AMENDED IN ASSEMBLY APRIL 9, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1766

Introduced by Assembly Member Bonilla

February 17, 2012

An act to amend Section 100502 of the Government Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1766, as amended, Bonilla. California Health Benefit Exchange.

Existing law establishes the California Health Benefit Exchange (Exchange) for the purpose of facilitating the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014. ~~Existing law specifies the duties of the board of the Exchange with respect to implementing a specified provision of the federal Patient Protection and Affordable Care Act.~~ *Existing law requires the board of the Exchange to inform individuals of eligibility requirements for state or local public programs and to enroll eligible individuals in those programs, as specified, and to perform duties relating to determining eligibility for premium tax credits, among other things. Existing law also requires the Exchange to establish the Small Business Health Options Program to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market.*

This bill would prohibit the Small Business Health Options Program from informing an eligible employee or dependent thereof about, or screening that employee or dependent for eligibility for, a premium tax credit, the Medi-Cal program, the Healthy Families Program, or any other state or local public program.

~~This bill would make technical, nonsubstantive changes to those duties.~~

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

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

SECTION 1. Section 100502 of the Government Code is amended to read:

100502. The board shall, at a minimum, do all of the following to implement Section 1311 of the federal act:

(a) Implement procedures for the certification, recertification, and decertification, consistent with the guidelines established by the United States Secretary of Health and Human Services, of health plans as qualified health plans. The board shall require health plans seeking certification as qualified health plans to do all of the following:

(1) Submit a justification for any premium increase prior to implementation of the increase. The plans shall prominently post that information on their Internet Web sites. The board shall take this information, and the information and the recommendations provided to the board by the Department of Insurance or the Department of Managed Health Care under paragraph (1) of ~~subdivision~~ *subsection* (b) of Section 2794 of the federal Public Health Service Act, into consideration when determining whether to make the health plan available through the Exchange. The board shall take into account any excess of premium growth outside the Exchange as compared to the rate of that growth inside the Exchange, including information reported by the Department of Insurance and the Department of Managed Health Care.

(2) (A) Make available to the public and submit to the board, the United States Secretary of Health and Human Services, and the Insurance Commissioner or the Department of Managed Health Care, as applicable, accurate and timely disclosure of the following information:

(i) Claims payment policies and practices.

(ii) Periodic financial disclosures.

(iii) Data on enrollment.

(iv) Data on disenrollment.

(v) Data on the number of claims that are denied.

(vi) Data on rating practices.

(vii) Information on cost sharing and payments with respect to any out-of-network coverage.

(viii) Information on enrollee and participant rights under Title I of the federal act.

(ix) Other information as determined appropriate by the United States Secretary of Health and Human Services.

(B) The information required under subparagraph (A) shall be provided in plain language, as defined in subparagraph (B) of paragraph (3) of ~~subdivision~~ *subsection* (e) of Section 1311 of the federal act.

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(b) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(c) Maintain an Internet Web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans.

(d) Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the United States Secretary of Health and Human Services.

(e) Utilize a standardized format for presenting health benefits plan options in the Exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15).

(f) Inform individuals of eligibility requirements for the Medi-Cal program, the Healthy Families Program, or any applicable state or local public program and, if, through screening of the application by the Exchange, the Exchange determines that an individual is eligible for any such program, enroll that individual in the program.

(g) Establish and make available by electronic means a calculator to determine the actual cost of coverage after the

application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the federal act.

(h) Grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by that section because of either of the following:

(1) There is no affordable qualified health plan available through the Exchange or the individual's employer covering the individual.

(2) The individual meets the requirements for any other exemption from the individual responsibility requirement or penalty.

(i) Transfer to the Secretary of the Treasury all of the following:

(1) A list of the individuals who are issued a certification under subdivision (h), including the name and taxpayer identification number of each individual.

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 because of either of the following:

(A) The employer did not provide minimum essential coverage.

(B) The employer provided the minimum essential coverage but it was determined under subparagraph (C) of paragraph (2) of subsection (c) of Section 36B of the Internal Revenue Code of 1986 to either be unaffordable to the employee or not provide the required minimum actuarial value.

(3) The name and taxpayer identification number of each individual who notifies the Exchange under paragraph (4) of subsection (b) of Section 1411 of the federal act that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(j) Provide to each employer the name of each employee of the employer described in paragraph (2) of subdivision (i) who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation.

(k) Perform duties required of, or delegated to, the Exchange by the United States Secretary of Health and Human Services or

the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost sharing, or individual responsibility exemptions.

(*l*) Establish the navigator program in accordance with ~~subdivision~~ *subsection* (i) of Section 1311 of the federal act. Any entity chosen by the Exchange as a navigator shall do all of the following:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans.

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal act.

(3) Facilitate enrollment in qualified health plans.

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the federal Public Health Service Act, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under that plan or coverage.

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

(m) Establish the Small Business Health Options Program, separate from the activities of the board related to the individual market, to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the Exchange in the small employer market in a manner consistent with paragraph (2) of ~~subdivision~~ *subsection* (a) of Section 1312 of the federal act. *Notwithstanding any other provision of this section, the Small Business Health Options Program shall not inform an eligible employee or dependent thereof about, or screen that employee or dependent for eligibility for, the Medi-Cal program, the Healthy Families Program, or any other state or local public program, or a premium tax credit under Section 36B of the Internal Revenue Code. For purposes of this subdivision, "eligible employee or dependent thereof" means an*

employee of a qualified small employer, or dependent thereof, who is eligible for coverage through that small employer.

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