Assembly Bill No. 2088

Passed the Assembly August 28, 2014

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Chief Clerk of the Assembly

Passed the Senate August 27, 2014

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2014, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Section 1367.010 to the Health and Safety Code, and to add Section 10112.9 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2088, Roger Hernández. Health insurance: minimum value: large group market policies.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014, and exempts health insurance coverage that provides excepted benefits from those reforms. PPACA requires each state to establish an American Health Benefits Exchange and allows qualified individuals to obtain premium assistance for coverage purchased through the Exchange. PPACA specifies that this premium assistance is not available if the individual is eligible for affordable employer-sponsored coverage that provides minimum value, as specified.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires that health benefit plans issued by health insurers and health care service plans in the small group market and the individual market comply with specified requirements. Existing law defines a health benefit plan for the purpose of health benefit plans issued by health insurers to exclude a policy or certificate of specified disease or hospital confinement indemnity if the insurer certifies to the commissioner that the policy is being offered as supplemental health insurance and not as a substitute for essential health benefits. Existing law requires an insurer issuing these policies in the small group market or the individual market to require that the persons to be covered are covered by coverage that is not designed to serve as supplemental coverage.

This bill would extend that requirement to a health care service plan that offers, amends, or renews a group health plan contract and an insurer issuing a policy, except a health care service plan or insurer issuing a specialized health care service plan or policy, that provides less than 60% minimum value in the large group market and would require that the persons to be covered are also covered by a contract or plan that provides at least 60% minimum value. The bill would require a health care service plan and an insurer, except a health care service plan or insurer issuing a specialized health care service plan or policy, issuing those plan contracts and policies in the large group market to file a certification with the director or commissioner stating that the policies are being offered or marketed as supplemental health insurance and not as a substitute for minimum essential coverage. This bill would exempt an insurer that is subject to specified disclosure requirements from these provisions. By expanding the scope of an existing crime, this bill would impose a state-mandated local program.

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

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

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

SECTION 1. Section 1367.010 is added to the Health and Safety Code, immediately following Section 1367.009, to read:

1367.010. (a) A health care service plan, except a health care service plan offering a specialized health care service plan contract, that offers, amends, or renews a group plan contract that provides minimum value of less than 60 percent to a large group shall require that the persons to be covered by the plan contract are covered by an individual or group plan contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans and that provides at least 60 percent minimum value.

(b) A health care service plan, except a health care service plan offering a specialized health care service plan contract, may offer,

market, or sell a health plan contract in the large group market that provides a minimum of less than 60 percent if the health care service plan complies with the following, in addition to complying with subdivision (a):

(1) The health care service plan files, on or before March 1 of each year, a certification with the director that contains the statement and information described in paragraph (2).

(2) The certification required in paragraph (1) shall contain the following:

(A) A statement from the health care service plan certifying that group plan contract described in this section (i) is being offered and marketed as supplemental health insurance and not as a substitute for coverage that provides minimum essential coverage as defined in Section 5000A of the federal Internal Revenue Code, and (ii) the disclosure form as described in Section 1363 contains the following statement prominently on the first page:

"This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

(B) A summary description of each group plan contract described in this section.

(3) In the case of a group plan contract that is described in this section and that is offered for the first time in this state with respect to plan years on or after July 1, 2015, the health care service plan files with the director the information and statement required in paragraph (2) at least 30 days prior to the date that the plan contract is issued or delivered in this state.

(c) For purposes of this section, a plan provides a minimum value of at least 60 percent if it complies with Section 36B(c)(2)(C) of the federal Internal Revenue Code and any regulations or guidance adopted under that section.

(d) For purposes of this section, the following definitions apply:

(1) "Large group health care service plan contract" means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(2) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

SEC. 2. Section 10112.9 is added to the Insurance Code, to read:

10112.9. (a) An insurer, except an insurer issuing a specialized health insurance policy, issuing a policy or certificate of health insurance that provides a minimum value of less than 60 percent to a large group shall require that the persons to be covered by the policy are covered by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or government plans and that provides at least 60 percent minimum value.

(b) An insurer, except an insurer offering a specialized health insurance policy, may offer, market, or sell a policy or certificate of health insurance in the large group market that provides a minimum value of less than 60 percent if the insurer offering the policy or certificate complies with the following, in addition to complying with subdivision (a):

(1) The insurer files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in paragraph (2).

(2) The certification required in paragraph (1) shall contain the following:

(A) A statement from the insurer certifying that policies or certificates described in this section (i) are being offered and marketed as supplemental health insurance and not as a substitute for coverage that provides minimum essential coverage as defined in Section 5000A of the federal Internal Revenue Code, and (ii) the disclosure form as described in Section 10603 contains the following statement prominently on the first page:

"This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law."

(B) A summary description of each policy or certificate described in this section.

(3) In the case of a policy or certificate that is described in this section and that is offered for the first time in this state with respect to plan years on or after July 1, 2015, the insurer files with the commissioner the information and statement required in paragraph (2) at least 30 days prior to the date that the policy or certificate is issued or delivered in this state.

(c) For purposes of this section, a plan provides a minimum value of at least 60 percent if it complies with Section 36B(c)(2)(C)

of the federal Internal Revenue Code and any regulations or guidance adopted under that section.

(d) This section shall not apply to an insurer that is subject to the disclosure requirements described in Section 10198.61.

(e) For purposes of this section, the following definitions apply:

(1) "Large group" means a group that is not a small employer, as defined in Section 10753.

(2) "Plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

SEC. 3. 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.

Approved _____, 2014

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Governor