

AMENDED IN ASSEMBLY APRIL 5, 2016

AMENDED IN ASSEMBLY MARCH 18, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2115

Introduced by Assembly Member Wood

February 17, 2016

An act to amend ~~Section 1367.009~~ *Sections 1366.24 and 1366.50 of the Health and Safety Code, and to amend Sections 10128.54 and 10786 of the Insurance Code, relating to health care service plans: coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2115, as amended, Wood. ~~Health care service plans: levels of coverage: coverage: disclosures.~~

Existing law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law establishes the California Health Benefit Exchange within state government for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the 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 Department of Insurance. Existing law requires specified health care service plans and health insurers to provide to individuals who cease to be enrolled in individual or group health care coverage a notice informing those individuals that they may be eligible for

reduced-cost coverage through the California Health Benefit Exchange or no-cost coverage through Medi-Cal. Existing law also requires every disclosure form issued by a health care service plan or insurer for specified group benefit plans to include a statement notifying the individual to examine his or her options carefully before declining the group coverage.

This bill would instead require every disclosure form issued by a health care service plan or insurer for specified group benefit plans to include a statement notifying the individual that he or she may be eligible for reduced-cost coverage through the California Health Benefit Exchange, no-cost coverage through Medi-Cal, coverage through an insured spouse, or free or discounted prescription medicines through a manufacturer's patient assistance program. The bill would also require a statement regarding patient assistance programs to be included in the notice from health care service plans and health insurers to individuals who cease to be enrolled in individual or group health care coverage. Because a willful violation of these requirements by a health care service plan would be a crime, the 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.

~~Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA establishes annual limits on deductibles for employer-sponsored plans and defines bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets.~~

~~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, including defining levels of coverage. Existing law makes a willful violation of the act a crime. Existing law requires the actuarial value for nongrandfathered small group markets to be determined in accordance with, among other things, a consideration by the Department of Managed Health Care, in consultation with the Department of Insurance and the California Health Benefit Exchange, of whether to exercise state-level flexibility with~~

respect to the actuarial value calculator in order to take into account the unique characteristics of the California health care coverage market.

~~This bill would require the Department of Managed Health Care to also work in consultation with the State Department of Health Care Services in making the above consideration.~~

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: ~~no~~-yes.

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

1 SECTION 1. Section 1366.24 of the Health and Safety Code
2 is amended to read:

3 1366.24. (a) Every health care service plan evidence of
4 coverage, provided for group benefit plans subject to this article,
5 that is issued, amended, or renewed on or after January 1, 1999,
6 shall disclose to covered employees of group benefit plans subject
7 to this article the ability to continue coverage pursuant to this
8 article, as required by this section.

9 (b) This disclosure shall state that all enrollees who are eligible
10 to be qualified beneficiaries, as defined in subdivision (c) of
11 Section 1366.21, shall be required, as a condition of receiving
12 benefits pursuant to this article, to notify, in writing, the health
13 care service plan, or the employer if the employer contracts to
14 perform the administrative services as provided for in Section
15 1366.25, of all qualifying events as specified in paragraphs (1),
16 (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60
17 days of the date of the qualifying event. This disclosure shall
18 inform enrollees that failure to make the notification to the health
19 care service plan, or to the employer when under contract to
20 provide the administrative services, within the required 60 days
21 will disqualify the qualified beneficiary from receiving continuation
22 coverage pursuant to this article. The disclosure shall further state
23 that a qualified beneficiary who wishes to continue coverage under
24 the group benefit plan pursuant to this article must request the
25 continuation in writing and deliver the written request, by first-class
26 mail, or other reliable means of delivery, including personal
27 delivery, express mail, or private courier company, to the health
28 care service plan, or to the employer if the plan has contracted
29 with the employer for administrative services pursuant to
30 subdivision (d) of Section 1366.25, within the 60-day period

1 following the later of (1) the date that the enrollee's coverage under
2 the group benefit plan terminated or will terminate by reason of a
3 qualifying event, or (2) the date the enrollee was sent notice
4 pursuant to subdivision (e) of Section 1366.25 of the ability to
5 continue coverage under the group benefit plan. The disclosure
6 required by this section shall also state that a qualified beneficiary
7 electing continuation shall pay to the health care service plan, in
8 accordance with the terms and conditions of the plan contract,
9 which shall be set forth in the notice to the qualified beneficiary
10 pursuant to subdivision (d) of Section 1366.25, the amount of the
11 required premium payment, as set forth in Section 1366.26. The
12 disclosure shall further require that the qualified beneficiary's first
13 premium payment required to establish premium payment be
14 delivered by first-class mail, certified mail, or other reliable means
15 of delivery, including personal delivery, express mail, or private
16 courier company, to the health care service plan, or to the employer
17 if the employer has contracted with the plan to perform the
18 administrative services pursuant to subdivision (d) of Section
19 1366.25, within 45 days of the date the qualified beneficiary
20 provided written notice to the health care service plan or the
21 employer, if the employer has contracted to perform the
22 administrative services, of the election to continue coverage in
23 order for coverage to be continued under this article. This
24 disclosure shall also state that the first premium payment must
25 equal an amount sufficient to pay any required premiums and all
26 premiums due, and that failure to submit the correct premium
27 amount within the 45-day period will disqualify the qualified
28 beneficiary from receiving continuation coverage pursuant to this
29 article.

30 (c) The disclosure required by this section shall also describe
31 separately how qualified beneficiaries whose continuation coverage
32 terminates under a prior group benefit plan pursuant to subdivision
33 (b) of Section 1366.27 may continue their coverage for the balance
34 of the period that the qualified beneficiary would have remained
35 covered under the prior group benefit plan, including the
36 requirements for election and payment. The disclosure shall clearly
37 state that continuation coverage shall terminate if the qualified
38 beneficiary fails to comply with the requirements pertaining to
39 enrollment in, and payment of premiums to, the new group benefit

1 plan within 30 days of receiving notice of the termination of the
2 prior group benefit plan.

3 (d) Prior to August 1, 1998, every health care service plan shall
4 provide to all covered employees of employers subject to this
5 article a written notice containing the disclosures required by this
6 section, or shall provide to all covered employees of employers
7 subject to this section a new or amended evidence of coverage that
8 includes the disclosures required by this section. Any specialized
9 health care service plan that, in the ordinary course of business,
10 maintains only the addresses of employer group purchasers of
11 benefits and does not maintain addresses of covered employees,
12 may comply with the notice requirements of this section through
13 the provision of the notices to its employer group purchasers of
14 benefits.

15 (e) Every plan disclosure form issued, amended, or renewed on
16 and after January 1, 1999, for a group benefit plan subject to this
17 article shall provide a notice that, under state law, an enrollee may
18 be entitled to continuation of group coverage and that additional
19 information regarding eligibility for this coverage may be found
20 in the plan's evidence of coverage.

21 ~~(f) Every disclosure issued, amended, or renewed on and after~~
22 ~~July 1, 2006, for a group benefit plan subject to this article shall~~
23 ~~include the following notice:~~

24 ~~“Please examine your options carefully before declining this~~
25 ~~coverage. You should be aware that companies selling individual~~
26 ~~health insurance typically require a review of your medical history~~
27 ~~that could result in a higher premium or you could be denied~~
28 ~~coverage entirely.”~~

29 (f) *A disclosure issued, amended, or renewed on or after July*
30 *1, 2017, for a group plan subject to this article shall include the*
31 *following notice:*

32
33 *“In addition to your coverage continuation options, you may be*
34 *eligible for the following:*

35 *(1) Coverage through Covered California. By enrolling through*
36 *Covered California during the annual open enrollment period,*
37 *you may qualify for lower monthly premiums and lower*
38 *out-of-pocket costs. Your family members may also qualify for*
39 *coverage through Covered California. To find out more about how*

1 *to apply through Covered California, visit the Covered California*
2 *Internet Web site at <http://www.coveredca.com>.*

3 *(2) Coverage through Medi-Cal. Depending on your income,*
4 *you may qualify for low- or no-cost coverage through Medi-Cal*
5 *and can apply anytime. Your family members may also qualify for*
6 *Medi-Cal. To find out more about how to apply for Medi-Cal, visit*
7 *the Covered California Internet Web site at*
8 *<http://www.coveredca.com>.*

9 *(3) Coverage through an insured spouse. If your spouse has*
10 *coverage that extends to family members, you may be eligible to*
11 *be added to that benefit plan.*

12 *(4) Free or discounted prescription medicines through a*
13 *manufacturer. You may be eligible for a patient assistance program*
14 *offered by the manufacturer of any medicines you currently may*
15 *be taking. To find out more about these programs, contact the*
16 *manufacturer of your medicine or use an Internet Web site search*
17 *tool, such as those provided by the Partnership for Prescription*
18 *Assistance at <https://www.ppars.org> or RxAssist at*
19 *<http://www.rxassist.org>.”*

20
21 *SEC. 2. Section 1366.50 of the Health and Safety Code is*
22 *amended to read:*

23 *1366.50. (a) On and after January 1, ~~2014~~, 2017, a health care*
24 *service plan providing individual or group health care coverage*
25 *shall provide to enrollees or subscribers who cease to be enrolled*
26 *in coverage a notice informing them that they may be eligible for*
27 *reduced-cost coverage through the California Health Benefit*
28 *Exchange established under Title 22 (commencing with Section*
29 *100500) of the Government ~~Code~~ or Code, no-cost coverage*
30 *through ~~Medi-Cal~~ Medi-Cal, or free or reduced prescription*
31 *coverage medicines through a manufacturer’s patient assistance*
32 *program. The notice shall include information on obtaining*
33 *coverage or assistance pursuant to those programs, shall be in no*
34 *less than 12-point type, and shall be developed by the department,*
35 *no later than July 1, ~~2013~~, 2017, in consultation with the*
36 *Department of Insurance and the California Health Benefit*
37 *Exchange.*

38 *(b) The notice described in subdivision (a) may be incorporated*
39 *into or sent simultaneously with and in the same manner as any*
40 *other notices sent by the health care service plan.*

1 (c) This section shall not apply with respect to a specialized
2 health care service plan contract or a Medicare supplemental plan
3 contract.

4 *SEC. 3. Section 10128.54 of the Insurance Code is amended*
5 *to read:*

6 10128.54. (a) Every insurer's evidence of coverage for group
7 benefit plans subject to this article, that is issued, amended, or
8 renewed on or after January 1, 1999, shall disclose to covered
9 employees of group benefit plans subject to this article the ability
10 to continue coverage pursuant to this article, as required by this
11 section.

12 (b) This disclosure shall state that all insureds who are eligible
13 to be qualified beneficiaries, as defined in subdivision (c) of
14 Section 10128.51, shall be required, as a condition of receiving
15 benefits pursuant to this article, to notify, in writing, the insurer,
16 or the employer if the employer contracts to perform the
17 administrative services as provided for in Section 10128.55, of all
18 qualifying events as specified in paragraphs (1), (3), (4), and (5)
19 of subdivision (d) of Section 10128.51 within 60 days of the date
20 of the qualifying event. This disclosure shall inform insureds that
21 failure to make the notification to the insurer, or to the employer
22 when under contract to provide the administrative services, within
23 the required 60 days will disqualify the qualified beneficiary from
24 receiving continuation coverage pursuant to this article. The
25 disclosure shall further state that a qualified beneficiary who wishes
26 to continue coverage under the group benefit plan pursuant to this
27 article must request the continuation in writing and deliver the
28 written request, by first-class mail, or other reliable means of
29 delivery, including personal delivery, express mail, or private
30 courier company, to the disability insurer, or to the employer if
31 the plan has contracted with the employer for administrative
32 services pursuant to subdivision (d) of Section 10128.55, within
33 the 60-day period following the later of (1) the date that the
34 insured's coverage under the group benefit plan terminated or will
35 terminate by reason of a qualifying event, or (2) the date the insured
36 was sent notice pursuant to subdivision (e) of Section 10128.55
37 of the ability to continue coverage under the group benefit plan.
38 The disclosure required by this section shall also state that a
39 qualified beneficiary electing continuation shall pay to the disability
40 insurer, in accordance with the terms and conditions of the policy

1 or contract, which shall be set forth in the notice to the qualified
2 beneficiary pursuant to subdivision (d) of Section 10128.55, the
3 amount of the required premium payment, as set forth in Section
4 10128.56. The disclosure shall further require that the qualified
5 beneficiary's first premium payment required to establish premium
6 payment be delivered by first-class mail, certified mail, or other
7 reliable means of delivery, including personal delivery, express
8 mail, or private courier company, to the disability insurer, or to
9 the employer if the employer has contracted with the insurer to
10 perform the administrative services pursuant to subdivision (d) of
11 Section 10128.55, within 45 days of the date the qualified
12 beneficiary provided written notice to the insurer or the employer,
13 if the employer has contracted to perform the administrative
14 services, of the election to continue coverage in order for coverage
15 to be continued under this article. This disclosure shall also state
16 that the first premium payment must equal an amount sufficient
17 to pay all required premiums and all premiums due, and that failure
18 to submit the correct premium amount within the 45-day period
19 will disqualify the qualified beneficiary from receiving continuation
20 coverage pursuant to this article.

21 (c) The disclosure required by this section shall also describe
22 separately how qualified beneficiaries whose continuation coverage
23 terminates under a prior group benefit plan pursuant to Section
24 10128.57 may continue their coverage for the balance of the period
25 that the qualified beneficiary would have remained covered under
26 the prior group benefit plan, including the requirements for election
27 and payment. The disclosure shall clearly state that continuation
28 coverage shall terminate if the qualified beneficiary fails to comply
29 with the requirements pertaining to enrollment in, and payment of
30 premiums to, the new group benefit plan within 30 days of
31 receiving notice of the termination of the prior group benefit plan.

32 (d) Prior to August 1, 1998, every insurer shall provide to all
33 covered employees of employers subject to this article written
34 notice containing the disclosures required by this section, or shall
35 provide to all covered employees of employers subject to this
36 article a new or amended evidence of coverage that includes the
37 disclosures required by this section. Any insurer that, in the
38 ordinary course of business, maintains only the addresses of
39 employer group purchasers of benefits, and does not maintain
40 addresses of covered employees, may comply with the notice

1 requirements of this section through the provision of the notices
2 to its employer group purchases of benefits.

3 (e) Every disclosure form issued, amended, or renewed on and
4 after January 1, 1999, for a group benefit plan subject to this article
5 shall provide a notice that, under state law, an insured may be
6 entitled to continuation of group coverage and that additional
7 information regarding eligibility for this coverage may be found
8 in the evidence of coverage.

9 ~~(f) Every disclosure form issued, amended, or renewed on and~~
10 ~~after July 1, 2006, for a group benefit plan subject to this article~~
11 ~~shall include the following notice:~~

12 ~~“Please examine your options carefully before declining this~~
13 ~~coverage. You should be aware that companies selling individual~~
14 ~~health insurance typically require a review of your medical history~~
15 ~~that could result in a higher premium or you could be denied~~
16 ~~coverage entirely.”~~

17 (f) A disclosure issued, amended, or renewed on or after July
18 1, 2017, for a group plan subject to this article shall include the
19 following notice:

20
21 “In addition to your coverage continuation options, you may be
22 eligible for the following:

23 (1) Coverage through Covered California. By enrolling through
24 Covered California during the annual open enrollment period,
25 you may qualify for lower monthly premiums and lower
26 out-of-pocket costs. Your family members may also qualify for
27 coverage through Covered California. To find out more about how
28 to apply through Covered California, visit the Covered California
29 Internet Web site at <http://www.coveredca.com>.

30 (2) Coverage through Medi-Cal. Depending on your income,
31 you may qualify for low- or no-cost coverage through Medi-Cal
32 and can apply anytime. Your family members may also qualify for
33 Medi-Cal. To find out more about how to apply for Medi-Cal, visit
34 the Covered California Internet Web site at
35 <http://www.coveredca.com>.

36 (3) Coverage through an insured spouse. If your spouse has
37 coverage that extends to family members, you may be eligible to
38 be added to that benefit plan.

39 (4) Free or discounted prescription medicines through a
40 manufacturer. You may be eligible for a patient assistance program

1 *offered by the manufacturer of any medicines you currently may*
2 *be taking. To find out more about these programs, contact the*
3 *manufacturer of your medicine or use an Internet Web site search*
4 *tool, such as those provided by the Partnership for Prescription*
5 *Assistance at <https://www.ppars.org> or RxAssist at*
6 *<http://www.rxassist.org>.”*
7

8 *SEC. 4. Section 10786 of the Insurance Code is amended to*
9 *read:*

10 10786. (a) On and after January 1, ~~2014~~, 2017, a health insurer
11 providing health insurance coverage shall provide to policyholders
12 in individual policies or certificate holders in group policies who
13 cease to be enrolled in coverage a notice informing them that they
14 may be eligible for reduced-cost coverage through the California
15 Health Benefit Exchange established under Title 22 (commencing
16 with Section 100500) of the Government ~~Code~~ or *Code*, no-cost
17 coverage through ~~Medi-Cal~~. *Medi-Cal, or free or reduced*
18 *prescription coverage medicines through a manufacturer’s patient*
19 *assistance program.* The notice shall include information on
20 obtaining coverage pursuant to those programs, shall be in no less
21 than 12-point type, and shall be developed by the department, no
22 later than July 1, ~~2013~~, 2017, in consultation with the Department
23 of Managed Health Care and the California Health Benefit
24 Exchange.

25 (b) The notice described in subdivision (a) may be incorporated
26 into or sent simultaneously with and in the same manner as any
27 other notices sent by the health insurer.

28 (c) This section shall not apply with respect to a specialized
29 health insurance policy or a health insurance policy consisting
30 solely of coverage of excepted benefits as described in Section
31 2722 of the federal Public Health Service Act (42 U.S.C. Sec.
32 300gg-21).

33 *SEC. 5. No reimbursement is required by this act pursuant to*
34 *Section 6 of Article XIII B of the California Constitution because*
35 *the only costs that may be incurred by a local agency or school*
36 *district will be incurred because this act creates a new crime or*
37 *infraction, eliminates a crime or infraction, or changes the penalty*
38 *for a crime or infraction, within the meaning of Section 17556 of*
39 *the Government Code, or changes the definition of a crime within*

1 *the meaning of Section 6 of Article XIII B of the California*
2 *Constitution.*

3 ~~SECTION 1. Section 1367.009 of the Health and Safety Code~~
4 ~~is amended to read:~~

5 ~~1367.009. (a) Levels of coverage for the nongrandfathered~~
6 ~~small group market are defined as follows:~~

7 ~~(1) Bronze level: A health care service plan contract in the~~
8 ~~bronze level shall provide a level of coverage that is actuarially~~
9 ~~equivalent to 60 percent of the full actuarial value of the benefits~~
10 ~~provided under the plan contract.~~

11 ~~(2) Silver level: A health care service plan contract in the silver~~
12 ~~level shall provide a level of coverage that is actuarially equivalent~~
13 ~~to 70 percent of the full actuarial value of the benefits provided~~
14 ~~under the plan contract.~~

15 ~~(3) Gold level: A health care service plan contract in the gold~~
16 ~~level shall provide a level of coverage that is actuarially equivalent~~
17 ~~to 80 percent of the full actuarial value of the benefits provided~~
18 ~~under the plan contract.~~

19 ~~(4) Platinum level: A health care service plan contract in the~~
20 ~~platinum level shall provide a level of coverage that is actuarially~~
21 ~~equivalent to 90 percent of the full actuarial value of the benefits~~
22 ~~provided under the plan contract.~~

23 ~~(b) Actuarial value for nongrandfathered small employer health~~
24 ~~care service plan contracts shall be determined in accordance with~~
25 ~~all of the following:~~

26 ~~(1) Actuarial value shall not vary by more than plus or minus~~
27 ~~2 percent.~~

28 ~~(2) Actuarial value shall be determined on the basis of essential~~
29 ~~health benefits as defined in Section 1367.005 and as provided to~~
30 ~~a standard, nonelderly population. For this purpose, a standard~~
31 ~~population shall not include those receiving coverage through the~~
32 ~~Medi-Cal or Medicare programs.~~

33 ~~(3) The department may use the actuarial value methodology~~
34 ~~developed consistent with Section 1302(d) of PPACA.~~

35 ~~(4) The actuarial value for pediatric dental benefits, whether~~
36 ~~offered by a full service plan or a specialized plan, shall be~~
37 ~~consistent with federal law and guidance applicable to the plan~~
38 ~~type.~~

39 ~~(5) The department, in consultation with the Department of~~
40 ~~Insurance, the State Department of Health Care Services, and the~~

1 Exchange, shall consider whether to exercise state-level flexibility
2 with respect to the actuarial value calculator in order to take into
3 account the unique characteristics of the California health care
4 coverage market, including the prevalence of health care service
5 plans, total cost of care paid for by the plan, price of care, patterns
6 of service utilization, and relevant demographic factors.

7 (6) Employer contributions toward health reimbursement
8 accounts and health savings accounts shall count toward the
9 actuarial value of the product in the manner specified in federal
10 rules and guidance.

11 (e) “PPACA” means the federal Patient Protection and
12 Affordable Care Act (Public Law 111-148), as amended by the
13 federal Health Care and Education Reconciliation Act of 2010
14 (Public Law 111-152), and any rules, regulations, or guidance
15 issued thereunder.