Assembly Bill No. 112

CHAPTER 107

An act to amend Sections 1357.06, 1357.50, 1357.51, 1357.52, 1366.21, 1366.22, 1366.23, 1366.24, 1366.25, 1366.26, 1366.27, and 1373.621 of, to amend and repeal Section 1357.16 of, to repeal Section 1373.62 of, the Health and Safety Code, and to amend Sections 10116.5, 10128.51, 10128.52, 10128.53, 10128.54, 10128.55, 10128.56, 10128.57, 10128.58, 10194.8, 10198.6, 10273.4, 10273.6, 10700, 10705, and 10708 of, and to amend and repeal Section 10718.55 of, the Insurance Code, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor July 3, 1998. Filed with Secretary of State July 6, 1998.]

LEGISLATIVE COUNSEL'S DIGEST

AB 112, Escutia. Health.

Existing law provides for the regulation of health care service plans by the Commissioner of Corporations and of disability insurers by the Insurance Commissioner.

This bill would revise various provisions relating to these health plans and insurers.

Existing law regulates plans and insurers that provide coverage to small employers to require coverage to small employers in certain instances.

This bill would revise those provisions. Among other things, it would provide for the repeal of provisions that authorize qualified associations to provide administrative services, effective January 1, 2003.

Existing law regulates preexisting condition provisions.

This bill would, among other things, specify that those regulations are applicable to individuals that lose coverage because of legal separation for health care service plans as well as individuals who lose coverage for other reasons, and would revise definitions.

Existing law provides for continuation coverage to certain persons under the California COBRA Program.

This bill would revise those provisions. Among other things, it would revise provisions relating to noncore coverage, such as dental or vision coverage. It would revise disclosure requirements. It would prohibit the imposition of additional fees by health care service plans and disability insurers for administering Cal-COBRA.

Existing law contains other continuation of benefits provisions that became operative January 1, 1997, and limits the premiums that may be charged for that coverage.

This bill would revise the maximum premium that may be charged, as specified, and would require certain disclosures.

The bill would make other related and technical changes.

Since a willful violation of various requirements imposed by the bill upon a health care service plan would be a crime, the bill would impose a state-mandated local program by imposing a new crime.

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.

The bill would declare that it is to take effect immediately as an urgency statute.

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

SECTION 1. Section 1357.06 of the Health and Safety Code is amended to read:

1357.06. (a) Preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period no premiums shall be charged to the enrollee or the subscriber.

(c) In determining whether a preexisting condition provision or a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or

sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(d) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), health plans providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, no premiums shall be charged to the enrollee or the subscriber.

(e) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act(42 U.S.C. Sec. 300gg(e)).

(f) A health care service plan issuing group coverage may not impose a preexisting condition exclusion to any of the following:

(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, has applied for coverage through the employer-sponsored plan.

(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.

(3) To a condition relating to benefits for pregnancy or maternity care.

SEC. 2. Section 1357.16 of the Health and Safety Code is amended to read:

1357.16. (a) Health care service plans may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Health care service plans that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The health care service plan shall permit all qualified associations to assume one or more of these functions when the health care service plan determines the qualified association demonstrates the administrative capacity to assume these functions.

For the purposes of this section, administrative services provided by qualified associations or their third-party administrators shall be

services pertaining to eligibility determination, enrollment, premium collection, sales, or claims administration on a per-claim basis that would otherwise be provided directly by the health care service plan or through a third-party administrator on a commission basis or an agent or solicitor work force on a commission basis.

Each health care service plan that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the health care service plan has permitted the qualified association or its third-party administrator to assume. The health care service plan shall apply these uniform discounts to the health care service plan's risk adjusted employee risk rates after the health plan has determined the qualified association's risk adjusted employee risk rates pursuant to Section 1357.12. The health care service plan shall report to the Department of Corporations its schedule of discount for each administrative service.

In no instance may a health care service plan provide discounts to qualified associations that are in any way intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association. In addition to any other remedies available to the commissioner to enforce this chapter, the commissioner may declare a contract between a health care service plan and a qualified association for administrative services pursuant to this section null and void if the commissioner determines any discounts provided to the qualified association are intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association.

(b) For the purposes of this section, a qualified association is a nonprofit corporation comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, that conforms to all of the following requirements:

(1) It accepts for membership any individual or small employer meeting its membership criteria.

(2) It does not condition membership directly or indirectly on the health or claims history of any person.

(3) It uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.

(4) It is organized and maintained in good faith for purposes unrelated to insurance.

(5) It existed on January 1, 1972, and has been in continuous existence since that date.

(6) It has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.

(7) It offered, marketed, or sold health coverage to its members for 20 continuous years prior to January 1, 1993.

(8) It agrees to offer only to association members any plan contract.

(9) It agrees to include any member choosing to enroll in the plan contract offered by the association, provided that the member agrees to make required premium payments.

(10) It complies with all provisions of this article.

(11) It had at least 10,000 enrollees covered by association sponsored plans immediately prior to enactment of Chapter 1128 of the Statutes of 1992.

(12) It applies any administrative cost at an equal rate to all members purchasing coverage through the qualified association.

(c) A qualified association shall comply with Section 1357.52.

(d) The department shall monitor compliance with this section and report the impact of any noncompliance to the Assembly Insurance Committee and the Senate Insurance Committee on January 1, 2002.

(e) This section shall remain in effect only until January 1, 2003, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2003, deletes or extends that date.

SEC. 3. Section 1357.50 of the Health and Safety Code is amended to read:

1357.50. For purposes of this article:

(a) ''Health benefit plan'' means any individual or group, insurance policy or health care service plan contract, that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) ''Late enrollee'' means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible

employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment that coverage under another employer health benefit plan or no share-of-cost Medi-Cal coverage was the reason for declining enrollment provided that, if the individual was covered under another employer health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a person through whom the individual was covered as a dependent, legal separation, divorce, or loss of no share-of-cost Medi-Cal coverage.

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan.

(2) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan. The health benefit plan shall enroll a dependent child within 30 days after receipt of a court order or request from the district attorney, either parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, the employer, or the group administrator. In the case of children who are eligible for medicaid, the State Department of Health Services may also make the request.

(4) The plan cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a

six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision, and the coverage under that provision has been exhausted. For purposes of this section, the definition of ''COBRA'' set forth in subdivision (e) of Section 1373.621 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days of notification of this loss of coverage.

(c) ''Preexisting condition provision'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(d) ''Creditable coverage'' means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, nonprofit hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(e) ''Waivered condition'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

(f) ''Affiliation period'' means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

SEC. 4. Section 1357.51 of the Health and Safety Code is amended to read:

1357.51. (a) No plan contract that covers three or more enrollees shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No plan contract that covers one or two individuals shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(d) A plan that does not utilize a preexisting condition provision in plan contracts that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No plan may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(e) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any enrollee, a plan shall credit the time the enrollee was covered under creditable coverage, provided the enrollee becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting or affiliation period.

However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(f) No plan shall exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(g) A health care service plan issuing group coverage may not impose a preexisting condition exclusion to the following:

(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, has applied for coverage through the employer-sponsored plan.

(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.

(3) To a condition relating to benefits for pregnancy or maternity care.

(h) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act, 42 U.S.C. Sec. 300gg(e).

SEC. 5. Section 1357.52 of the Health and Safety Code is amended to read:

1357.52. Except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a plan may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability including conditions arising out of acts of domestic violence of that employee or dependent. No plan contract may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Sections 1357.06 and 1357.51.

SEC. 6. 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).

(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. 7. 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.

(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. 8. Section 1366.23 of the Health and Safety Code is amended to read:

1366.23. (a) Every health care service plan, including a specialized health care service plan contract, that provides coverage under a group benefit plan to an employer, as defined in Section 1366.21, shall offer continuation coverage, pursuant to this section, to a qualified beneficiary under the contract upon a qualifying event without evidence of insurability. The qualified beneficiary shall, upon election, be able to continue his or her coverage under the group benefit plan, subject to the contract's terms and conditions, and subject to the requirements of this article. Except as otherwise provided in this article, continuation coverage shall be provided under the same terms and conditions that apply to similarly situated individuals under the group benefit plan.

(b) Every health care service plan shall also offer the continuation coverage to a qualified beneficiary who (1) elects continuation coverage under a group benefit plan, as defined in this article or in Section 10128.51 of the Insurance Code, but whose continuation coverage is terminated pursuant to subdivision (b) of Section 1366.27, prior to any other termination date specified in Section 1366.27, or (2) who elects coverage through the health care service plan during any employer open enrollment, and the employer has contracted with the health care service plan to provide coverage to the employer's active employees. This continuation coverage shall be provided only for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan had the employer not terminated the group contract with the previous health care service plan or insurer.

(c) Every health care service plan or specialized health care service plan shall offer a qualified beneficiary the ability to elect the same core, noncore, or core and noncore coverage that the qualified beneficiary had immediately prior to the qualifying event.

(d) Any child who is born to a former employee who is a qualified beneficiary who has elected continuation coverage pursuant to this article or a child who is placed for adoption with a former employee who is a qualified beneficiary who has elected continuation coverage pursuant to this article during the period of continuation coverage provided by this article shall be considered a qualified beneficiary entitled to receive benefits pursuant to this article for the remainder of the period that the former employee is covered pursuant to this article, if the child is enrolled under a group benefit plan as a dependent of that former employee who is a qualified beneficiary within 30 days of the child's birth or placement for adoption.

(e) An individual who becomes a qualified beneficiary pursuant to this article shall continue to receive coverage pursuant to this article until continuation coverage is terminated at the qualified beneficiary's election or pursuant to Section 1366.27, whichever comes first, even if the employer that sponsored the group benefit plan that is continued subsequently 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.

(f) A qualified beneficiary electing coverage pursuant to this section shall be considered part of the group contract and treated as similarly situated employees for contract purposes, unless otherwise specified in this article.

SEC. 8.5. 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.

SEC. 9. 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.

SEC. 10. Section 1366.26 of the Health and Safety Code is amended to read:

1366.26. A qualified beneficiary electing continuation coverage shall pay to the health care service plan, on or before the due date of each payment but not more frequently than on a monthly basis, not more than 110 percent of the applicable rate charged for a covered employee or, in the case of dependent coverage, not more than 110 percent of the applicable rate charged to a similarly situated individual under the group benefit plan being continued under the group contract. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the qualified beneficiary shall be required to pay to the health care service plan an amount no greater than 150 percent of the group rate after the first 18 months of continuation coverage provided pursuant to this section. In no case shall a health care service plan charge an employer an additional fee for administering Cal-COBRA other than those incorporated in the risk adjusted employee risk rate as provided for in subdivision (i) of Section 1357.

SEC. 11. Section 1366.27 of the Health and Safety Code is amended to read:

1366.27. (a) The continuation coverage provided pursuant to this article shall terminate at the first to occur of the following:

(1) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, the date 18 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event.

(2) The end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the plan contract. In the case of nonpayment of premiums, reinstatement shall be governed by the terms and conditions of the plan contract.

(3) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (1), (3), (4), or (5) of subdivision (d) of Section 1366.21, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

(4) The requirements of this article no longer apply to the qualified beneficiary pursuant to the provisions of Section 1366.22.

(5) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage pursuant to this article, the date 29 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified beneficiary shall notify the plan, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 18-month continuation coverage period in order to be eligible for coverage pursuant to this subdivision. If the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act, the benefits provided in this paragraph shall terminate on the later of the date provided by paragraph (1), or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the United States Social Security Act that the qualified beneficiary is no longer disabled. A qualified beneficiary eligible for 29 months of continuation coverage as a result of a disability shall notify the plan, or the employer or administrator that contracts to perform the notice and administrative services, within 30 days of a determination that the qualified beneficiary is no longer disabled.

(6) In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, but who has another qualifying event, as described in paragraph (1), (3), (4), or (5) of subdivision (d) of Section 1366.21, within 18 months of the date of the first qualifying event, and the qualified beneficiary has notified the plan, or the employer or administrator under contract to provide administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

(7) The employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees.

(8) The qualified beneficiary moves out of the plan's service area or the qualified beneficiary commits fraud or deception in the use of plan services.

(b) If the group contract between the plan and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate pursuant to this section, coverage under the prior plan shall terminate and the qualified beneficiary may elect continuation coverage under the subsequent group benefit plan, if

any, pursuant to the requirements of subdivision (b) of Section 1366.23 and subdivision (c) of Section 1366.24.

SEC. 12. Section 1373.621 of the Health and Safety Code is amended to read:

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

(b) (1) In the event a former employee who worked for the employer for at least five years prior to the date of termination of employment and who is 60 years of age or older on the date employment ends is entitled to and so elects to continue benefits under COBRA or Cal-COBRA for himself or herself and for any spouse, the employee or spouse may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends, as set forth in paragraph (2). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. For the employee or spouse, continuation coverage following the end of COBRA or Cal-COBRA is subject to payment of premiums to the health care service plan. Individuals ineligible for COBRA or Cal-COBRA, or who are eligible but have not elected or exhausted continuation coverage under federal COBRA or Cal-COBRA, are not entitled to continuation coverage under this section. Premiums for continuation coverage under this section shall be billed by, and remitted to, the health care service plan in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the plan's group subscriber agreement with the former employer.

(2) The former employer shall notify the former employee or spouse or both, or the former spouse of the employee or former employee, of the availability of the continuation benefits under this section in accordance with Section 2800.2 of the Labor Code. To continue health care coverage pursuant to this section, the individual shall elect to do so by notifying the plan in writing within 30 calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end. 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 requirements of Section 2800.2 of the Labor Code.

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

(c) (1) If a former spouse of an employee or former employee was covered as a qualified beneficiary under COBRA or Cal-COBRA, the former spouse may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends, as set forth in paragraph (2) of subdivision (b). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. Continuation coverage following the end of COBRA or Cal-COBRA is subject to payment of premiums to the health care service plan. Premiums for continuation coverage under this section shall be billed by, and remitted to, the health care service plan in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the plan's group subscriber agreement with the employer or former employer.

(2) The continuation coverage for the former spouse shall end automatically on the earlier of (A) the date the individual reaches 65 years of age, (B) the date the individual is covered under any group health plan not maintained by the employer or any other health plan, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the former spouse, or (E) the date on which the employer or former employer terminates its group subscriber agreement with the health care service plan and ceases to provide coverage for any active employees through that plan, in which case the health care

service plan shall notify the former spouse of the right to a conversion plan in accordance with Section 1373.6.

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

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

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

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

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

(g) For the purposes of this section, ''former spouse'' means either an individual who is divorced from an employee or former employee or an individual who was married to an employee or former employee at the time of the death of the employee or former employee.

(h) Every plan evidence of coverage that is issued, amended, or renewed after July 1, 1999, shall contain a description of the

provisions and eligibility requirements for the continuation coverage offered pursuant to this section.

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

SEC. 13. Section 1373.62 of the Health and Safety Code is repealed.

SEC. 14. Section 10116.5 of the Insurance Code is amended to read:

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

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

(2) The former employer shall notify the former employee or spouse or both, or the former spouse of the employee or former employee, of the availability of the continuation benefits under this section in accordance with Section 2800.2 of the Labor Code. To continue health care coverage pursuant to this section, the individual shall elect to do so by notifying the insurer in writing within 30

calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end. 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 requirements of Section 2800.2 of the Labor Code.

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

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

(2) The continuation coverage for the former spouse shall end automatically on the earlier of (A) the date the individual reaches 65 years of age, (B) the date the individual is covered under any group health plan not maintained by the employer or any other health care service plan or insurer, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the former spouse, or (E) the date on which the employer or former employer terminates its group contract with the insurer and ceases to provide coverage for any active employees

through that insurer, in which case the insurer shall notify the former spouse of the right to a conversion policy.

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

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

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

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

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

(g) For the purposes of this section, ''former spouse'' means either an individual who is divorced from an employee or former employee or an individual who was married to an employee or former employee at the time of the death of the employee or former employee.

(h) Every group benefit plan evidence of coverage that is issued, amended, or renewed after January 1, 1999, shall contain a

description of the provisions and eligibility requirements for the continuation coverage offered pursuant to this section.

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

SEC. 15. 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).

(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. 16. 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.

(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. 17. Section 10128.53 of the Insurance Code is amended to read:

10128.53. (a) Every disability insurer, that provides coverage under a group benefit plan to an employer, including those policies and contracts that provide vision-only and dental-only benefits, as

defined in Section 10128.51, shall offer continuation coverage, pursuant to this section, to a qualified beneficiary under the contract upon a qualifying event without evidence of insurability. The qualified beneficiary shall, upon election, be able to continue his or her coverage under the group benefit plan, subject to the contract's terms and conditions, and subject to the requirements of this section. Except as otherwise provided in this section, continuation coverage shall be provided under the same terms and conditions that apply to similarly situated individuals under the group benefit plan.

(b) Every disability insurer shall also offer the continuation coverage to a qualified beneficiary who (1) elects continuation coverage under a group benefit plan as defined in this article or in Section 1366.21 of the Health and Safety Code, but whose continuation coverage is terminated under the group benefit plan pursuant to subdivision (b) of Section 10128.57, prior to any other termination date specified in Section 10128.57, or (2) who elects coverage through the disability insurer during any employer open enrollment, and the employer has contracted with the disability insurer to provide coverage to the employer's active employees. This continuation coverage shall be provided only for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan had the employer not terminated the contract with the previous insurer or health care service plan.

(c) Every disability insurer shall offer a qualified beneficiary the ability to elect the same core, noncore, or core and noncore coverage that the qualified beneficiary had immediately prior to the qualifying event.

(d) Any child who is born to a former employee who is a qualified beneficiary who has elected continuation coverage pursuant to this section, or a child who is placed for adoption with a former employee who is a qualified beneficiary who has elected continuation coverage pursuant to this article during the period of continuation coverage provided by this article shall be considered a qualified beneficiary entitled to receive benefits pursuant to this article for the remainder of the period that the former employee is covered pursuant to this article, if the child is enrolled under a group benefit plan as a dependent of that former employee who is a qualified beneficiary within 30 days of the child's birth or placement for adoption.

(e) An individual who becomes a qualified beneficiary pursuant to this article shall continue to receive coverage pursuant to this article until continuation coverage is terminated at the qualified beneficiary's election or pursuant to Section 10128.57, whichever comes first, even if the employer that sponsored the group benefit plan that is continued subsequently becomes subject to Section 4980B of the United States Internal Revenue Code of Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

(f) A qualified beneficiary electing coverage pursuant to this section shall be considered part of the group benefit plan and treated as similarly situated employees for contract purposes, unless otherwise specified in this article.

SEC. 18. 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.

SEC. 19. 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, 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.

SEC. 20. Section 10128.56 of the Insurance Code is amended to read:

10128.56. A qualified beneficiary electing continuation coverage shall pay to the disability insurer, on or before the due date of each payment but not more frequently than on a monthly basis, not more than 110 percent of the applicable rate charged for a covered employee or, in the case of dependent coverage, not more than 110 percent of the applicable rate charged to a similarly situated individual under the group benefit plan being continued under the group contract. In the case of a qualified beneficiary who is determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the qualified beneficiary shall be required to pay to the insurer an amount no greater than 150 percent of the group rate after the first 18 months of continuation coverage provided pursuant to this section. In no case shall an insurer charge an employer an additional fee for administering Cal-COBRA other than those incorporated in the risk adjusted employee risk rate as provided for in subdivision (t) of Section 10700.

SEC. 21. Section 10128.57 of the Insurance Code is amended to read:

10128.57. (a) The continuation coverage provided pursuant to this article shall terminate at the first to occur of the following:

(1) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 10128.51, the date 18 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event.

(2) The end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the policy or contract. In the case of nonpayment of premiums, reinstatement shall be governed by the terms and conditions of the plan contract.

(3) In the case of a qualified beneficiary who is eligible to continuation coverage pursuant to paragraph (1), (3), (4), or (5) of subdivision (d) of Section 10116.51, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

(4) The requirements of this article no longer apply to the qualified beneficiary pursuant to the provisions of Section 10128.52.

(5) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 10128.51, and determined, under Title II or Title XVI of the Social Security Act, to be disabled any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage pursuant to this article, the date 29 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified beneficiary shall notify the insurer, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of determination letter and prior to the end of the original 18-month continuation coverage period in order to be eligible for coverage pursuant to this subdivision. If the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act, the benefits provided in this paragraph shall terminate on the later of the date provided by paragraph (1), or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the United States Social Security Act that the qualified beneficiary is no longer disabled. A qualified beneficiary eligible for 29 months of continuation coverage as a result of a disability shall notify the insurer, or the employer or administrator that contracts to perform the notice and administrative services, within 30 days of a determination that the qualified beneficiary is no longer disabled.

(6) In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 10128.51, but who has another qualifying event, as described in paragraph (1), (3), (4), or (5) of subdivision (d) of Section 10128.51, within 18 months of the date of the first

qualifying event, and has notified the insurer, or employer or administrator under contract to provide administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

(7) The employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees.

(8) The qualified beneficiary moves out of the insurer's service area, or the qualified beneficiary commits fraud or deception in the use of benefits.

(b) If the group benefits contracts between the insurer and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate pursuant to this section, coverage under the prior plan shall terminate and the qualified beneficiary may elect continuation coverage under the subsequent group benefit plan, if any, pursuant to the requirements of subdivision (b) of Section 10128.53 and subdivision (c) of Section 10128.54.

SEC. 22. Section 10128.58 of the Insurance Code is amended to read:

10128.58. A disability insurer subject to this article shall not be obligated to provide continuation coverage to a qualified beneficiary pursuant to this article if an insured fails to make the notification required by Section 10128.54, or if the employer of the insured fails to comply with Section 10128.55.

SEC. 23. Section 10194.8 of the Insurance Code is amended to read:

10194.8. (a) No Medicare supplement insurer shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. This section shall not be construed as preventing the exclusion of benefits for preexisting conditions as defined in paragraph (1) of subdivision (a) of Section 10195, except as provided for in paragraph (1) of subdivision (b).

(b) (1) In determining whether an exclusion of benefits for a preexisting condition may be applied to any person during the open enrollment period provided in this section, a Medicare supplement insurer shall credit the time the person was covered under creditable coverage, provided the individual becomes eligible for coverage under the Medicare supplement policy:

(A) Within 180 days of the termination of any creditable coverage if the creditable coverage is offered through employment or sponsored by an employer and if the Medicare supplement insurance is offered through succeeding employment or sponsored by a succeeding employer, and is not in violation of the Medicare Secondary Payer provision of Section 1862(b) of the Social Security Act (42 U.S.C. Sec. 1395y(b)).

(B) In cases not covered by paragraph (1), within 30 days of the termination of any other qualifying prior coverage.

(2) For purposes of this section, ‘‘creditable coverage’’ means any of the following:

(A) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental coverage, vision coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(B) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(C) The medicaid program pursuant to Title XIX of the Social Security Act.

(D) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(E) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A state health benefits risk pool.

(H) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(I) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).

(K) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(c) An individual enrolled in Medicare Part B by reason of disability will be entitled to open enrollment described in this section for six months after he or she reaches age 65. Every insurer shall make available to every applicant qualified for open enrollment all policies and certificates offered by that insurer at the time of application. Insurers shall not discourage sales during the open enrollment period by any means, including the altering of the commission structure.

(d) An individual who is 65 years of age or older and enrolled in Medicare Part B is entitled to open enrollment described in this section for six months following:

(1) Receipt of a notice of termination or, if no notice is received, the effective date of termination, from any employer-sponsored health plan including an employer-sponsored retiree health plan. For purposes of this section, ''employer-sponsored retiree health plan'' includes any coverage for medical expenses that is directly or indirectly sponsored or established by an employer for employees or retirees, their spouses, dependents, or other included insureds.

(2) Termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure.

(e) An individual who is 65 years of age or older and enrolled in Medicare Part B is entitled to open enrollment described in this section if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

(f) An individual shall be entitled to an annual open enrollment period lasting 30 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement coverage, with the exception of a Medicare Select policy, that offers benefits equal to or lesser than those provided by the previous coverage. During this open enrollment period, no Medicare supplement insurer that falls under this provision shall deny or condition the issuance or effectiveness of Medicare supplement coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or medical condition of the individual if, at the time of the open enrollment period, the individual is covered under another Medicare supplement policy or contract. A Medicare supplement insurer shall notify a policyholder of his or her rights under this subdivision at least 30 and no more than 60 days before the beginning of the open enrollment period.

SEC. 24. Section 10198.6 of the Insurance Code is amended to read:

10198.6. For purposes of this article:

(a) ‘‘Health benefit plan’’ means any group or individual policy or contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) ‘‘Late enrollee’’ means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment that coverage under another employer health benefit plan or no share-of-cost Medi-Cal coverage was the reason for declining enrollment provided that, if the individual was covered under another employer health benefit plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan’s coverage, cessation of an employer’s contribution toward an employee or dependent’s coverage, death of a person through whom the individual was covered as a dependent, legal separation, divorce, or loss of no share-of-cost Medi-Cal coverage.

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan.

(2) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4) The carrier cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(5) The individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of ''COBRA'' set forth in subdivision (e) of Section 10116.5 shall apply.

(6) The individual is a dependent of an enrolled eligible employee who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days of notification of this loss of coverage.

(c) ''Preexisting condition provision'' means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(d) ''Creditable coverage'' means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(e) ''Affiliation period'' means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

(f) ''Waivered condition'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

SEC. 25. Section 10273.4 of the Insurance Code is amended to read:

10273.4. All disability insurers writing, issuing, or administering group health benefit plans shall make all of these health benefit plans renewable with respect to the policyholder, contractholder, or employer except as follows:

(a) For nonpayment of the required premiums by the policyholder, contractholder, or employer.

(b) For fraud or other intentional misrepresentation by the policyholder, contractholder, or employer.

(c) For noncompliance with a material health benefit plan contract provision.

(d) If the insurer ceases to provide or arrange for the provision of health care services for new group health benefit plans in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease writing, issuing, or administering new or existing group health benefit plans in that state is provided to the commissioner and to either the policyholder, contractholder, or employer at least 180 days prior to discontinuation of that coverage.

(2) Group health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any disability insurer that ceases to write, issue, or administer new group health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) Except as authorized under subdivision (h) of Section 10705, or unless the commissioner had made a determination pursuant to subdivision (q) of Section 10712, a disability insurer that ceases to write, issue, or administer new group health benefit plans in this state after the effective date of this section shall be prohibited from writing, issuing, or administering new group health benefit plans to employers in this state for a period of five years from the date of notice to the commissioner.

(e) If a disability insurer withdraws a group health benefit plan from the market; provided, that the plan notifies all affected contractholders, policyholders, or employers and the commissioner at least 90 days prior to the discontinuation of the health benefit plans, and that the insurer makes available to the contractholder, policyholder, or employer all health benefit plans that it makes available to new employer business without regard to the claims experience of health-related factors of insureds or individuals who may become eligible for the coverage.

(f) For the purposes of this section, ‘‘health benefit plan’’ shall have the same meaning as in subdivision (a) of Section 10198.6 and Section 10198.61.

(g) For the purposes of this section, ‘‘eligible employee’’ shall have the same meaning as in Section 10700, except that it applies to all health benefit plans issued to employer groups of two or more employees.

SEC. 26. Section 10273.6 of the Insurance Code is amended to read:

10273.6. All individual health benefit plans, except for short-term limited duration insurance, shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) For nonpayment of the required premiums or contributions by the individual in accordance with the terms of the health insurance coverage or the timeliness of the payments.

(b) For fraud or intentional misrepresentation of material fact under the terms of the coverage by the individual.

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

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

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

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

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

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

SEC. 27. Section 10700 of the Insurance Code is amended to read:

10700. As used in this chapter:

(a) ''Agent or broker'' means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) ''Benefit plan design'' means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) ''Board'' means the Major Risk Medical Insurance Board.

(d) ‘‘Carrier’’ means any disability insurance company or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the situs of the contract or master policyholder. For the purposes of Articles 3 (commencing with Section 10719) and 4 (commencing with Section 10730), ‘‘carrier’’ also includes health care service plans.

(e) ‘‘Dependent’’ means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (z).

(f) ‘‘Eligible employee’’ means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, in the small employer’s regular place of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer’s business, and they are included as employees under a health benefit plan of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee as defined in this paragraph who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer.

(2) Any member of a guaranteed association as defined in subdivision (z).

(g) ‘‘Enrollee’’ means an eligible employee or dependent who receives health coverage through the program from a participating carrier.

(h) ‘‘Financially impaired’’ means, for the purposes of this chapter, a carrier that, on or after the effective date of this chapter, is not insolvent and is either:

(1) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations.

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(i) ‘‘Fund’’ means the California Small Group Reinsurance Fund.

(j) ‘‘Health benefit plan’’ means a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered eligible employees of a small employer and their dependents. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement,

long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(k) ''In force business'' means an existing health benefit plan issued by the carrier to a small employer.

(*l*) ''Late enrollee'' means an eligible employee or dependent who has declined health coverage under a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's health benefit plan and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, another person eligible for coverage through a guaranteed association pursuant to subdivision (z), or dependent shall not be considered a late enrollee if: (1) the individual meets all of the following: (A) was covered under another employer health benefit plan or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll; (B) certified at the time of the initial enrollment that coverage under another employer health benefit plan or no share-of-cost Medi-Cal coverage was the reason for declining enrollment provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee; (C) has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual, or of a person through whom the individual was covered as a dependent, the termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, or loss of no share-of-cost Medi-Cal coverage; and (D) requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; (2) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; (3) a court has

ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan; (4) (A) in the case of an eligible employee as defined in paragraph (1) of subdivision (f), the carrier cannot produce a written statement from the employer stating that the individual or the person through whom an individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the individual meets the criteria specified in paragraph (1), (2), or (3); (B) in the case of an eligible employee who is a guaranteed association member, the plan cannot produce a written statement from the guaranteed association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or paragraph (2) or (3); or (C) in the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for coverage was made within 30 days of the change; (5) the individual is an employee or dependent who meets the criteria described in paragraph (1) and was under a COBRA continuation provision and the coverage under that provision has been exhausted. For purposes of this section, the definition of ''COBRA'' set forth in subdivision (e) of Section 1373.62 shall apply; or (6) the individual is a dependent of an enrolled eligible employee who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of coverage.

(m) ''New business'' means a health benefit plan issued to a small employer that is not the carrier's in force business.

(n) ''Participating carrier'' means a carrier that has entered into a contract with the program to provide health benefits coverage under this part.

(o) ''Plan of operation'' means the plan of operation of the fund, including articles, bylaws and operating rules adopted by the fund pursuant to Article 3 (commencing with Section 10719).

(p) ''Program'' means the Health Insurance Plan of California.

(q) ''Preexisting condition provision'' means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(r) ''Creditable coverage'' means:

(1) Any individual or group policy, contract, or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(s) ''Rating period'' means the period for which premium rates established by a carrier are in effect and shall be no less than six months.

(t) ''Risk adjusted employee risk rate'' means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(u) ''Risk adjustment factor'' means the percent adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard claims. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(v) ''Risk category'' means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30
30–39
40–49
50–54
55–59
60–64
65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the health benefit plan will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer carriers shall base rates to small employers using no more than the following family size categories:

(A) Single.
(B) Married couple.
(C) One adult and child or children.
(D) Married couple and child or children.

(3) (A) In determining rates for small employers, a carrier that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and shall divide no county into more than two regions. Carriers shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire

state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) In determining rates for small employers, a carrier that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census, of all counties which are included in their entirety in a carrier's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No carrier shall have less than one geographic area.

(w) ''Small employer'' means either of the following:

(1) Any person, proprietary or nonprofit firm, corporation, partnership, public agency, or association that is actively engaged in business or service that, on at least 50 percent of its working days during the preceding calendar quarter, or preceding calendar year, employed at least two, but not more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, the insurer shall use the test that ensures eligibility if only one test would establish eligibility. However, for purposes of subdivisions (b) and (h) of Section 10705, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined income tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer pursuant to this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of this chapter that apply to a small employer shall continue to apply until the health benefit plan anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (y), that purchases health coverage for members of the association.

(x) ‘‘Standard employee risk rate’’ means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(y) ‘‘Guaranteed association’’ means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria which (1) includes one or more small employers as defined in paragraph (1) of subdivision (w), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has been offering health insurance to its members for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any benefit plan design that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the benefit plan design offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the carrier with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a master policy by an admitted insurer is delivered directly to the association or a trust formed for or sponsored by an association to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(z) ‘‘Members of a guaranteed association’’ means any individual or employer meeting the association’s membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association’s discretion, it may also include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an

association chooses to include those persons as members of the guaranteed association, the association must so elect in advance of purchasing coverage from a plan. Health plans may require an association to adhere to the membership composition it selects for up to 12 months.

(aa) ''Affiliation period'' means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

SEC. 28. Section 10705 of the Insurance Code is amended to read:

10705. Upon the effective date of this act:

(a) No group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10717.

(b) Each carrier, except a self-funded employer, shall fairly and affirmatively offer, market, and sell all of the carrier's benefit plan designs that are sold to, offered through, or sponsored by, small employers or associations that include small employers to all small employers in each geographic region in which the carrier makes coverage available or provides benefits. A carrier contracting to participate in the Voluntary Alliance Uniting Employers Purchasing Program shall be deemed to be in compliance with this requirement for a benefit plan design offered through the program in those geographic regions in which the carrier participates in the program and the benefit plan design is offered exclusively through the program.

(1) Nothing in this section shall be construed to require an association, or a trust established and maintained by an association to receive a master insurance policy issued by an admitted insurer and to administer the benefits thereof solely for association members, to offer, market or sell a benefit plan design to those who are not members of the association. However, if the association markets, offers or sells a benefit plan design to those who are not members of the association it is subject to the requirements of this section. This shall apply to an association that otherwise meets the requirements of paragraph (5) formed by merger of two or more associations after January 1, 1992, if the predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and met the requirements of paragraph (5).

(2) A carrier which (A) effective January 1, 1992, and at least 20 years prior to that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer or sell any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers or sells any benefit plan design or any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits to those who are not members of the association it is subject to the requirements of this section.

(3) Each carrier that sells health benefit plans to members of one association pursuant to paragraph (2) shall submit an annual statement to the commissioner which states that the carrier is selling health benefit plans pursuant to paragraph (2) and which, for the one association, lists all the information required by paragraph (4).

(4) Each carrier that sells health benefit plans to members of any association shall submit an annual statement to the commissioner which lists each association to which the carrier sells health benefit plans, the industry or profession which is served by the association, the association's membership criteria, a list of officers, the state in which the association is organized, and the site of its principal office.

(5) For purposes of paragraphs (1) and (2), an association is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to that date, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

(c) Each carrier shall make available to each small employer all benefit plan designs that the carrier offers or sells to small employers or to associations that include small employers. Notwithstanding subdivision (d) of Section 10700, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(d) Each carrier shall do all of the following:

(1) Prepare a brochure that summarizes all of its benefit plan designs and make this summary available to small employers, agents and brokers upon request. The summary shall include for each benefit plan design information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard employee risk rates, an explanation of how creditable coverage is calculated if a preexisting condition or affiliation period is imposed, and a telephone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send copies to agents and brokers representing the carrier. Any entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan design.

(2) For each benefit plan design, prepare a more detailed evidence of coverage and make it available to small employers, agents and brokers upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making selections of benefit plan designs. An entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be required to prepare an evidence of coverage for that benefit plan design.

(3) Provide to small employers, agents, and brokers, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted standard employee risk rates. When requesting this information, small employers, agents and brokers shall provide the carrier with the information the carrier needs to determine the small employer’s risk adjusted employee risk rate.

(4) Provide copies of the current summary brochure to all agents or brokers who represent the carrier and, upon updating the brochure, send copies of the updated brochure to agents and brokers representing the carrier for the purpose of selling health benefit plans.

(5) Notwithstanding subdivision (d) of Section 10700, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(e) Every agent or broker representing one or more carriers for the purpose of selling health benefit plans to small employers shall do all of the following:

(1) When providing information on a health benefit plan to a small employer but making no specific recommendations on particular benefit plan designs:

(A) Advise the small employer of the carrier's obligation to sell to any small employer any of the benefit plan designs it offers to small employers and provide them, upon request, with the actual rates that would be charged to that employer for a given benefit plan design.

(B) Notify the small employer that the agent or broker will procure rate and benefit information for the small employer on any benefit plan design offered by a carrier for whom the agent or broker sells health benefit plans.

(C) Notify the small employer that, upon request, the agent or broker will provide the small employer with the summary brochure required in paragraph (1) of subdivision (d) for any benefit plan design offered by a carrier whom the agent or broker represents.

(2) When recommending a particular benefit plan design or designs, advise the small employer that, upon request, the agent will provide the small employer with the brochure required by paragraph (1) of subdivision (d) containing the benefit plan design or designs being recommended by the agent or broker.

(3) Prior to filing an application for a small employer for a particular health benefit plan:

(A) For each of the benefit plan designs offered by the carrier whose benefit plan design the agent or broker is presenting, provide the small employer with the benefit summary required in paragraph (1) of subdivision (d) and the sum of the standard employee risk rates for that particular employer.

(B) Notify the small employer that, upon request, the agent or broker will provide the small employer with an evidence of coverage brochure for each benefit plan design the carrier offers.

(C) Notify the small employer that, from July 1, 1993 to July 1, 1996, actual rates may be 20 percent higher or lower than the sum of the standard employee risk rates, and from July 1, 1996, and thereafter, actual rates may be 10 percent higher or lower than the sum of the standard employee risk rates depending on how the carrier assesses the risk of the small employer's group.

(D) Notify the small employer that, upon request, the agent or broker will submit information to the carrier to ascertain the small employer's sum of the risk adjusted standard employee risk rate for any benefit plan design the carrier offers.

(E) Obtain a signed statement from the small employer acknowledging that the small employer has received the disclosures required by paragraph (3) of subdivision (e) and by Section 10716.

(f) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10700, is provided in connection with the employee's employment or which, in the case of an eligible employee

as defined in paragraph (2) of subdivision (f) of Section 17000, is provided in connection with a guaranteed association.

(g) No carrier shall reject an application from a small employer for a benefit plan design provided:

(1) The small employer as defined by paragraph (1) of subdivision (w) of Section 10700 offers health benefits to 100 percent of its eligible employees as defined in paragraph (1) of subdivision (f) of Section 10700. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(h) No carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(2) Encourage or direct small employers to seek coverage from another carrier or the program because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(i) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer or the small employer's employees. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(j) Except in the case of a late insured, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a disability insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical

condition, or accident, except for preexisting conditions as permitted by Section 10198.7 or 10708.

(k) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

(*l*) (1) With respect to the obligation to provide coverage newly issued under subdivision (d), the carrier may cease enrolling new small employer groups and new eligible employees as defined by paragraph (2) of subdivision (f) of Section 10700 if it certifies to the commissioner that the number of eligible employees and dependents, of the employers newly enrolled or insured during the current calendar year by the carrier equals or exceeds: (A) in the case of a carrier that administers any self-funded health benefits arrangement in California, 10 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured in California by that carrier as of December 31 of the preceding year, or (B) in the case of a carrier that does not administer any self-funded health benefit arrangements in California, 8 percent of the total number of eligible employees, or eligible employees and dependents, respectively, enrolled or insured by the carrier in California as of December 31 of the preceding year.

(2) Certification shall be deemed approved if not disapproved within 45 days after submission to the commissioner. If that certification is approved, the small employer carrier shall not offer coverage to any small employers under any health benefit plans during the remainder of the current year. If the certification is not approved, the carrier shall continue to issue coverage as required by subdivision (d) and be subject to administrative penalties as established in Section 10718.

SEC. 29. Section 10708 of the Insurance Code is amended to read:

10708. (a) Preexisting condition provisions of health benefit plans shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including the use of prescription medications, was recommended by or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care benefits and no premiums shall be charged to the subscriber or enrollee.

(c) In determining whether a preexisting condition provision or a waiting period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding health benefit plan contract within the applicable enrollment period. A plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any postenrollment or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding health benefit plan within the applicable enrollment period.

(d) Group health benefit plans may not impose a preexisting conditions exclusion to the following:

(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, applied for coverage through the employer-sponsored plan.

(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the employer-sponsored plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.

(3) To a condition relating to benefits for pregnancy or maternity care.

(e) A carrier providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this section concerning preexisting condition provisions and waiting or affiliation periods.

(f) In addition to the preexisting condition exclusions authorized by subdivision (a) and the waiting or affiliation period authorized by subdivision (b), carriers providing coverage to a guaranteed association may impose on employers or individuals purchasing coverage who would not be eligible for guaranteed coverage if they were not purchasing through the association a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this chapter shall become effective. During the waiting or affiliation

period, the carrier is not required to provide health care benefits and no premiums shall be charged to the insured.

SEC. 30. Section 10718.55 of the Insurance Code is amended to read:

10718.55. (a) Carriers may enter into contractual agreements with qualified associations, as defined in subdivision (b), under which these qualified associations may assume responsibility for performing specific administrative services, as defined in this section, for qualified association members. Carriers that enter into agreements with qualified associations for assumption of administrative services shall establish uniform definitions for the administrative services that may be provided by a qualified association or its third-party administrator. The carrier shall permit all qualified associations to assume one or more of these functions when the carrier determines the qualified association demonstrates that it has the administrative capacity to assume these functions.

For the purposes of this section, administrative services provided by qualified associations or their third-party administrators shall be services pertaining to eligibility determination, enrollment, premium collection, sales, or claims administration on a per-claim basis that would otherwise be provided directly by the carrier or through a third-party administrator on a commission basis or an agent or solicitor work force on a commission basis.

Each carrier that enters into an agreement with any qualified association for the provision of administrative services shall offer all qualified associations with which it contracts the same premium discounts for performing those services the carrier has permitted the qualified association or its third-party administrator to assume. The carrier shall apply these uniform discounts to the carrier's risk adjusted employee risk rates after the carrier has determined the qualified association's risk adjusted employee risk rates pursuant to Section 10714. The carrier shall report to the department its schedule of discounts for each administrative service.

In no instance may a carrier provide discounts to qualified associations that are in any way intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association. In addition to any other remedies available to the commissioner to enforce this chapter, the commissioner may declare a contract between a carrier and a qualified association for administrative services pursuant to this section null and void if the commissioner determines any discounts provided to the qualified association are intended to, or materially result in, a reduction in premium charges to the qualified association due to the health status of the membership of the qualified association.

(b) For the purposes of this section, a qualified association is a nonprofit corporation comprised of a group of individuals or

employers who associate based solely on participation in a specified profession or industry, that conforms to all of the following requirements:

(1) It accepts for membership any individual or small employer meeting its membership criteria.

(2) It does not condition membership, directly or indirectly, on the health or claims history of any person.

(3) It uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association.

(4) It is organized and maintained in good faith for purposes unrelated to insurance.

(5) It existed on January 1, 1972, and has been in continuous existence since that date.

(6) It has a constitution and bylaws or other analogous governing documents that provide for election of the governing board of the association by its members.

(7) It offered, marketed, or sold health coverage to its members for 20 continuous years prior to January 1, 1993.

(8) It agrees to offer any plan contract only to association members.

(9) It agrees to include any member choosing to enroll in the plan contract offered by the association, provided that the member agrees to make required premium payments.

(10) It complies with all provisions of this article.

(11) It had at least 10,000 enrollees covered by association-sponsored plans immediately prior to enactment of Chapter 1128 of the Statutes of 1992.

(12) It applies any administrative cost at an equal rate to all members purchasing coverage through the qualified association.

(c) A qualified association shall comply with the requirements set forth in Section 10198.9.

(d) This section shall remain in effect only until January 1, 2003, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2003, deletes or extends that date.

SEC. 31. 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.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative

on the same date that the act takes effect pursuant to the California Constitution.

SEC. 32. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to comply with and conform to provisions of federal law, it is necessary for this act to take effect immediately.

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