AMENDED IN SENATE JULY 15, 2010

AMENDED IN SENATE JUNE 22, 2010

AMENDED IN SENATE MAY 27, 2010

AMENDED IN ASSEMBLY MAY 10, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

# ASSEMBLY BILL No. 2787

**Introduced by Assembly Member Monning**
(Principal coauthor: Senator Alquist)

March 9, 2010

An act ~~to add Section 1374.18 to, and~~ to add Division 115 (commencing with Section 136000) to~~,~~ the Health and Safety Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2787, as amended, Monning. Office of the California Health Ombudsman.

Existing law, the federal Patient Protection and Affordable Care Act, requires the United States Secretary of Health and Human Services to award grants to states to enable them to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs and imposes specified eligibility requirements on states in order to receive those grants.

This bill would establish the Office of the California Health Ombudsman in state government, to be governed by a chief executive officer known as the California Health Ombudsman who would be appointed ~~in an unspecified manner~~ *by the Governor, subject to confirmation by the Senate*. The bill would require the ombudsman to,

among other things, educate consumers on their rights and responsibilities with respect to health care coverage, assist consumers with enrollment in health care coverage, and resolve problems with obtaining specified premium tax credits. The bill would also require the ombudsman to operate a specified hotline and Internet Web site and would require that the telephone number and Web site be included on every membership card and evidence of coverage issued to Medi-Cal beneficiaries and to individuals with coverage under health care service plans or health insurers*, as specified*. The bill would require the ombudsman to apply to the United States Secretary of Health and Human Services for a grant to implement these requirements and would create the California Health Ombudsman Trust Fund as a continuously appropriated fund in the State Treasury for purposes of the act. The bill would also impose ~~fees~~ *an annual fee* on health care service plans and health insurers for purposes of funding these provisions, as specified.

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

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

SECTION 1. Division 115 (commencing with Section 136000) is added to the Health and Safety Code, to read:

DIVISION 115. OFFICE OF THE CALIFORNIA HEALTH OMBUDSMAN

136000. (a) There is hereby created in state government an independent office of health care coverage consumer assistance called the Office of the California Health Ombudsman. The office shall operate in compliance with the criteria established by the United States Secretary of Health and Human Services and shall be under the direction of a chief executive officer who shall be known as the California Health Ombudsman. The ombudsman shall be appointed by——— *the Governor, subject to confirmation by the Senate*.

(b) The ombudsman shall, in coordination with the Department of Managed Health Care, the Department of Insurance, the State Department of Health Care Services, the Managed Risk Medical Insurance Board, the Exchange, as defined in subdivision (j), and consumer assistance organizations, receive and respond to

inquiries, complaints, and requests for assistance concerning health care coverage with respect to requirements under federal and state law.

(c) The ombudsman shall do all of the following with respect to all health care coverage available in California, including coverage available through public programs and coverage available through health care service plans under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code and health insurers under Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code:

(1) Assist with the filing of complaints and appeals, including appeals with the internal appeal or grievance process of the health care service plan, health insurer, or group health plan involved, and providing information about any external appeal process.

(2) Collect, track, quantify, and analyze problems and inquiries encountered by consumers with respect to health care coverage, including, but not limited to, the complaints reported to the ombudsman under subdivision (h). The ombudsman shall publicly report its analysis of these problems and inquiries at least annually on the Internet Web site of the office. The ombudsman shall track, analyze, and publicly report on complaints reported to the ombudsman under subdivision (h) according to the nature and resolution of the complaints and the health status, age, race, ethnicity, language, geographic region, and gender of the complainants in order to identify the most common types of problems and the problems faced by particular populations. In addition, the ombudsman shall track, analyze, and report on those complaints by health insurer or health care service plan and by the type of health care coverage program, including the timeliness of resolution of the complaints, and shall take into account the number of individuals enrolled in each health insurer or health care service plan and in each health care coverage program.

(3) Educate consumers on their rights and responsibilities with respect to health care coverage and provide this information in plain language.

(4) Assist consumers with enrollment in health care coverage by providing information, referral, and assistance.

(5) Resolve problems with obtaining premium tax credits under Section 36B of the Internal Revenue Code.

(6) Provide the assistance and education described in this subdivision to consumers with limited English language proficiency in their primary language.

(d) (1) In order to assist consumers in navigating and resolving problems with health care coverage and programs, the ombudsman shall do both of the following:

(A) Operate a HealthHelp hotline that is available 24 hours a day, seven days a week.

(B) Operate a HealthHelp Internet Web site, other social media, and up-to-date communication systems.

(2) The telephone number and Internet Web site for the HealthHelp hotline described in paragraph (1) shall be included on every membership card and evidence of coverage issued to the following:

(A) An individual insured under a policy of health insurance regulated under the Insurance Code. *A health insurer shall reissue membership cards that were issued to insureds prior to January 1, 2011, in order to comply with this paragraph.*

(B) An individual enrolled in a health care service plan contract regulated under Chapter 2.2 (commencing with Section 1340) of Division 2. *A plan shall reissue membership cards that were issued to enrollees prior to January 1, 2011, in order to comply with this paragraph.*

(C) A beneficiary of the Medi-Cal program. *Except with respect to Medi-Cal managed care plans subject to subparagraph (B), this requirement shall only apply to membership cards issued to beneficiaries on or after January 1, 2011.*

(e) In order to carry out the duties described in subdivision (c), the ombudsman shall utilize a network of local community-based non-profit consumer assistance programs with experience in the following areas:

(1) Assisting consumers in navigating the local health care system.

(2) Enrolling consumers in health care coverage.

(3) Resolving consumer problems associated with health care access.

(4) Serving consumers with special needs, including, but not limited to, consumers with limited English language proficiency, low-income consumers, consumers with disabilities, and consumers with multiple health conditions.

(5) Collecting and reporting data on the types of health care coverage problems consumers face.

(f) The ombudsman shall collect and report data to the United States Secretary of Health and Human Services on the types of problems and inquiries encountered by consumers.

(g) The ombudsman shall develop protocols and procedures for the resolution of consumer complaints and the establishment of responsibility or referral as appropriate with regard to the following agencies:

(1) The federal Department of Labor with respect to employee welfare benefit plans regulated under ERISA to enable the ombudsman to provide accurate information and referrals to consumers covered under those plans.

(2) The Centers for Medicare and Medicaid Services to enable the ombudsman to give accurate information and referrals for consumers covered under the Medicare Program.

(3) The Department of Managed Health Care regarding consumers enrolled in coverage under health care service plans regulated under Chapter 2.2 (commencing with Section 1340) of Division 2. The ombudsman shall also directly assist these consumers.

(4) The Department of Insurance regarding consumers with policies of health insurance regulated under the Insurance Code. The ombudsman shall also directly assist these consumers.

(5) The State Department of Health Care Services regarding consumers enrolled in the Medi-Cal Program. The ombudsman shall also directly assist these consumers.

(6) The Managed Risk Medical Insurance Board regarding consumers enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), and the federal temporary high risk pool established under Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). The ombudsman shall also directly assist these consumers.

(7) The Exchange regarding consumers enrolled in coverage pursuant to the Exchange. The ombudsman shall also directly assist these consumers.

(h) The Department of Managed Health Care, the Department of Insurance, the State Department of Health Care Services, the Managed Risk Medical Insurance Board, the State Department of Public Health, and the Exchange shall report data and other information to the ombudsman regarding consumer complaints submitted to those agencies, including the nature of the complaints, the resolution of the complaints and the timeliness thereof, and the health status, age, race, ethnicity, language, geographic region, and gender of the complainants. This information shall be reported according to the particular health insurer or health care service plan involved.

(i) (1) The ombudsman shall apply to the United States Secretary of Health and Human Services for a grant under Section 2793 of the federal Public Health Service Act, as added by Section 1002 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), to implement the requirements of this section.

~~(2) The office and the services provided by local consumer assistance programs under subdivision (e) shall be also be funded out of licensure fees on health care service plans, consistent with Section 1356, and out of fees on health insurers by assessing a per policy assessment. The fees shall be set by the Director of the Department of Managed Health Care or the Insurance Commissioner, as applicable, in consultation with the ombudsman. The fees shall be allocated based on the number of covered lives and shall be the same per covered life regardless of the regulator.~~

~~(3)~~

*(2)* To the extent permitted by federal law, the ombudsman may seek federal financial participation for assisting beneficiaries of the Medi-Cal program.

*(j) For fiscal years 2010–11 to 2014–15, inclusive, each health care service plan, including a specialized health care service plan, and each health insurer shall be assessed an annual fee in an amount determined through regulation that shall be proportionate to the number of covered lives regulated by the Department of Managed Health Care and the Department of Insurance. The amount of the fee shall be determined by the Department of*

*Managed Health Care and the Department of Insurance in consultation with the ombudsman and shall be limited to the amount necessary to fund the actual and necessary expenses of the office and its work in implementing this division.*

*(k) The fee on plans and insurers described in subdivision (j) shall be assessed by the Department of Managed Health Care and the Department of Insurance, respectively, in coordination with the ombudsman.*

*(1) Health care service plans shall be notified of the fee on or before June 15 of each year. That notice shall be included with the annual assessment notice issued pursuant to Section 1356. The fee imposed under this section is separate and independent of the assessments imposed under Section 1356.*

*(2) Health insurers shall be notified of the fee in accordance with the notice sent for the annual assessment or quarterly premium tax revenues.*

*(3) The fee shall be paid on an annual basis no later than August 1 of each year. The Department of Managed Health Care and the Department of Insurance shall forward the assessments to the Controller for deposit in the California Health Ombudsman Trust Fund immediately following their receipt.*

~~(j)~~

*(l)* For purposes of this section, the following definitions shall apply:

(1) "Exchange" means the American Health Benefit Exchange established in California under Section 1311 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(2) "Group health plan" has the same meaning set forth in Section 2791 of the federal Public Health Service Act (42 U.S.C. 300gg-91).

*(3) "Health care service plan" or "specialized health care service plan" has the same meaning as that set forth in subdivision (f) of Section 1345.*

*(4) "Health insurance" has the same meaning as that set forth in Section 106 of the Insurance Code.*

*(5) "Health insurer" means an insurer that issues policies of health insurance.*

136020. (a) The California Health Ombudsman Trust Fund is hereby created in the State Treasury for the purpose of this division. Notwithstanding Section 13340 of the Government Code, all

moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this division. Any moneys in the fund that are unexpended or unencumbered at the end of the fiscal year may be carried forward to the next succeeding fiscal year.

(b) The ombudsman shall establish and maintain a prudent reserve in the fund.

(c) Notwithstanding Section 16305.7 of the Government Code, all interest earned on moneys that have been deposited in the fund shall be retained in the fund and used for purposes consistent with this division.

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