined in  
 9 subdivision (e) of Section 10900, who purchases individual  
 10 coverage pursuant to Section 10785.

11 (2) An individual offered conversion coverage pursuant to  
 12 Sections 12672 and 12682.1.

13 (3) An individual enrolled in the Medi-Cal program pursuant  
 14 to Chapter 7 (commencing with Section 14000) of Part 3 of  
 15 Division 9 of the Welfare and Institutions Code.

16 (4) An individual enrolled in the Access for Infants and Mothers  
 17 Program, pursuant to Part 6.3 (commencing with Section 12695).

18 (5) An individual enrolled in the Healthy Families Program  
 19 pursuant to Part 6.2 (commencing with Section 12693).

20 (f) It is the intent of the Legislature that individuals shall have  
 21 more choice in their health care coverage when health insurers  
 22 guarantee the right of an individual to transfer to another product  
 23 based on the insurer’s own ranking system. The Legislature does  
 24 not intend for the department to review or verify the insurer’s  
 25 ranking for actuarial or other purposes.

26 (g) (1) *This section shall be inoperative on January 1, 2014.*

27 (2) *If Section 5000A of the Internal Revenue Code, as added by*  
 28 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
 29 *to the individual market, as defined in Section 2794 of the federal*  
 30 *Public Health Service Act (42 U.S.C. Sec. 300gg-04), this section*  
 31 *shall become operative on the date of that repeal or amendment.*

32 (3) *For purposes of this subdivision, “PPACA” means the*  
 33 *federal Patient Protection and Affordable Care Act (Public Law*  
 34 *111-148), as amended by the federal Health Care and Education*  
 35 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*  
 36 *regulations, or guidance issued pursuant to that law.*

37 SEC. 9. *Section 10127.14 of the Insurance Code is amended*  
 38 *to read:*

39 10127.14. (a) The department and the Department of Managed  
 40 Health Care shall compile information required by this section and

1 Section 1363.06 of the Health and Safety Code into two  
2 comparative benefit matrices. The first matrix shall compare benefit  
3 packages offered pursuant to Section 1373.62 of the Health and  
4 Safety Code and Section 10127.15. The second matrix shall  
5 compare benefit packages offered pursuant to Sections 1366.35,  
6 1373.6, and 1399.804 of the Health and Safety Code and Sections  
7 10785, 10901.2, and 12682.1.

8 (b) The comparative benefit matrix shall include:

9 (1) Benefit information submitted by health care service plans  
10 pursuant to Section 1363.06 of the Health and Safety Code and by  
11 health insurers pursuant to subdivision (d).

12 (2) The following statements in at least 12-point type at the top  
13 of the matrix:

14 (A) "This benefit summary is intended to help you compare  
15 coverage and benefits and is a summary only. For a more detailed  
16 description of coverage, benefits, and limitations, please contact  
17 the health care service plan or health insurer."

18 (B) "The comparative benefit summary is updated annually, or  
19 more often if necessary to be accurate."

20 (C) "The most current version of this comparative benefit  
21 summary is available on (address of the plan's or insurer's site)."

22 This subparagraph applies only to those health insurers that  
23 maintain an Internet Web site.

24 (3) The telephone number or numbers that may be used by an  
25 applicant to contact either the department or the Department of  
26 Managed Health Care, as appropriate, for further assistance.

27 (c) The department and the Department of Managed Health  
28 Care shall jointly prepare two standardized templates for use by  
29 health care service plans and health insurers in submitting the  
30 information required pursuant to subdivision (d) of Section 1363.06  
31 and subdivision (d). The templates shall be exempt from the  
32 provisions of Chapter 3.5 (commencing with Section 11340) of  
33 Part 1 of Division 3 of Title 2 of the Government Code.

34 (d) Health insurers shall submit the following to the department  
35 by January 31, 2003, and annually thereafter:

36 (1) A summary explanation of the following for each product  
37 described in subdivision (a):

38 (A) Eligibility requirements.

39 (B) The full premium cost of each benefit package in the service  
40 area in which the individual and eligible dependents work or reside.

- 1 (C) When and under what circumstances benefits cease.  
2 (D) The terms under which coverage may be renewed.  
3 (E) Other coverage that may be available if benefits under the  
4 described benefit package cease.  
5 (F) The circumstances under which choice in the selection of  
6 physicians and providers is permitted.  
7 (G) Lifetime and annual maximums.  
8 (H) Deductibles.  
9 (2) A summary explanation of the following coverages, together  
10 with the corresponding copayments and limitations, for each  
11 product described in subdivision (a):  
12 (A) Professional services.  
13 (B) Outpatient services.  
14 (C) Hospitalization services.  
15 (D) Emergency health coverage.  
16 (E) Ambulance services.  
17 (F) Prescription drug coverage.  
18 (G) Durable medical equipment.  
19 (H) Mental health services.  
20 (I) Residential treatment.  
21 (J) Chemical dependency services.  
22 (K) Home health services.  
23 (L) Custodial care and skilled nursing facilities.  
24 (3) The telephone number or numbers that may be used by an  
25 applicant to access a health insurer customer service representative  
26 and to request additional information about the insurance policy.  
27 (4) Any other information specified by the department in the  
28 template.  
29 (e) Each health insurer shall provide the department with updates  
30 to the information required by subdivision (d) at least annually, or  
31 more often if necessary to maintain the accuracy of the information.  
32 (f) The department and the Department of Managed Health Care  
33 shall make the comparative benefit matrices available on their  
34 respective Internet Web sites and to the health care service plans  
35 and health insurers for dissemination as required by Section 1373.6  
36 of the Health and Safety Code and Section 12682.1, after  
37 confirming the accuracy of the description of the matrices with  
38 the health insurers and health care service plans.  
39 (g) As used in this section, “benefit matrix” shall have the same  
40 meaning as benefit summary.

1 (h) This section shall not apply to accident-only, specified  
2 disease, hospital indemnity, CHAMPUS supplement, long-term  
3 care, Medicare supplement, dental-only, or vision-only insurance  
4 policies.

5 (i) (1) *This section shall be inoperative on January 1, 2014.*

6 (2) *If Section 5000A of the Internal Revenue Code, as added by*  
7 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
8 *to the individual market, as defined in Section 2794 of the federal*  
9 *Public Health Service Act (42 U.S.C. Sec. 300gg-04), this section*  
10 *shall become operative on the date of that repeal or amendment.*

11 (3) *For purposes of this subdivision, "PPACA" means the*  
12 *federal Patient Protection and Affordable Care Act (Public Law*  
13 *111-148), as amended by the federal Health Care and Education*  
14 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*  
15 *regulations, or guidance issued pursuant to that law.*

16 SEC. 10. *Section 10127.18 of the Insurance Code is amended*  
17 *to read:*

18 10127.18. (a) On and after January 1, 2005, a health insurer  
19 issuing individual policies of health insurance that ceases to offer  
20 individual coverage in this state shall offer coverage to the  
21 policyholders who had been covered by those policies at the time  
22 of withdrawal under the same terms and conditions as provided in  
23 paragraph (3) of subdivision (a), paragraphs (2) to (4), inclusive,  
24 of subdivision (b), subdivisions (c) to (e), inclusive, and subdivision  
25 (h) of Section 12682.1.

26 (b) The department may adopt regulations to implement this  
27 section.

28 (c) This section shall not apply when a plan participating in  
29 Medi-Cal, Healthy Families, Access for Infants and Mothers, or  
30 any other contract between the plan and a government entity no  
31 longer contracts with the government entity to provide health  
32 coverage in the state, or a specified area of the state, nor shall this  
33 section apply when a plan ceases entirely to market, offer, and  
34 issue any and all forms of coverage in any part of this state after  
35 the effective date of this section.

36 (d) (1) *This section shall be inoperative on January 1, 2014.*

37 (2) *If Section 5000A of the Internal Revenue Code, as added by*  
38 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
39 *to the individual market, as defined in Section 2794 of the federal*

1 *Public Health Service Act (42 U.S.C. Sec. 300gg-04), this section*  
2 *shall become operative on the date of that repeal or amendment.*

3 (3) *For purposes of this subdivision, “PPACA” means the*  
4 *federal Patient Protection and Affordable Care Act (Public Law*  
5 *111-148), as amended by the federal Health Care and Education*  
6 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*  
7 *regulations, or guidance issued pursuant to that law.*

8 *SEC. 11. Section 10902.4 of the Insurance Code is repealed.*

9 ~~10902.4. Carriers and health care service plans that offer~~  
10 ~~contracts to individuals may elect to establish a mechanism or~~  
11 ~~method to share in the financing of high-risk individuals. This~~  
12 ~~mechanism or method shall be established through a committee~~  
13 ~~of all carriers and health care service plans offering coverage to~~  
14 ~~individuals by July 1, 2002, and shall be implemented by January~~  
15 ~~1, 2003. If carriers and health care service plans wish to establish~~  
16 ~~a risk-sharing mechanism but cannot agree on the terms and~~  
17 ~~conditions of such an agreement, the Managed Risk Medical~~  
18 ~~Insurance Board shall develop a risk-sharing mechanism or method~~  
19 ~~by January 1, 2003, and it shall be implemented by July 1, 2003.~~

20 *SEC. 12. Section 10902.6 of the Insurance Code is repealed.*

21 ~~10902.6. This chapter shall apply to policies or contracts~~  
22 ~~offered, delivered, amended, or renewed on or after January 1,~~  
23 ~~2001.~~

24 *SEC. 13. Section 10902.6 is added to the Insurance Code, to*  
25 *read:*

26 *10902.6. (a) On and after January 1, 2014, this chapter and*  
27 *Sections 10785 and 12682.1 shall apply only to grandfathered*  
28 *individual health insurance policies previously issued to federally*  
29 *eligible defined individuals.*

30 *(b) If Section 5000A of the Internal Revenue Code, as added by*  
31 *Section 1501 of PPACA, is repealed or amended to no longer apply*  
32 *to the individual market, as defined in Section 2791 of the federal*  
33 *Public Health Service Act (42 U.S.C. Sec. 300gg-04), this section*  
34 *shall become inoperative and shall be repealed on January 1*  
35 *following the date that it becomes inoperative.*

36 *(c) For purposes of this section, the following definitions apply:*

37 *(1) “Grandfathered health insurance policy” has the same*  
38 *meaning as “grandfathered health plan” in Section 1251 of*  
39 *PPACA.*

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

6 SEC. 14. Section 12672 of the Insurance Code is amended to  
7 read:

8 12672. (a) Any group policy issued, amended, or renewed in  
9 this state on or after January 1, 1983, which provides insurance  
10 for employees or members on an expense-incurred or service basis,  
11 other than for a specific disease or for accidental injuries only,  
12 shall contain a provision that an employee or member whose  
13 coverage under the group policy has been terminated for any reason  
14 except as provided in this part, shall be entitled to have a converted  
15 policy issued to him or her by the insurer under whose group policy  
16 he or she was covered, without evidence of insurability, subject  
17 to the terms and conditions of this part.

18 (b) (1) This section shall be inoperative on January 1, 2014.

19 (2) If Section 5000A of the Internal Revenue Code, as added by  
20 Section 1501 of PPACA, is repealed or amended to no longer apply  
21 to the individual market, as defined in Section 2794 of the federal  
22 Public Health Service Act (42 U.S.C. Sec. 300gg-04), this section  
23 shall become operative on the date of that repeal or amendment.

24 (3) For purposes of this subdivision, “PPACA” means the  
25 federal Patient Protection and Affordable Care Act (Public Law  
26 111-148), as amended by the federal Health Care and Education  
27 Reconciliation Act of 2010 (Public Law 111-152), and any rules,  
28 regulations, or guidance issued pursuant to that law.

29 SECTION 1. ~~Section 1399.805 of the Health and Safety Code~~  
30 ~~is repealed.~~

31 SEC. 2. ~~Section 1399.805 is added to the Health and Safety~~  
32 ~~Code, to read:~~

33 ~~1399.805. (a) After the federally eligible defined individual~~  
34 ~~submits a completed application form for a plan contract, the plan~~  
35 ~~shall, within 30 days, notify the individual of the individual’s actual~~  
36 ~~premium charges for that plan contract, unless the plan has~~  
37 ~~provided notice of the premium charge prior to the application~~  
38 ~~being filed. In no case shall the premium charged for any health~~  
39 ~~care service plan contract identified in subdivision (d) of Section~~  
40 ~~1366.35 exceed the premium for the second lowest cost silver plan~~

1 of the individual market in the rating area in which the individual  
2 resides which is offered through the California Health Benefit  
3 Exchange established under Title 22 (commencing with Section  
4 100500) of the Government Code, as described in Section  
5 36B(b)(3)(B) of Title 26 of the United States Code.

6 (b) ~~When a federally eligible defined individual submits a~~  
7 ~~premium payment, based on the quoted premium charges, and that~~  
8 ~~payment is delivered or postmarked, whichever occurs earlier,~~  
9 ~~within the first 15 days of the month, coverage shall begin no later~~  
10 ~~than the first day of the following month. When that payment is~~  
11 ~~neither delivered nor postmarked until after the 15th day of a~~  
12 ~~month, coverage shall become effective no later than the first day~~  
13 ~~of the second month following delivery or postmark of the~~  
14 ~~payment.~~

15 (e) ~~During the first 30 days after the effective date of the plan~~  
16 ~~contract, the individual shall have the option of changing coverage~~  
17 ~~to a different plan contract offered by the same health care service~~  
18 ~~plan. If the individual notified the plan of the change within the~~  
19 ~~first 15 days of a month, coverage under the new plan contract~~  
20 ~~shall become effective no later than the first day of the following~~  
21 ~~month. If an enrolled individual notified the plan of the change~~  
22 ~~after the 15th day of a month, coverage under the new plan contract~~  
23 ~~shall become effective no later than the first day of the second~~  
24 ~~month following notification.~~

25 ~~SEC. 3. Section 1399.811 of the Health and Safety Code is~~  
26 ~~repealed.~~

27 ~~SEC. 4. Section 1399.811 is added to the Health and Safety~~  
28 ~~Code, to read:~~

29 ~~1399.811. Premiums for contracts offered, delivered, amended,~~  
30 ~~or renewed by plans on or after January 1, 2014, shall be subject~~  
31 ~~to the following requirements:~~

32 (a) ~~The premium for in force or new business for a federally~~  
33 ~~eligible defined individual shall not exceed the premium for the~~  
34 ~~second lowest cost silver plan of the individual market in the rating~~  
35 ~~area in which the individual resides which is offered through the~~  
36 ~~California Health Benefit Exchange established under Title 22~~  
37 ~~(commencing with Section 100500) of the Government Code, as~~  
38 ~~described in Section 36B(b)(3)(B) of Title 26 of the United States~~  
39 ~~Code.~~

1 ~~(b) For a contract that a plan has discontinued offering, the~~  
2 ~~premium applied to the first rating period of the new contract that~~  
3 ~~the federally eligible defined individual elects to purchase shall~~  
4 ~~be no greater than the premium applied in the prior rating period~~  
5 ~~to the discontinued contract.~~

6 ~~SEC. 5. Section 10901.3 of the Insurance Code is repealed.~~

7 ~~SEC. 6. Section 10901.3 is added to the Insurance Code, to~~  
8 ~~read:~~

9 ~~10901.3. (a) After the federally eligible defined individual~~  
10 ~~submits a completed application form for a health benefit plan,~~  
11 ~~the carrier shall, within 30 days, notify the individual of the~~  
12 ~~individual's actual premium charges for that health benefit plan~~  
13 ~~design. In no case shall the premium charged for any health benefit~~  
14 ~~plan identified in subdivision (d) of Section 10785 exceed the~~  
15 ~~premium for the second lowest cost silver plan of the individual~~  
16 ~~market in the rating area in which the individual resides which is~~  
17 ~~offered through the California Health Benefit Exchange established~~  
18 ~~under Title 22 (commencing with Section 100500) of the~~  
19 ~~Government Code, as described in Section 36B(b)(3)(B) of Title~~  
20 ~~26 of the United States Code.~~

21 ~~(b) When a federally eligible defined individual submits a~~  
22 ~~premium payment, based on the quoted premium charges, and that~~  
23 ~~payment is delivered or postmarked, whichever occurs earlier,~~  
24 ~~within the first 15 days of the month, coverage shall begin no later~~  
25 ~~than the first day of the following month. When that payment is~~  
26 ~~neither delivered or postmarked until after the 15th day of a month,~~  
27 ~~coverage shall become effective no later than the first day of the~~  
28 ~~second month following delivery or postmark of the payment.~~

29 ~~(c) During the first 30 days after the effective date of the health~~  
30 ~~benefit plan, the individual shall have the option of changing~~  
31 ~~coverage to a different health benefit plan design offered by the~~  
32 ~~same carrier. If the individual notified the plan of the change within~~  
33 ~~the first 15 days of a month, coverage under the new health benefit~~  
34 ~~plan shall become effective no later than the first day of the~~  
35 ~~following month. If an enrolled individual notified the carrier of~~  
36 ~~the change after the 15th day of a month, coverage under the health~~  
37 ~~benefit plan shall become effective no later than the first day of~~  
38 ~~the second month following notification.~~

39 ~~SEC. 7. Section 10901.9 of the Insurance Code is repealed.~~

1 SEC. 8.— Section 10901.9 is added to the Insurance Code, to read:  
 2 10901.9.— Commencing on January 1, 2014, premiums for health  
 3 benefit plans offered, delivered, amended, or renewed by carriers  
 4 shall be subject to the following requirements:

5 (a) ~~The premium for in force or new business for a federally~~  
 6 ~~eligible defined individual shall not exceed the premium for the~~  
 7 ~~second lowest cost silver plan of the individual market in the rating~~  
 8 ~~area in which the individual resides which is offered through the~~  
 9 ~~California Health Benefit Exchange established under Title 22~~  
 10 ~~(commencing with Section 100500) of the Government Code, as~~  
 11 ~~described in Section 36B(b)(3)(B) of Title 26 of the United States~~  
 12 ~~Code.~~

13 (b) ~~For a contract that a carrier has discontinued offering, the~~  
 14 ~~premium applied to the first rating period of the new contract that~~  
 15 ~~the federally eligible defined individual elects to purchase shall~~  
 16 ~~be no greater than the premium applied in the prior rating period~~  
 17 ~~to the discontinued contract.~~

18 SEC. 9.— ~~No reimbursement is required by this act pursuant to~~  
 19 ~~Section 6 of Article XIII B of the California Constitution because~~  
 20 ~~the only costs that may be incurred by a local agency or school~~  
 21 ~~district will be incurred because this act creates a new crime or~~  
 22 ~~infraction, eliminates a crime or infraction, or changes the penalty~~  
 23 ~~for a crime or infraction, within the meaning of Section 17556 of~~  
 24 ~~the Government Code, or changes the definition of a crime within~~  
 25 ~~the meaning of Section 6 of Article XIII B of the California~~  
 26 ~~Constitution.~~