§ 1373.6. Conversion coverage

This section does not apply to a specialized health care service plan contract or to a plan contract that primarily or solely supplements Medicare. The director may adopt rules consistent with federal law to govern the discontinuance and replacement of plan contracts that primarily or solely supplement Medicare.

(a)(1) Every group contract entered into, amended, or renewed on or after September 1, 2003, that provides hospital, medical, or surgical expense benefits for employees or members shall provide that an employee or member whose coverage under the group contract has been terminated by the employer shall be entitled to convert to nongroup membership, without evidence of insurability, subject to the terms and conditions of this section.

(2) If the health care service plan provides coverage under an individual health care service plan contract, other than conversion coverage under this section, it shall offer one of the two plans that it is required to offer to a federally eligible defined individual pursuant to Section 1366.35. The plan shall provide this coverage at the same rate established under Section 1399.805 for a federally eligible defined individual. A health care service plan that is federally qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) may charge a rate for the coverage that is consistent with the provisions of that act.

(3) If the health care service plan does not provide coverage under an individual health care service plan contract, it shall offer a health benefit plan contract that is the same as a health benefit contract offered to a federally eligible defined individual pursuant to Section 1366.35. The health care service plan may offer either the most popular health maintenance organization model plan or the most popular preferred provider organization plan, each of which has the greatest number of enrolled individuals for its type of plan as of January 1 of the prior year, as reported by plans that provide coverage under an individual health care service plan contract to the department or the Department of Insurance by January 31, 2003, and annually thereafter. A health care service plan subject to this paragraph shall provide this coverage with the same cost-sharing terms and at the same premium as a health care service plan providing coverage to that individual under an individual health care service plan contract pursuant to Section 1399.805. The health care service plan shall file the health benefit plan it will offer, including the premium it will charge and the cost-sharing terms of the plan, with the Department of Managed Health Care.

(b) A conversion contract shall not be required to be made available to an employee or member if termination of his or her coverage under the group contract occurred for any of the following reasons:

(1) The group contract terminated or an employer's participation terminated and the group contract is replaced by similar coverage under another group contract within 15 days of the date of termination of the group coverage or the subscriber's participation.

(2) The employee or member failed to pay amounts due the health care service plan.

(3) The employee or member was terminated by the health care service plan from the plan for good cause.

(4) The employee or member knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan.

(5) The employer's hospital, medical, or surgical expense benefit program is self-insured.

(c) A conversion contract is not required to be issued to any person if any of the following facts are present:

(1) The person is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act.

(2) The person is covered by or is eligible for hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured.

(3) The person is covered for similar benefits by an individual policy or contract.

(4) The person has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(d) Benefits of a conversion contract shall meet the requirements for benefits under this chapter.

(e) Unless waived in writing by the plan, written application and first premium payment for the conversion contract shall be made not later than 63 days after termination from the group. A conversion contract shall be issued by the plan which shall be effective on the day following the termination of coverage under the group contract if the written application and the first premium payment for the conversion contract are made to the plan not later than 63 days after the termination of coverage, unless these requirements are waived in writing by the plan.

(f) The conversion contract shall cover the employee or member and his or her dependents who were covered under the group contract on the date of their termination from the group.

(g) A notification of the availability of the conversion coverage shall be included in each evidence of coverage. However, it shall be the sole responsibility of the employer to notify its employees of the availability, terms, and conditions of the conversion coverage which responsibility shall be satisfied by notification within 15 days of termination of group coverage. Group coverage shall not be deemed terminated until the expiration of any continuation of the group coverage. For purposes of this subdivision, the employer shall not be deemed the agent of the plan for purposes of notification of the availability, terms, and conditions of conversion coverage.

(h) As used in this section, "hospital, medical, or surgical benefits under state or federal law" do not include benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Title XIX of the United States Social Security Act.

(i) Every group contract entered into, amended, or renewed before September 1, 2003, shall be subject to the provisions of this section as it read prior to its amendment by Assembly Bill 1401 of the 2001-02 Regular Session.

(j)(1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plan contracts previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment.

(3) For purposes of this subdivision, the following definitions apply:

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

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

HISTORY:

Added Stats 1981 ch 1096 § 1, operative January 1, 1983. Amended Stats 1982 ch 1038 § 1, effective September 14, 1982, ch 1186 § 1.5; Stats 1983 ch 642 § 1; Stats 1984 ch 914 § 1; Stats 1992 ch 287 § 4 (SB 925), effective July 21, 1992; Stats 2002 ch 794 § 5 (AB 1401); Stats 2013 ch 441 § 5 (AB 1180), effective October 1, 2013.

§ 1373.62. [Section repealed 2008.]

HISTORY:

Added Stats 2002 ch 794 § 6 (AB 1401), operative September 1, 2003, inoperative September 1, 2007, repealed January 1, 2008. Amended Stats 2006 ch 683 § 1 (SB 1702), effective January 1, 2007, operative until December 31, 2007. Repealed, January 1, 2008, by its own terms. The repealed section related to standard benefit plan, and pilot program.