Date of Hearing: May 3, 2011

ASSEMBLY COMMITTEE ON HEALTH
William W. Monning, Chair
AB 1083 (Monning) – As Amended: March 29, 2011

SUBJECT: Health care coverage.

SUMMARY: Effective January 1, 2014, conforms state law to provisions in the federal Patient Protection and Affordable Care Act (PPACA). Requires solicitors to notify the small employer of the availability of coverage through the California Health Benefit Exchange (Exchange), makes premium rates established by health care service plans and health insurers (carriers) in effect for 12 months, prohibits carriers from entering into contracts with solicitors for varied compensation based on whether the employer obtains coverage through the Exchange or directly from a carrier. Specifically, this bill:

SMALL GROUP CONFORMING

1) Expands definition of eligible employee by calculating the hours in a normal work week as an average of, rather than at least 30 hours over the course of a month.

2) Prohibits, effective January 1, 2014, carriers from limiting or excluding coverage for any individual based on a preexisting condition, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

3) Eliminates the ability of carriers to impose a risk adjustment factor to premium rates effective January 1, 2014.

4) Allows premium rate variation based upon age of no more than three to one for adults effective January 1, 2014.

5) Maintains existing state definition of small employer (two to 50 eligible employees) until January 1, 2017, except that this bill adds to the definition, on or after January 1, 2014, a self-employed individual who obtains at least 50% of annual income from self-employment as demonstrated through personal income tax filings for the current or prior year.

6) Implements federal definition of small employer as having at least one, but no more than 100 eligible employees, as specified, on or after January 1, 2017.

7) Replaces an obsolete reference to an employer purchasing program that is no longer in existence with a reference to the Exchange.

8) Requires employer contribution requirements to be consistent with PPACA.

9) Prohibits carriers from establishing rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, based on any other health status-related factor as determined by the regulators (The Department of Managed Health Care (DMHC) for health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-

Keene) and the Department of Insurance (CDI) for health insurers under the Insurance Code).

10) Repeals authority for carriers to exclude late enrollees or for the satisfaction of a preexisting condition clause, initial coverage of an eligible employee, based on actual or expected health condition on January 1, 2014. Prohibits carriers from excluding any eligible employee or dependent who would otherwise be entitled to health care service on the basis of an actual or expected heath condition on or after January 1, 2014.

11) Repeals authority for carriers to impose up to a six month preexisting condition exclusion period related to medical conditions, as specified, on January 1, 2014 and on or after January 1, 2014 prohibits preexisting condition provisions from excluding coverage following the individual's effective date of coverage for a condition based on the fact the condition was present before the date of enrollment.

12) Repeals authority for carriers who do not utilize a preexisting condition provision to impose a waiting or affiliation period, not to exceed 60 days, before coverage is issued, on January 1, 2014, and prohibits waiting or affiliation periods from being imposed on or after January 1, 2014.

13) Repeals authority for carriers to exclude late enrollees from coverage for more than 12 months from the date of the application on January 1, 2014, and permits carriers to exclude late enrollees from coverage for up to 90 days from the date of the late enrollee's application. Prohibits premiums from being charged to the late enrollee until the exclusion period has ended.

14) Repeals authority for carriers to notify the small employer about rate increases on January 1, 2014, and, on or after January 1, 2013, requires carriers to notify the small employer, that effective July 1, 2013, the actual rates are required to be the same for all small employers.

15) Defines wellness incentive or wellness program as a program of health promotion or disease prevention that is designed to promote health or prevent disease and that meets the standards specified in 22) below.

16) Establishes requirements for a carrier implemented wellness program as contemplated in PPACA which prohibits in contracts offered on or after January 1, 2012, a rebate, discount, or other incentive offered under the wellness program from resulting in a variation in the premium of greater than 1.2 to one.

SMALL GROUP NOT CONFORMING

17) Increases the minimum hours an employee must work to be eligible under other specified circumstances to 20 (from 10) hours per normal work week for at least 50% of the weeks in the previous calendar quarter.

18) Permits a self-employed individual with specified income to, at his or her discretion, enroll in the Exchange as an individual rather than a small employer.

19) Requires solicitors to notify the small employer of the availability of coverage through the Exchange.

20) Makes premium rates established by the carrier in effect for 12 (rather than 6) months.

21) Prohibits carriers, effective January 1, 2014, from directly or indirectly, entering into any contract, agreement, or arrangement with a solicitor for the sale of a health plan contract to be varied based on whether the small employer obtains coverage through the Exchange or directly from a carrier.

22) Requires carriers to file a notice of material modification with their respective regulators at least 60 business days (rather than 20) prior to renewing or amending a plan contract, as specified.

23) Requires that a carrier wellness program be based on demonstrated scientific evidence to improve health outcomes as documented by peer-reviewed scientific evidence involving multiple studies over time as demonstrated by the regulators, includes additional standards.

INDIVIDUAL AND GROUP CONFORMING

24) Changes the definition of health benefit plan to include essential health benefits as defined consistent with PPACA on or after January 1, 2014.

25) Prohibits carriers from establishing any preexisting condition exclusion or limitation for any individual or dependent of an individual, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date on or after January 1, 2014.

26) Repeals authority for carriers to impose up to a six month preexisting condition exclusion period related to medical conditions on contracts that cover three or more enrollees on January 1, 2014.

27) Repeals authority for carriers to impose up to a 12 month preexisting condition provision related to medical condition on contracts that cover one or two individuals on January 1, 2014.

28) Repeals authority for carriers that do not impose a preexisting condition provision to impose an up to 60 day waiting or affiliation period on January 1, 2014.

29) Repeals authority for carriers that do not impose a preexisting condition provision to impose a 12 month exclusion of coverage for a waivered condition on contracts that cover one or two individuals on January 1, 2014.

30) Repeals authority for carriers to impose a coverage exclusion period of no more than 12 months on late enrollees on January 1, 2014.

31) Prohibits, effective January 1, 2014, any plan contract that covers one or more enrollees from excluding coverage for any individual on the basis of preexisting condition. Prohibits a plan contract for group coverage from imposing any preexisting condition provision upon any individual. Prohibits a plan contract for individual coverage that is not a grandfathered health plan within the meaning of PPACA from imposing any preexisting condition provisions upon any individual. Permits carriers to impose a 90-day waiting period from the

date of the late enrollee's application for coverage. Prohibits carriers issuing group coverage from imposing a preexisting condition exclusion based on health-status-related factors, as specified.

32) Repeals authority for carriers to exclude from coverage based on health status, and other conditions, as specified late enrollees or for the satisfaction of a preexisting condition clause, initial coverage of an eligible employee on January 1, 2014. Prohibits carriers from excluding any eligible employee or dependent who would otherwise be entitled to health care services on the basis of health status, and other conditions, as specified, on or after January 1, 2014.

EXISTING LAW:

1) Provides for the regulation of health plans by DMHC under the Knox-Keene, and for the regulation of health insurers by CDI under provisions of the Insurance Code.

2) Requires carriers to fairly and affirmatively offer, market, and sell all of the plan's contracts that are sold to small employers to all small employers in the state.

3) Defines a small employer as any person, firm proprietary or nonprofit corporation, partnership public agency, or association that is actively engaged in business or service, that, on at least 50% of its working days during the preceding calendar quarter or preceding calendar year, employed at least two, but no more 50, eligible employees, the majority of whom were employed within this state.

4) Defines an eligible employee as any permanent employee who is actively engaged on a full time-basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the employer's place of business, who has met any statutory waiting periods. Deems permanent employees who work at least 20 hours but not more than 29 hours eligible if certain conditions apply.

5) Defines preexisting condition provision as a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

6) Prohibits a plan contract for group coverage from imposing any preexisting condition provision upon any child under 19 years of age.

7) Prohibits a plan contract for individual coverage that is not a grandfathered health plan within the meaning in PPACA from imposing any preexisting condition provision upon any children under 19 years of age.

8) Prohibits, with respect to the individual market child coverage, except to the extent permitted by federal law, carriers from conditioning the issuance or offering of individual coverage on any of the following factors:

   a) Health status;
   b) Medical condition, including physical and mental illness;

c) Claims experience;
d) Receipt of health care;
e) Medical history;
f) Genetic information;
g) Evidence of insurability, including conditions arising out of acts of domestic violence;
h) Disability; and,
i) Any other health status-related factor as determined by the regulators.

9) Defines a rating period as the period for which premium rates established by a plan are in effect and requires them to be in effect no less than six months.

10) Establishes the following risk categories for rating purposes: age, geographic region, and family composition, plus the health benefit plan selected by the small employer. Specifies age categories, family size categories, and nine geographic regions.

11) Prohibits a plan from, directly or indirectly, entering into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

12) Prohibits a policy or contract that covers two or more employees from establishing rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:
a) Health status;
b) Medical condition, including physical and mental illnesses;
c) Claims experience;
d) Receipt of health care;
e) Medical history;
f) Genetic information;
g) Evidence of insurability, including conditions arising out of acts of domestic violence; and,
h) Disability.

13) Establishes the Exchange in California and its authority in a manner that is consistent with PPACA.

14) Requires as a condition of participation in the Exchange, carriers that sell any products outside the Exchange to fairly and affirmatively offer, market and sell all products made available in the Exchange to individuals and small employers purchasing coverage outside of the Exchange.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. Approximately 3.4 million Californians enjoy the protections brought about by California's landmark small employer group health insurance rating and underwriting rules which have applied to employer groups with two to 50 workers since

1993. These rules require carriers to offer health plan contracts and insurance policies (health insurance) to small employer purchasers on a guaranteed issue (accept a group applying for coverage regardless of the health status or claims experience of group members). They also require carriers to offer renewal contracts, limit the rating factors carriers can employ in pricing small group products, require carriers to guarantee issue all small employer products to all small group purchasers, and limit the ways in which carriers can exclude coverage for existing health care conditions. PPACA includes several significant reforms to the health insurance market, including numerous provisions that interact with California's small group laws. According to the author, implementation of PPACA small group reforms in California has the potential to bring millions of people into the small group market. This bill is intended to revise California law to conform to the federal law in order to bring more uninsured into coverage.

There are some provisions in this bill that go beyond PPACA. For example, this bill limits the variation in compensation for insurance agents and brokers so that they cannot be paid more for selling products outside of the California Health Benefit Exchange (in effect steering employers away from participating in the Exchange). Also, this bill requires carrier rates to be in effect for no less than 12, rather than six months, and requires carriers to notify small employers of the availability of coverage through the Exchange. This bill also makes conforming changes in California law that applies to the individual and group market.

2) SMALL GROUP MARKET IN CA. A 2003 report published by the California HealthCare Foundation (CHCF) describes features of California's small group laws, established under AB 1672 (Margolin and Hansen), Chapter 1128, Statutes of 1992. The comparison chart below describes many of the provisions in California's small group law. A 2011 CHCF report indicates that 3.4 million or 9% of Californians have health coverage through small group insurance products. There are 2.2 million people who purchase insurance for themselves in the individual market. Of those 2.2 million, 32% are self-employed and another 26% work for small employers. Another 3 million people who are uninsured have a head of family who works for a small employer or is self-employed.

3) PPACA. The PPACA [Public Law (P.L.) 111-148] was signed into law on March 23, 2010. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010. In general, P.L. 111-148 and its amendments are referred to as PPACA. The federal law makes several significant changes to the group and individual insurance markets. As an example, PPACA eliminates the pricing of premiums based on health status, limits the range of premiums based on age, adds the self-employed to those eligible for guaranteed issue of coverage, includes wellness incentives in the coverage available to small businesses and expands the rules to employers with one to 100 employees. The comparison chart below describes many of the provisions affecting small groups in PPACA.

4) COMPARISON CHART

	California Law	**PPACA**	**AB 1083**

	California Law	PPACA	AB 1083
Small employer	At least two but not more than 50 eligible employees.	At least one but not more than 100 employees. State option to define at least one but not more than 50 as small before 1/1/2016.	Two to 50 until 1/1/2017. After 1/1/2017, one to 100. [I don't read the "final" bill that way]
Employee	Normal workweek of at least 30 hours at place of employment. Permanent employees who work at least 20 hours but not more than 29 hours are deemed eligible under specified circumstances including worked at least 20 hours per normal work week for at least 50% of weeks in previous quarter.	Full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours of service per week.	Average of 30 hours over the course of a month. Permanent employees who work at least 10 but not more than 29, and at least 10 hours per normal work week for at least 50% of weeks in previous quarter.
Guaranteed issue	Requires carriers to fairly and affirmatively offer, market and sell to small employers.	Requires carriers who offer in the individual or group market to accept every employer and individual who applies. Authorizes open or special enrollment provisions.	Requires carriers to offer coverage that includes the "essential" health benefits package, with restrictions on cost-sharing.
Guaranteed renewal	Requires renewal of coverage, at the option of policy holder, unless there is fraud or nonpayment of premium or carrier leaves the market.	If carrier offers health insurance coverage in the individual or group market must renew or continue at the option of the plan sponsor or individual.	No change.
Rating rules	Allows premium variance of plus or minus 10% from a standard rate based on health status. Restricts a plan's ability to set initial and renewal premium rates to a group of specified risk categories (age, geographic region, family size, and plan).	Prohibits carriers from pricing based on health factors but allows for age (3 to 1 ratio for adults), geography, gender and family. Allows for tobacco rating of 1.5 to 1.	Makes risk adjustment factor zero effective January 1, 2014. Premiums can vary for age by no more than 3 to 1. Maintains geographic region, family size, and plan.
Limitations on the use of pre-existing condition exclusions	Only for one period of six months from the effective date of coverage with credit for time the individual was previously covered under a different plan. Prohibits pre-existing condition exclusions of more than 12-months in policies and contracts covering one or two individuals, with credit for previous coverage. No pre-existing exclusions for children.	Prohibits carriers from imposing a pre-existing condition exclusion for children 9/23/10 and adults 1/1/14.	No preexisting conditions allowed for adults 1/1/14. Allows 90 day waiting period for late enrollees.

	California Law	PPACA	AB 1083
Health status discrimination	Prohibits carriers in individual market with respect to child coverage from conditioning coverage on health status factors, including any other health status-related factor as determined by regulators.	Prohibits carriers in group and individual market from establishing rules for eligibility based on health status factors, including any other health status-related factor determined appropriate by the Secretary of the federal Department Of Health and Human Services.	Prohibits carriers in group market from conditioning coverage on health status factors, including any other health status-related factor as determined by regulators.
Steering	Carriers cannot pay agent and brokers varied compensation based on health status, claims experience, industry, occupation, etc.		Carriers cannot pay agent and brokers varied compensation on products obtained through the Exchange or directly from carrier.

5) SUPPORT. The Small Business Majority (SBM) writes in strong support for this bill, that it is critical to pass this legislation to strengthen safeguards in California. SBM indicates that this bill eliminates the practice of determining rates based on health status, reins in rates based on age by limiting premiums that an older person must pay to a maximum of three times the amount a younger person pays, and guarantees coverage for the self-employed. The Latino Health Alliance supports this bill because it conforms and phases-in new insurance market rules for small businesses, particularly so that small employers don't get additional premium spikes based on the health of their workforce. Health Access California supports this bill because it will make health insurance more available to 5.3 million small business owners, their employees and self-employed Californians.

6) OPPOSITION UNLESS AMENDED. The California Association of Health Plans (CAHP) opposes this bill unless it is amended to carefully and precisely conform to federal law. CAHP believes this bill is ambitious and notes that several provisions are not contained in the federal law or differ from the federal law, such as a provision that makes changes to how (broker and agent) commissions are handled, how employers calculate coverage for part time employees and notification requirements.

7) OPPOSITION. The California Association of Health Underwriters (CAHU) is in opposition to this bill. They are specifically opposed to the "anti-steering" language in this bill. CAHU asserts that this creates a situation where the California Health Benefit Exchange is setting commissions for agents – even for products outside the Exchange.

8) AUTHOR'S AMENDMENTS. The author intends to amend this bill to address some technical inconsistences with the drafting, date corrections, implement federal small employer definition of one to 50 employees on January 1, 2014, specify material modification submissions requirements of 60 "calendar" rather than "business" days, and to eliminate sections 10 and 33, which establish standards for carrier implemented wellness programs.

REGISTERED SUPPORT / OPPOSITION:

Support

Health Access California
Small Business Majority
Latino Health Alliance

Opposition

California Association of Health Underwriters

Analysis Prepared by: Teri Boughton / HEALTH / (916) 319-2097