

AMENDED IN ASSEMBLY APRIL 20, 2016

AMENDED IN ASSEMBLY APRIL 5, 2016

AMENDED IN ASSEMBLY MARCH 18, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

## **ASSEMBLY BILL**

**No. 2115**

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**Introduced by Assembly Member Wood**

February 17, 2016

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An act to amend 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 coverage.

### LEGISLATIVE COUNSEL'S DIGEST

AB 2115, as amended, Wood. Health care 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~~, *spouse or parent*, 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.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: 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

1 benefits pursuant to this article, to notify, in writing, the health  
2 care service plan, or the employer if the employer contracts to  
3 perform the administrative services as provided for in Section  
4 1366.25, of all qualifying events as specified in paragraphs (1),  
5 (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60  
6 days of the date of the qualifying event. This disclosure shall  
7 inform enrollees that failure to make the notification to the health  
8 care service plan, or to the employer when under contract to  
9 provide the administrative services, within the required 60 days  
10 will disqualify the qualified beneficiary from receiving continuation  
11 coverage pursuant to this article. The disclosure shall further state  
12 that a qualified beneficiary who wishes to continue coverage under  
13 the group benefit plan pursuant to this article must request the  
14 continuation in writing and deliver the written request, by first-class  
15 mail, or other reliable means of delivery, including personal  
16 delivery, express mail, or private courier company, to the health  
17 care service plan, or to the employer if the plan has contracted  
18 with the employer for administrative services pursuant to  
19 subdivision (d) of Section 1366.25, within the 60-day period  
20 following the later of (1) the date that the enrollee's coverage under  
21 the group benefit plan terminated or will terminate by reason of a  
22 qualifying event, or (2) the date the enrollee was sent notice  
23 pursuant to subdivision (e) of Section 1366.25 of the ability to  
24 continue coverage under the group benefit plan. The disclosure  
25 required by this section shall also state that a qualified beneficiary  
26 electing continuation shall pay to the health care service plan, in  
27 accordance with the terms and conditions of the plan contract,  
28 which shall be set forth in the notice to the qualified beneficiary  
29 pursuant to subdivision (d) of Section 1366.25, the amount of the  
30 required premium payment, as set forth in Section 1366.26. The  
31 disclosure shall further require that the qualified beneficiary's first  
32 premium payment required to establish premium payment be  
33 delivered by first-class mail, certified mail, or other reliable means  
34 of delivery, including personal delivery, express mail, or private  
35 courier company, to the health care service plan, or to the employer  
36 if the employer has contracted with the plan to perform the  
37 administrative services pursuant to subdivision (d) of Section  
38 1366.25, within 45 days of the date the qualified beneficiary  
39 provided written notice to the health care service plan or the  
40 employer, if the employer has contracted to perform the

1 administrative services, of the election to continue coverage in  
2 order for coverage to be continued under this article. This  
3 disclosure shall also state that the first premium payment must  
4 equal an amount sufficient to pay any required premiums and all  
5 premiums due, and that failure to submit the correct premium  
6 amount within the 45-day period will disqualify the qualified  
7 beneficiary from receiving continuation coverage pursuant to this  
8 article.

9 (c) The disclosure required by this section shall also describe  
10 separately how qualified beneficiaries whose continuation coverage  
11 terminates under a prior group benefit plan pursuant to subdivision  
12 (b) of Section 1366.27 may continue their coverage for the balance  
13 of the period that the qualified beneficiary would have remained  
14 covered under the prior group benefit plan, including the  
15 requirements for election and payment. The disclosure shall clearly  
16 state that continuation coverage shall terminate if the qualified  
17 beneficiary fails to comply with the requirements pertaining to  
18 enrollment in, and payment of premiums to, the new group benefit  
19 plan within 30 days of receiving notice of the termination of the  
20 prior group benefit plan.

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

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

(f) A disclosure issued, amended, or renewed on or after July 1, 2017, for a group *benefit* 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 through Medi-Cal. Depending on your income, you may qualify for low- or no-cost coverage through 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~~. *spouse or parent*. If your spouse has coverage that extends to family members, you may be eligible to be added to that benefit plan. *Federal law does not require employers to offer coverage to spouses.*

(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>~~ *<http://www.rxassist.org>. The manufacturer determines which individuals and which prescription medications are eligible for the manufacturer’s program. This assistance does not constitute coverage and will not meet the requirements of the individual mandate under the Affordable Care Act.*”

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

1366.50. (a) On and after January 1, 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, no-cost coverage through 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, 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

1 receiving continuation coverage pursuant to this article. The  
2 disclosure shall further state that a qualified beneficiary who wishes  
3 to continue coverage under the group benefit plan pursuant to this  
4 article must request the continuation in writing and deliver the  
5 written request, by first-class mail, or other reliable means of  
6 delivery, including personal delivery, express mail, or private  
7 courier company, to the disability insurer, or to the employer if  
8 the plan has contracted with the employer for administrative  
9 services pursuant to subdivision (d) of Section 10128.55, within  
10 the 60-day period following the later of (1) the date that the  
11 insured's coverage under the group benefit plan terminated or will  
12 terminate by reason of a qualifying event, or (2) the date the insured  
13 was sent notice pursuant to subdivision (e) of Section 10128.55  
14 of the ability to continue coverage under the group benefit plan.  
15 The disclosure required by this section shall also state that a  
16 qualified beneficiary electing continuation shall pay to the disability  
17 insurer, in accordance with the terms and conditions of the policy  
18 or contract, which shall be set forth in the notice to the qualified  
19 beneficiary pursuant to subdivision (d) of Section 10128.55, the  
20 amount of the required premium payment, as set forth in Section  
21 10128.56. The disclosure shall further require that the qualified  
22 beneficiary's first premium payment required to establish premium  
23 payment be delivered by first-class mail, certified mail, or other  
24 reliable means of delivery, including personal delivery, express  
25 mail, or private courier company, to the disability insurer, or to  
26 the employer if the employer has contracted with the insurer to  
27 perform the administrative services pursuant to subdivision (d) of  
28 Section 10128.55, within 45 days of the date the qualified  
29 beneficiary provided written notice to the insurer or the employer,  
30 if the employer has contracted to perform the administrative  
31 services, of the election to continue coverage in order for coverage  
32 to be continued under this article. This disclosure shall also state  
33 that the first premium payment must equal an amount sufficient  
34 to pay all required premiums and all premiums due, and that failure  
35 to submit the correct premium amount within the 45-day period  
36 will disqualify the qualified beneficiary from receiving continuation  
37 coverage pursuant to this article.

38 (c) The disclosure required by this section shall also describe  
39 separately how qualified beneficiaries whose continuation coverage  
40 terminates under a prior group benefit plan pursuant to Section

1 10128.57 may continue their coverage for the balance of the period  
2 that the qualified beneficiary would have remained covered under  
3 the prior group benefit plan, including the requirements for election  
4 and payment. The disclosure shall clearly state that continuation  
5 coverage shall terminate if the qualified beneficiary fails to comply  
6 with the requirements pertaining to enrollment in, and payment of  
7 premiums to, the new group benefit plan within 30 days of  
8 receiving notice of the termination of the prior group benefit plan.

9 (d) Prior to August 1, 1998, every insurer shall provide to all  
10 covered employees of employers subject to this article written  
11 notice containing the disclosures required by this section, or shall  
12 provide to all covered employees of employers subject to this  
13 article a new or amended evidence of coverage that includes the  
14 disclosures required by this section. Any insurer that, in the  
15 ordinary course of business, maintains only the addresses of  
16 employer group purchasers of benefits, and does not maintain  
17 addresses of covered employees, may comply with the notice  
18 requirements of this section through the provision of the notices  
19 to its employer group ~~purchasers~~ *purchasers* of benefits.

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

26 (f) A disclosure issued, amended, or renewed on or after July  
27 1, 2017, for a group *benefit* plan subject to this article shall include  
28 the following notice:  
29

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

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

39 (2) Coverage through Medi-Cal. Depending on your income,  
40 you may qualify for low- or no-cost coverage through Medi-Cal



1 and can apply anytime. Your family members may also qualify  
2 for Medi-Cal. To find out more about how to apply for Medi-Cal,  
3 visit the Covered California Internet Web site at  
4 <http://www.coveredca.com>.

5 (3) Coverage through an insured ~~spouse~~. *spouse or parent*. If  
6 your spouse has coverage that extends to family members, you  
7 may be eligible to be added to that benefit plan. *Federal law does*  
8 *not require employers to offer coverage to spouses*.

9 (4) Free or discounted prescription medicines through a  
10 manufacturer. You may be eligible for a patient assistance program  
11 offered by the manufacturer of any medicines you currently may  
12 be taking. To find out more about these programs, contact the  
13 manufacturer of your medicine or use an Internet Web site search  
14 tool, such as those provided by the Partnership for Prescription  
15 Assistance at <https://www.ppars.org> or RxAssist at  
16 <http://www.rxassist.org>.” *http://www.rxassist.org. The*  
17 *manufacturer determines which individuals and which prescription*  
18 *medications are eligible for the manufacturer’s program. This*  
19 *assistance does not constitute coverage and will not meet the*  
20 *requirements of the individual mandate under the Affordable Care*  
21 *Act.*”  
22

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

25 10786. (a) On and after January 1, 2017, a health insurer  
26 providing health insurance coverage shall provide to policyholders  
27 in individual policies or certificate holders in group policies who  
28 cease to be enrolled in coverage a notice informing them that they  
29 may be eligible for reduced-cost coverage through the California  
30 Health Benefit Exchange established under Title 22 (commencing  
31 with Section 100500) of the Government Code, no-cost coverage  
32 through Medi-Cal, or free or reduced prescription coverage  
33 medicines through a manufacturer’s patient assistance program.  
34 The notice shall include information on obtaining coverage  
35 pursuant to those programs, shall be in no less than 12-point type,  
36 and shall be developed by the department, no later than July 1  
37 2017, in consultation with the Department of Managed Health  
38 Care and the California Health Benefit Exchange.

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

4 (c) This section shall not apply with respect to a specialized  
5 health insurance policy or a health insurance policy consisting  
6 solely of coverage of excepted benefits as described in Section  
7 2722 of the federal Public Health Service Act (42 U.S.C. Sec.  
8 300gg-21).

9 SEC. 5. No reimbursement is required by this act pursuant to  
10 Section 6 of Article XIII B of the California Constitution because  
11 the only costs that may be incurred by a local agency or school  
12 district will be incurred because this act creates a new crime or  
13 infraction, eliminates a crime or infraction, or changes the penalty  
14 for a crime or infraction, within the meaning of Section 17556 of  
15 the Government Code, or changes the definition of a crime within  
16 the meaning of Section 6 of Article XIII B of the California  
17 Constitution.