Senate Bill No. 719

CHAPTER 665

An act to amend, repeal, and add Section 1373.621 of, to add Article 4.5 (commencing with Section 1366.20) to Chapter 2.2 of Division 2 of the Health and Safety Code, to amend, repeal, and add Section 10116.5 of, and to add Article 1.7 (commencing with Section 10128.50) to Chapter 1 of Part 2 of Division 2 of the Insurance Code, relating to health coverage.

[Approved by Governor October 3, 1997. Filed with Secretary of State October 6, 1997.]

LEGISLATIVE COUNSEL'S DIGEST

SB 719, Johnston. Health coverage: continuation of coverage.

(1) Existing law provides for the regulation of health care service plans by the Commissioner of Corporations, and of policies of disability insurance by the Insurance Commissioner.

Existing law also requires certain group plans and policies to provide for conversion benefits. Existing federal law, added by the Consolidated Omnibus Budget Reconciliation Act of 1985, and known as COBRA, requires that certain employers provide former employees with continuation of benefits.

This bill would enact the California Continuation Benefits Replacement Act (Cal-COBRA) that would require every group health care service plan contract and group disability insurance contract or policy providing specified coverage to employers with 2 to 19 eligible employees to offer continuation coverage to a qualified beneficiary under the contract upon a qualifying event without evidence of insurability. The qualified beneficiary would, upon election, be able to continue his or her group benefit plan, subject to the contract's terms and conditions, and subject to the requirements of the bill. The bill would limit premiums to a percentage of the rate charged to a covered employee.

The bill would exclude certain individuals including those who are subject to specified federal laws. This bill would require disclosure of this coverage to employees.

(2) Existing law requires health care service plan contracts and disability insurance policies issued, amended, delivered, or renewed in this state on or after January 1, 1996, that provide hospital, medical, or surgical expense coverage under the plan of an employer subject to COBRA, to permit an employer to provide extended coverage to eligible former employees, their spouses, and former spouses that would automatically terminate under specified conditions.

This bill would permit an employer to provide extended coverage under Cal-COBRA to eligible former employees, their spouses, and former spouses under health care service plan contracts and disability insurance policies issued, amended, delivered, or renewed in this state on or after January 1, 1999, to the same extent as an employer whose plan is subject to COBRA.

Since a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program by expanding the definition of a crime.

(3) 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 people of the State of California do enact as follows:

SECTION 1. Article 4.5 (commencing with Section 1366.20) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 4.5. California Cobra Program

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

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

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 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, including a specialized 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 this section.

(c) ''Qualified beneficiary'' means any individual who, on the date of 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).

(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 or subscriber.

(2) The termination or reduction of hours of the covered employee’s or subscriber’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 dependent only, the covered employee’s or subscriber’s eligibility for coverage 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) employs fewer than 20 eligible employees on at least 50 percent of its working days during the preceding calendar year, (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.

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

(a) Individuals who are entitled or become entitled to coverage pursuant to Title XVIII of the United States Social Security Act (Medicare), as amended or superseded.

(b) Individuals 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 beneficiary is or becomes covered.

(c) Individuals who are covered, become covered, or could become covered 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 could become covered 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.

1366.23. (a) Every group health care service plan contract, or 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 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 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 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 and group service agreement had the employer not terminated the group service agreement or contract with the previous group benefit plan.

(c) A health care service plan that provides coverage for basic health care services as well as coverage for dental and vision care shall not be required to offer to qualified beneficiaries continuation coverage for basic health care services unless the health care service plan is the only plan or insurer providing a group benefit plan to the employees of the employer. In no case shall a health care service plan that provides coverage for basic health care services as well as coverage for dental and vision care within a single group benefit plan be required to offer qualified beneficiaries continuation coverage for dental or vision care only.

(d) Any child who is born to a qualified beneficiary or who is placed for adoption with a qualified beneficiary during the period of continuation coverage provided by this article shall be entitled to receive benefits pursuant to this article, if the child is enrolled by the qualified beneficiary under a group benefit plan as a dependent of

that beneficiary within 30 days of the child's birth or placement for adoption.

1366.24. (a) Every health care service plan shall disclose to subscribers of group benefit plans subject to this article the ability to continue coverage pursuant to this article in the plan's evidence of coverage.

(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 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, 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 of the qualifying event, (2) the date the qualified beneficiary is given notice pursuant to subdivision (d) of Section 1366.25 of the ability to continue coverage under the group benefit plan by either the health care service plan or his or her employer, or (3) the date coverage under the employer's group benefit plan terminates. 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 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 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 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) Every plan evidence of coverage that is issued, amended, or renewed after January 1, 1999, shall contain the information required by this section. Prior to January 1, 1999, plans shall provide to all qualified beneficiaries identified by the employer pursuant to subdivision (a) of Section 1366.25 a written notice containing the information required by this section.

(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, a subscriber or eligible family member 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.

1366.25. (a) Every group service agreement between a health care service plan and an employer subject to this chapter shall require the employer to notify the plan of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 1366.21, within 31 days of the qualifying event.

(b) Every group service agreement between a plan and an employer 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, a minimum of 30 days prior to the termination, 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. Notwithstanding subdivision (a), the

group service agreement between the health care service plan and the employer shall require the employer to provide to a qualified beneficiary subject to this section the necessary benefits information, premium information, enrollment forms, and instructions consistent with the the disclosure required by subdivision (c) of Section 1366.24 to allow the qualified beneficiary to continue coverage. This information shall be sent to the qualified beneficiary's last known address, as provided by the health care service plan, disability insurer, or self-funded employee welfare benefit plan currently providing continuation coverage to the qualified beneficiary.

(c) A health care service plan may contract with an employer, or an administrator, to perform the administrative requirements of this article, including required notifications and collecting and forwarding premiums to the health care service plan.

(d) Every health care service plan, or employer 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 instructions consistent with the notice requirements contained in subdivisions (b) and (c) of Section 1359.24 to allow the qualified beneficiary to formally elect continuation coverage. This information shall be sent to the qualified beneficiary's last known address.

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.

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 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 or the employee's becoming entitled to benefits under Title XVIII of the United States Social Security Act.

(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 Section 1366.21, and determined, under Title II or Title XVI of the Social Security Act, to be disabled at the time of termination of employment or eligibility or within 60 days afterward, the date 29 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. 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.

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

(b) If the group service agreement between the plan and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate pursuant to this section, 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.

1366.28. A health care service plan subject to this article shall not be obligated to provide continuation coverage to a qualified beneficiary pursuant to this article if an enrollee fails to make the notification required by Section 1366.24, or if the employer of the enrollee fails to comply with Section 1366.25.

SEC. 2. 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, 1996, that provides hospital, medical, or surgical expense coverage under an employer-sponsored group plan for an employer subject to COBRA, as defined herein, 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 for himself or herself and for any spouse, the employee or spouse may further continue benefits beyond the date coverage under 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 had remained in force. For the employee or spouse, continuation coverage following the end of COBRA is subject to payment of premiums to the health care service plan. Individuals ineligible for 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 is scheduled to end.

(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, 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 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, the former spouse may further continue benefits beyond the date coverage

under 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 had remained in force. Continuation coverage following the end of 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, 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 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 is adjusted for the age of the specific employee 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. 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.

(2) If the premium charged to the employer for a specific employee is not adjusted for age of the specific employee, 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. 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 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.

(g) This section shall remain in effect only until January 1, 1999, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 1999, deletes or extends that date.

SEC. 3. Section 1373.621 is added to the Health and Safety Code, 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 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.

(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, 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, 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 is adjusted for the age of the specific employee 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. 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.

(2) If the premium charged to the employer for a specific employee is not adjusted for age of the specific employee, 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. 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) This section shall take effect on January 1, 1999.

SEC. 4. 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, 1996, that provides hospital, medical, or surgical expense coverage

under an employer-sponsored group plan for an employer subject to COBRA, as defined herein, 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 for himself or herself and for any spouse, the employee or spouse may further continue benefits beyond the date coverage under 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 had remained in force. For the employee or spouse, continuation coverage following the end of COBRA is subject to payment of premiums to the insurer. Individuals ineligible for 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 is scheduled to end.

(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, 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 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, the former

spouse may further continue benefits beyond the date coverage under 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 had remained in force. Continuation coverage following the end of 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, 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 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 is adjusted for the age of the specific employee 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. 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.

(2) If the premium charged to the employer for a specific employee is not adjusted for age of the specific employee, 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. 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 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.

(g) This section shall remain in effect only until January 1, 1999, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 1999, deletes or extends that date.

SEC. 5. Section 10116.5 is added to the Insurance Code, 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 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.

(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, 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, 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 is adjusted for the age of the specific employee 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. 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.

(2) If the premium charged to the employer for a specific employee is not adjusted for age of the specific employee, 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. 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) This section shall take effect on January 1, 1999.

SEC. 6. Article 1.7 (commencing with Section 10128.50) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 1.7. California Cobra Program

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

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

10128.51. (a) ‘‘Continuation coverage’’ means extended coverage under the group benefit plan under which an eligible employee 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 date of 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.

(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 or insured.

(2) The termination or reduction of hours of the covered employee’s or insured’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 dependent only, the covered employee’s or insured’s eligibility for coverage 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) employs fewer than 20 eligible employees on at least 50 percent of its working days during the preceding calendar year, (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.

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

(a) Individuals who are entitled or become entitled to coverage pursuant to Title XVIII of the United States Social Security Act (Medicare), as amended or superseded.

(b) Individuals 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 beneficiary is or becomes covered.

(c) Individuals who are covered, become covered, or could become covered 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 could become covered 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.

10128.53. (a) Every group disability insurance contract or policy, including those policies and contracts that provide vision-only and dental-only benefits, that provides coverage under a group benefit plan to an employer, 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 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 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 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 and group service agreement had the employer not

terminated the group service agreement or contract with the previous group benefit plan.

(c) A disability insurer that provides coverage for hospital, medical, and surgical care as well as coverage for dental and vision care shall not be required to offer to qualified beneficiaries continuation coverage for hospital, medical, and surgical care unless the disability insurer is the only health plan or disability insurer providing a group benefit plan to the employees of the employer. In no case shall a disability insurer that provides coverage for hospital, medical, and surgical care as well as coverage for dental and vision care within a single group benefit plan be required to offer qualified beneficiaries continuation coverage for dental or vision care only.

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

10128.54. (a) Every disability insurer shall disclose to policyholders or contractholders of group benefit plans subject to this article the ability to continue coverage pursuant to this article in the insurer's evidence of coverage.

(b) This disclosure shall state that all enrollees 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 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 enrollees 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, 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 of the qualifying event, (2) the date the qualified beneficiary is given notice pursuant to subdivision (d) of Section 10128.55 of the ability to continue coverage under the group benefit plan by either the

insurer or his or her employer, or (3) the date coverage under the employer's group benefit plan terminates. 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 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) Every group benefit plan evidence of coverage that is issued, amended, or renewed after January 1, 1999, shall contain the information required by this section. Prior to January 1, 1999, insurers shall provide to all qualified beneficiaries identified by the employer pursuant to subdivision (a) of Section 10128.55 a written notice containing the information required by this section.

(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 or eligible family member 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.

10128.55. (a) Every group benefit plan contract between a disability insurer and an employer subject to this article shall require the employer to notify the insurer of any employee who has had a qualifying event, as defined in paragraph (2) of subdivision (d) of Section 10128.51, within 31 days of the qualifying event.

(b) Every group benefit plan contract between a disability insurer and an employer 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 a minimum of 30 days prior to the termination, 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. Notwithstanding subdivision (a), the group benefit plan contract between the insurer and the employer shall require the employer to provide to a qualified beneficiary subject to this section the necessary benefits information, premium information, enrollment forms, and instructions consistent with the disclosure required by subdivision (c) of Section 10128.54 to allow the qualified beneficiary to continue coverage. This information shall be sent to the qualified beneficiary's last known address, as provided by the health care service plan, disability insurer, or self-funded employee welfare benefit plan currently providing continuation coverage to the qualified beneficiary.

(c) A disability insurer may contract with an employer, or an administrator, to perform the administrative requirements of this article, including required notifications and collecting and forwarding premiums to the insurer.

(d) Every insurer, or employer 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 instructions 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.

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.

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 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 or the employee's becoming entitled to benefits under Title XVIII of the United States Social Security Act.

(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 Section 10128.51, and determined, under Title II or Title XVI of the Social Security Act, to be disabled at the time of termination of employment or eligibility or within 60 days afterward, the date 29 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. 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.

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

(b) If the group service agreement between the insurer and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate pursuant to this section, 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.

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 enrollee fails to make the notification required by Section 10128.54, or if the employer of the enrollee fails to comply with Section 10128.55.

SEC. 7. 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.

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