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:

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

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

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

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

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

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

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

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

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

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

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

"In addition to your coverage continuation options, you may be eligible for the following:

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

to apply through Covered California, visit the Covered California Internet Web site at http:www.coveredca.com.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"In addition to your coverage continuation options, you may be eligible for the following:

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

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

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

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

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

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

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

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

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

SEC. 5. 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.

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

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

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

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

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

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

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

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

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

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

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

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

~~Exchange, shall consider 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, including the prevalence of health care service plans, total cost of care paid for by the plan, price of care, patterns of service utilization, and relevant demographic factors.~~

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

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

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