California Legislature

SENATE COMMITTEE ON HEALTH

DR. RICHARD PAN
CHAIR

STATE CAPITOL, ROOM 2191
SACRAMENTO, CA 95814
TEL (916) 651-4111
FAX (916) 266-9438

STAFF DIRECTOR
MELANIE MORENO

CONSULTANTS
TERI BOUGHTON
KIMBERLY CHEN
REYES DIAZ
VINCENT D. MARCHAND

COMMITTEE ASSISTANTS
AIMEE ANSPACH
COURTNEY SKINNER

California Laws Implementing the Federal Patient Protection and Affordable Care Act (ACA)

2009-10

SB 227 (Alquist) – Health care coverage: temporary high risk pool. Requires the Managed Risk Medical Insurance Board (MRMIB) to enter into an agreement with the federal Department of Health and Human Services to administer a qualified high-risk pool to provide health coverage, until January 1, 2014, to individuals who have pre-existing conditions, consistent with the ACA. Establishes the authority and requirements for MRMIB in administering the federal pool, consistent with federal law. Appropriates $761 million from the Federal Trust Fund to MRMIB. Makes this bill operative contingent upon enactment of AB 1887 (Villines) and sunsets both bills on January 1, 2020. Takes effect immediately as an urgency bill. ***(Chapter 31, Statutes of 2010).***

SB 900 (Alquist & Steinberg) – California Health Benefit Exchange. Establishes in state government Covered California as an independent public entity. Requires the Exchange be governed by a board that includes the Secretary of the Health and Human Services Agency and four members with specified expertise who are appointed by the Governor and the Legislature. Specifies the expertise required for board membership and the duties of board members, the duration of terms of board members, and enacts conflict-of-interest provisions that apply to board members and Covered California staff. Provides that its provisions only take effect if AB 1602 (Perez) is also chaptered. ***(Chapter 659, Statutes of 2010).***

SB 1088 (Price) – Health care coverage: dependents. Prohibits health plans and insurers from using a limiting age for dependent children covered by their parent's health plan contract, or health insurance policy, from being less than 26 years of age beginning on or after September 23, 2010. Allows, but does not require, employers to pay premiums associated with extending dependent coverage for those between 23 and 26 years old. Specifies timelines for health plan contracts and insurance policies for those 26 years of age. Clarifies circumstances for young adults who previously lost or were denied dependent health coverage to re-enroll on their parent's health plan or insurance policy, and requires plans and insurers to provide written notice related to those circumstances. (***Chapter 660, Statutes of 2010).***

SB 1163 (Leno) – Health care coverage: denials: premium rates. Requires health plans and health insurers to file with the Department of Managed Health Care and the California Department of Insurance specified rate information for at least 60 days prior to implementing any rate change. Requires rate filings to be actuarially sound. Increases, from 30 days to 60 days, the amount of time that a health plan or insurer must provide written notice before a change in premium rates or coverage becomes effective. Requires health plans and insurers that decline to offer coverage or that deny enrollment for a large group applying for coverage, or that offer small group coverage at a rate that is higher than the standard employee risk rate, to provide the applicant with reason for the decision. (***Chapter 661, Statues of 2010).***

AB 1602 (Pérez) – California Health Benefit Exchange. Specifies the duties and authority of Covered California. Requires Covered California to determine the minimum requirements health plans must meet for participation in Covered California and the standards and criteria for selecting health plans to be offered in Covered California. Requires Covered California to provide in each region of the state a choice of qualified health plans, at each of the five levels of coverage contained in federal law (a platinum, gold, silver, bronze and catastrophic level benefit plan). Provides that its provisions only take effect if SB 900 (Alquist) is also chaptered. *(**Chapter 655, Statutes of 2010).***

AB 1887 (Villines) – Temporary high risk pool. Establishes the Federal Temporary High Risk Health Insurance Fund. Requires money in the Fund to be continuously appropriated to the Managed Risk Medical Insurance Board the purpose of establishing a federal temporary high-risk pool established under SB 227 (Alquist) for individuals with a pre-existing medical condition. Takes effect immediately as an urgency statute, contingent upon the enactment of SB 227. (***Chapter 32, Statutes of 2010).***

AB 2244 (Feuer) – Health care coverage. Requires guaranteed issue of health plan and insurance products for children in 2011 and adults in 2014. Establishes standard individual market rating factors (age, geographic region, family composition and health benefit plan design). Limits premium variation for children's coverage until 2014 by requiring health plans and insurers to use "rate bands" that limit premium variation to no more than a specified percentage of a standard rate for a child in each particular rating category and benefit plan for children who are in an open enrollment period. (***Chapter 656, Statutes of 2010).***

AB 2345 (De La Torre) – Health care coverage: preventive services. Requires health plan contracts and health insurance policies issued, amended, renewed, or delivered on or after September 23, 2010, to comply with the provisions of the ACA regarding coverage of, and cost-sharing for, preventive services, and any rules or regulations issued pursuant to the ACA. (***Chapter 657, Statutes of 2010).***

AB 2470 (De La Torre) – Health care coverage. Prohibits a health plan or insurer from rescinding or canceling a health plan contract insurance policy unless there was fraud or an intentional misrepresentation of material fact. (***Chapter 658, Statutes of 2010).***

2011-12

SB 51 (Alquist) – Health care coverage. Establishes enforcement authority in California law to implement provisions of the ACA related to Medical Loss Ratio requirements on health plans and insurers and prohibitions on annual and lifetime benefits. (***Chapter 644, Statutes of 2011).***

SB 951 (Hernandez) – Health care coverage: essential health benefits. Establishes the Kaiser Foundation Health Plan Small Group Health Maintenance Organization 30 plan contract as California's Essential Health Benefits benchmark plan for health insurers regulated by the California Department of Insurance. (***Chapter 866, Statutes of 2012).***

SB 1529 (Alquist) – Medi-Cal: providers: fraud. Revises various provisions related to the screening, enrollment, disenrollment, suspensions, and other sanctions against fee-for service providers and suppliers participating in the Medi-Cal Program to conform to requirements of the ACA. (***Chapter 797, Statutes of 2012).***

AB 151 (Monning) – Medicare supplement coverage. Requires health plans and insurers offering Medicare supplement coverage (Medigap policies) to issue coverage for a Medigap policy on a guaranteed issue basis to an individual enrolled in a Medicare Advantage (MA) plan issued by the same issuer if there is an increase in the enrollee's premium, requires all health plans and insurers offering Medigap policies to issue such coverage on a guaranteed issue basis to an individual enrolled in a MA plan offered by a different health plan or insurer under specified circumstances, and makes technical changes to the requirements and standards that apply to Medigap policies, for the purpose of complying with recent changes in federal law. Establishes a threshold for a change in the premium or cost sharing levels to be met before MA plan enrollees may switch to another carrier for Medigap coverage on a guaranteed-issue basis. (***Chapter 270, Statutes of 2011).***

AB 792 (Bonilla) – Health care coverage: California Health Benefit Exchange. Requires a court, upon the filing of a petition for dissolution of marriage, nullity of marriage, or legal separation on and after January 1, 2014, to provide a specified notice informing the petitioner and respondent that they may be eligible for reduced-cost coverage through Covered *California*, or no-cost coverage through Medi-Cal. Requires health plans and insurers to 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 Covered *California* or no-cost coverage through Medi-Cal. (***Chapter 851, Statutes of 2012).***

AB 922 (Monning) – Office of Patient Advocate. Transfers the Department of Managed Health Care (DMHC) from the Business, Transportation and Housing Agency to the California Health and Human Services Agency (HHS), transfers the Office of the Patient Advocate (OPA) from DMHC to HHS effective July 1, 2012, revises OPA's current purpose and duties, and assigns new duties consistent with requirements of the ACA. (***Chapter 552, Statutes of 2011).***

AB 1083 (Monning) – Health care coverage. Makes conforming and other changes to state law governing the sale of small group health insurance products to implement provisions of the ACA. (***Chapter 852, Statutes of 2012).***

AB 1296 (Bonilla) – Health Care Eligibility, Enrollment, and Retention Act. Establishes the Health Care Eligibility, Enrollment, and Retention Act, which requires the California Health and Human Services Agency, in consultation with other state departments and stakeholders, to have undertaken a planning process to develop plans and procedures regarding these provisions relating to enrollment in state health programs and federal law. Requires that an individual would have the option to apply for state health programs through a variety of means. (***Chapter 641, Statutes of 2011).***

AB 1453 (Monning) – Health care coverage: essential health benefits. Establishes the Kaiser Foundation Health Plan Small Group Health Maintenance Organization 30 plan contract as California's Essential Health Benefits benchmark plan for health plans regulated by the Department of Managed Health Care. (***Chapter 854, Statutes of 2012).***

AB 1580 (Bonilla) – Health care eligibility: enrollment. Makes technical and clarifying changes to AB 1296, the Health Care Reform Eligibility, Enrollment, and Retention Planning Act (Act) relating to applications for state health subsidy programs. (***Chapter 856, Statutes of 2012).***

AB 1761 (Pérez) – California Health Benefit Exchange. Prohibits an individual or entity from holding himself, herself, or itself out as representing, constituting, or otherwise providing services on behalf of Covered *California* unless that individual or entity has a valid agreement with Covered *California* to engage in those activities. (***Chapter 876, Statutes of 2012).***

AB 1846 (Gordon) – Consumer operated and oriented plans. Creates a licensing framework for consumer operated and oriented health plans that can offer health coverage through Covered *California*. (***Chapter 859, Statutes of 2012).***

2013-14

SB 18 (Leno & Hernandez) – Medi-Cal renewal. Requires the Department of Health Care Services (DHCS) to accept contributions by private foundations in the amount of at least $6 million for the purpose of providing Medi-Cal renewal assistance payments starting January 1, 2015. Requires authorized payments to be made to counties by DHCS for distribution of funds to community-based organizations providing renewal assistance to Medi-Cal beneficiaries. (***Chapter 551, Statues of 2014).***

SB 20 (Hernandez) – Individual health care coverage: enrollment periods. Establishes an annual open enrollment period for purchasers in the individual health insurance market for the policy year beginning on January 1, 2015, from November 15, 2014 to February 15, 2015 inclusive. Takes effect immediately as an urgency bill. (***Chapter 24, Statutes of 2014).***

SB 28 (Hernandez & Steinberg) – California Health Benefit Exchange. Requires the Managed Risk Medical Insurance Board (MRMIB) to provide Covered *California* with the name, contact information, and spoken language of Major Risk Medical Insurance Program subscribers and applicants in order to assist Covered *California* in conducting outreach. Requires Covered *California* to use the information from MRMIB to provide a notice to these individuals informing them of their potential eligibility for coverage through Covered *California* or Medi-Cal. Permits the Department of Health Care Services (DHCS) to implement provisions of ABX1-1 (John A. Pérez) and SBX1-1 (Hernandez and Steinberg) by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. Requires DHCS to adopt regulations by July 1, 2017, in accordance with the requirements of the rulemaking requirements of the Administrative Procedure Act. Requires DHCS to provide a status report to the Legislature on a semiannual basis until regulations have been adopted. Makes technical and clarifying changes to provisions relating to a new budgeting methodology for Medi-Cal county administrative costs. (***Chapter 442, Statutes of 2013).***

SB 161 (Hernandez) – Stop-loss insurance coverage. Establishes regulatory requirements for stop-loss insurance for small employers, including on or after January 1, 2016, setting an individual attachment point of $40,000 or greater and an aggregate attachment point of the greater of $5,000 times the total

number of group members, 120% of expected claims, or $40,000. Exempts small employer stop-loss insurance issued prior to September 1, 2013, from these attachment point requirements. (***Chapter 443, Statutes of 2013).***

SB 332 (Emmerson & DeSaulnier) – California Health Benefit Exchange: records. Makes contracts and rates of payment under those contracts of Covered *California* open to public inspection under the California Public Records Act except for health plan contracts and their rates, which are made public in three and four years respectively. Makes the impressions, opinions, recommendations, meeting minutes, research, work product, theories, and strategy of the board or the staff of Covered *California*, or records that provide instructions, advice, or training to employees subject to the Public Records Act by deleting an exemption from disclosure for these items. (***Chapter 446, Statutes of 2013).***

SB 508 (Hernandez) – Medi-Cal: eligibility. Makes changes to the eligibility requirements for the Medi-Cal program, to codify existing eligibility levels or clarify changes made to the program's eligibility requirements when the state expanded eligibility under the ACA, in particular conforming existing law to the federal requirement to use modified adjusted gross income for eligibility determination. (***Chapter 831, Statutes of 2014).***

SB 509 (DeSaulnier & Emmerson) – California Health Benefit Exchange: background checks. Requires the Executive Board of Covered California, consistent with federal guidance, to submit to the Department of Justice fingerprint images and related information of all employees, prospective employees, contractors, subcontractors, volunteers, or vendors whose duties include or would include access to confidential information, personal identifying information, personal health information, federal tax information, financial information, or the purposes of obtaining information of the existence and content of a record of state or federal criminal history and information as to the existence and content of pending state or federal arrests, as specified. (***Chapter 10, Statutes of 2013).***

SB 639 (Hernandez) – Health care coverage. Codifies provisions of ACA relating to out-of-pocket maximums on cost-sharing, health plan and insurer actuarial value coverage levels and catastrophic coverage requirements, and requirements on health insurers for coverage of out-of-network emergency services. Applies out-of-pocket limits to specialized products that offer essential health benefits and permits carriers in the small group market to establish an index rate no more frequently than each calendar quarter. (***Chapter 316, Statutes of 2013).***

SB 800 (Lara) – Health care coverage programs: transition. Requires the Department of Health Care Services (DHCS) to provide Covered CA with contact information of parents of children enrolled in the Healthy Families Program or Medi-Cal, as specified, in order to assist Covered California in conducting outreach. Requires, if any statute dissolves or terminates the Managed Risk Medical Insurance Board (MRMIB), employees at MRMIB to transfer either to Covered *California* (in the case of employees assigned to the Pre-existing Condition Insurance Program) or to DHCS (in the case of employees assigned to other programs). (***Chapter 448, Statutes of 2013).***

SB 959 (Hernandez) – Health care coverage. Requires health plans and insurers to deliver notice of rate changes at least 15 days in advance of the annual open enrollment period and makes numerous additional changes to current law related to health plans and insurers. (***Chapter 572, Statutes of 2014).***

SB 964 (Hernandez) – Health care coverage. Increases oversight of health plans with respect to compliance with timely access and provider network adequacy standards by requiring health plans to submit data to the Department of Managed Health Care (DMHC) about health care providers and hospitals, grievances, and whether or not a provider has an open practice. With regard to timely access reporting, requires health plans to use standardized survey methodology if developed by DMHC for timely access reporting. Eliminates a requirement in existing law that exempts a Medi-Cal managed care plan from DMHC medical surveys upon the submission by the Department of Health Care Services of its medical audit of the plan. (***Chapter 573, Statutes of 2014).***

SB 972 (Torres) – California Health Benefit Exchange: board: membership. Adds new areas of expertise that qualify a potential member to serve on the California Health Benefit Exchange Board. These areas of expertise include: 1) marketing of health insurance products; 2) information technology system management; 3) management information systems; and 4) enrollment counseling assistance, with priority to cultural and linguistic competency. (***Chapter 172, Statutes of 2014***).

SB 1034 (Monning) – Health care coverage: waiting periods. Prohibits health plans and health insurance policies in the group market from imposing a waiting or affiliation period. States legislative intent to: 1) prohibit a group health plan or insurer from imposing a separate waiting or affiliation period in addition to any employer-imposed waiting period; and 2) permit a group health plan or insurer to administer a waiting period imposed by a plan sponsor, as specified. (***Chapter 195, Statutes of 2014***).

SB 1052 (Torres) – Health care coverage. Requires Covered California to provide links to the formularies of qualified health plans. Requires health plans and insurers that provide prescription drug benefits and maintain drug formularies to post the formulary or formularies for each product offered by the plan on the plan's website in a manner that is accessible and searchable by potential enrollees, enrollees and providers. Requires the Department of Managed Health Care and the California Department of Insurance to develop a standard formulary template that contains specified information by January 1, 2017. Requires health plans and insurers to use the standard formulary template within six months of the date the template is developed and to update their posted formularies with any change to those formularies on a monthly basis. (***Chapter 575, Statutes of 2014).***

SB 1053 (Mitchell) – Health care coverage: contraceptives. Requires, effective January 1, 2016, most health plans and insurers to cover a variety of Food and Drug Administration-approved contraceptive drugs, devices, and products for women, as well as related counseling and follow-up services and voluntary sterilization procedures. Prohibits cost-sharing, restrictions, or delays in the provision of covered services, but allows cost-sharing and utilization management procedures if a therapeutic equivalent drug or device is offered by the plan with no cost sharing. (***Chapter 576, Statutes of 2014).***

SB 1446 (DeSaulnier) – Health care coverage: small employer market. Authorizes a small employer health plan or health benefit plan (another name for health insurance policy) in effect on October 1, 2013, and renewed by December 31, 2013, that does not qualify as a grandfathered health plan or health benefit plan, to avoid compliance with specified provisions of the ACA and related state law, and, be renewed until October 2016, at which time compliance with the ACA and state law is required. Takes effect immediately as an urgency bill. (***Chapter 84, Statutes of 2014).***

SBX1-1 (Hernandez & Steinberg) – Medi-Cal: eligibility. Establishes the existing Medi-Cal benefit package as the benefit package for the expansion population eligible under the ACA, and expands the Medi-Cal benefit package for the existing population and newly eligible under the ACA to include mental health services and substance use disorder services required under the essential health benefit legislation adopted in 2012 that are not currently covered by Medi-Cal. Makes recent immigrant adults who do not have minor children eligible for Medi-Cal, who would be eligible for Medicaid except for the five-year bar under federal law, and who are enrolled in Covered California with a tax credit also eligible for Medi-Cal benefits not covered by their Covered California plan, and requires DHCS to pay the individual's premium costs and cost-sharing (referred to as a "Medi-Cal wrap"). Implements a number of the Medicaid ACA-related provisions to simplify the eligibility, enrollment and renewal processes for Medi-Cal. Makes the enactment of this bill contingent upon enactment of ABX1-1 (John A. Pérez). (***Chapter 4, Statutes of 2013-1, First Extraordinary Session).***

SBX1-2 (Hernandez) – Health care coverage. Reforms California's individual market in accordance with the ACA and applies its provisions to health plans regulated by the Department of Managed Health Care in the individual market; requires guaranteed issue of individual market health plans; prohibits the use of preexisting condition exclusions; establishes open and special enrollment periods consistent with Covered California*;* prohibits conditioning the issuance or offering based on specified rating factors; prohibits specified marketing and solicitation practices consistent with small group requirements; requires guaranteed renewability of plans; and permits rating factors based on age, geographic region and family size only. Makes changes to California's small group law enacted in AB 1083 (Monning, Chapter 852, Statutes of 2012) to be consistent with draft federal rules released in November 2012. (***Chapter 2, Statutes of 2013-14, First Extraordinary Session).***

SBX1-3 (Hernandez) – Health care coverage: bridge plan. Requires Covered California by means of of selective contracting, to make a bridge plan product available to specified eligible individuals, as a qualified health plan (QHP). Exempts the bridge plan product from certain requirements that apply to QHPs relating to making the product available and marketing and selling to all individuals equally (guaranteed issue) outside of Covered California and selling products at other levels of coverage. Requires the Department of Health Care Services to include provisions relating to bridge plan products in its contracts with Medi-Cal managed care plans. Requires Covered California to evaluate three years of data from the bridge plan products, as specified. Sunsets Covered California's authority for enrollment in a bridge plan product that falls five years after the date of federal approval. (***Chapter 5, Statutes of 2013-14, First Extraordinary Session).***

AB 361 (Mitchell) – Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Populations with Chronic and Complex Conditions. Permits the Department of Health Care Services to establish a California Health Home Program to provide health home services to Medi-Cal beneficiaries and Section 1115 waiver demonstration populations with chronic conditions. Implements this bill only if federal financial participation is available and the federal Centers for Medicare and Medicaid Services approves the state plan amendment to implement this bill. (***Chapter 642, Statutes of 2013*).**

AB 422 (Nazarian) – School lunch program applications: health care notice. Requires the notification schools are authorized to include with information about the school lunch program, to advise the applicant that he/she may be eligible for reduced-cost comprehensive health care coverage through Covered California or no-cost coverage through Medi-Cal, and to provide the applicant with the contact information for Covered California, including its Internet Web site and telephone number. Requires a county that receives the information provided on a school lunch program application, for a pupil who is not already enrolled in a health insurance affordability program, to treat the school lunch program application as an application for a health insurance affordability program. (***Chapter 440, Statutes of 2013).***

AB 617 (Nazarian) – California Health Benefit Exchange: appeals. Establishes in state law proposed federal appeals rights for health subsidy programs, such as coverage through Covered California. Requires Covered California to enter into a contract with the Department of Social Services to serve as the Covered California appeals entity designated to hear appeals of eligibility or enrollment determination or redetermination for persons in the individual market. Requires the hearing process to be governed by the Medi-Cal hearing process established in law, except as otherwise required by this bill. Adopts federal options to establish an informal resolution process, details the provisions of that process, and designates the state entities to conduct that process. Adopts the federal option to require state entities to assist individuals with making an appeal request. ***(Chapter 869, Statutes of 2014).***

AB 1180 (Pan) – Health care coverage: federally eligible defined individuals: conversion or continuation of coverage. Makes inoperative because of the ACA several provisions in existing law that implement the health insurance laws of the federal Health Insurance Portability and Accountability Act of 1996 and additional provisions that provide former employees rights to convert their group health insurance coverage to individual market coverage without medical underwriting. Establishes notification requirements informing individuals affected by this bill of health insurance available in 2014. (***Chapter 91, Statutes of 2013).***

AB 1428 (Conway) – California Health Benefit Exchange: employees and contractors. Requires the Covered California board criminal background check requirement for specified employees and volunteers and vendors to be consistent with a specific federal Centers for Medicare and Medicaid Services document or further updates guidance or regulations. (***Chapter 561, Statutes of 2013).***

ABX1-1 (Perez) – Medi-Cal: eligibility. Implements specified Medicaid provisions of the ACA, including the expansion of federal Medi-Cal coverage to low-income adults with incomes between zero and 138% of the federal poverty level and the use of Modified Adjusted Gross Income to determine Medi-Cal eligibility for most applicants. Requires the Medi-Cal expansion population to enroll in managed care plans to receive Medi-Cal services. Implements a number of the Medicaid ACA provisions to simplify the eligibility, enrollment and renewal processes for Medi-Cal, including eliminating the asset test, eliminating the deprivation and the semi-annual status report requirements, and modifying the requirements that apply prior to terminating an individual's Medi-Cal coverage. Establishes processes for how applications sent to Covered *California* for individuals who are Medi-Cal eligible are processed. Takes effect only if SBX1-1 (Hernandez and Steinberg) also takes effect. (***Chapter 3, Statutes of 2013-14, First Extraordinary Session).***

ABX1-2 (Pan) – Health care coverage. Reforms California's individual market in accordance with the ACA and applies its provisions to insurers regulated by the California Department of Insurance in the individual market; requires guaranteed issue of individual market health insurance policies; prohibits the use of preexisting condition exclusions; establishes open and special enrollment periods consistent with Covered California; prohibits conditioning issuance or offering based on specified rating factors; prohibits specified marketing and solicitation practices consistent with small group requirements; requires guaranteed renewability of plans; and permits rating factors based on age, geographic region and family size only. Makes conforming changes to California's small group law enacted in AB 1083 (Monning, Chapter 852, Statutes of 2012). (***Chapter 1, Statutes of 2013-14, First Extraordinary Session).***

2015-16

SB 10 (Lara) – Health care coverage: immigration status. Requires Covered California to apply to the United States Department of Health and Human Services for a Section 1332 waiver authorized under the ACA to allow persons who are not otherwise able to obtain coverage through Covered California by reason of immigration status to obtain coverage from Covered CA by waiving the requirement that Covered California offer only qualified health plans. (***Chapter 22, Statutes of 2016).***

SB 43 (Hernandez) -- Health care coverage: essential health benefits. Updates California's essential health benefits to make them consistent with new federal requirements promulgated under the ACA, which includes adoption of the federally required definition of habilitative services and devices. *(**Chapter 648, Statutes of 2015).***

SB 125 (Hernandez) -- Health care coverage. Establishes an annual open enrollment period for purchasers in the individual health insurance market for the policy year beginning on January 1, 2016, from November 1, of the preceding calendar year, to January 31, of the benefit year, inclusive. Conforms state law to federal requirements regarding how to count employees for the purposes of determining employer size with regard to small or large group health insurance markets. ***(Chapter 9, Statutes of 2015).***

SB-388 (Mitchell) -- Solicitation and enrollment. Makes uniform summary of benefits and coverage (SBC) information which must be provided to consumers by health plans and insurers under the federal ACA and California law, a vital document, subject to specified translation requirements commencing October 1, 2016. Requires, not later than July 1, 2016, the Department of Managed Health Care and the California Department of Insurance, to make available on their Internet Web sites written translations of the template of uniform SBC, and specifies the language groups which require translation. ***(Chapter 655, Statutes of 2015).***

SB 546 (Leno) -- Health care coverage: rate review. Establishes weighted average rate increase disclosure requirements for a health plan's or insurer's aggregated large group market products and requires the Department of Managed Health Care and the California Department of Insurance to conduct a public meeting regarding large group rate changes for each plan or insurer that offers coverage in the large group market between November 1, 2016, and March 1, 2017, and annually thereafter. Creates a notice to employers 60 days prior to renewal about the rate increase relative to rate increases negotiated by the California Health Benefit Exchange and CalPERS, and whether the rate change includes any portion of the excise tax paid by the plan. ***(Chapter 801, Statutes of 2015).***

SB 908 (Hernandez) -- Health care coverage: premium rate change: notice: other health coverage. Requires health plans and health insurers to notify purchasers in the individual and small group market if premium rate changes have been determined unreasonable or unjustified associated with the health insurance rate review process. ***(Chapter 498, Statutes of 2016).***

SB 923 (Hernandez) -- Health care coverage: cost sharing changes. Prohibits a health plan contract or health insurance policy from changing any cost sharing design during the plan or policy year, except when required by state or federal law. (***Chapter 192, Statutes of 2016).***

SB 1477 (Committee on Health) -- Health. Requires the California Health Benefit Exchange to also be known as Covered California, replaces references from the now-repealed Healthy Families Program to the Medi-Cal program, and from the repealed AIM-Linked Infants Program to the Medi-Cal Access Program, permits the Department of Health Care Services to enter into contracts for administrative activities to help implement the new Medicaid Managed Care regulations, and makes a technical change to ensure that trade associations remain eligible for federal emergency preparedness funds. ***(Chapter 733, Statutes of 2016).***

AB 248 (Roger Hernández) -- Health insurance: minimum value: large group market policies. Prohibits non-grandfathered health plans or health insurers that offer, amend, or renew a large group health plan contract or health insurance policy from marketing, offering, amending, or renewing a large group plan contract or health insurance policy that provides a minimum value of less than 60% (at least 60% of an enrollees' or insureds medical costs are covered by the plan). (***Chapter 617, Statutes of 2015)*.**

AB 339 (Gordon) -- Health care coverage: outpatient prescription drugs. Requires health plans and health insurers that provide coverage for outpatient prescription drugs to have formularies that do not discourage the enrollment of individuals with health conditions, and requires combination antiretroviral drug treatment coverage of a single-tablet that is as effective as a multitablet regimen for the treatment of HIV/AIDS. Places in state law, federal requirements related to pharmacy and therapeutics committees, access to in-network retail pharmacies, standardized formulary requirements, formulary tier requirements similar to those required of health plans and insurers participating in Covered California and copayment caps of $250 and $500 for a supply of up to 30 days for an individual prescription. (***Chapter 619, Statutes of 2015).***

AB 1305 (Bonta) -- Limitations on cost sharing: family coverage. Requires maximum out-of-pocket limits and deductibles for health plan or health insurance coverage for families to include maximum out-of-pocket limits and deductibles for each individual of the family to be less than or equal to the maximum out-of-pocket limit and deductibles that apply for coverage purchased for an individual. Implements the individual deductible requirement in the large group market on contracts and policies issued, amended, or renewed on or after July 1, 2016. (***Chapter 641, Statutes of 2015)*.**

SB 223 (Atkins) -- Health care language assistance services. Requires health plans, including Medi-Cal managed care plans and health insurers to include information about the availability of language assistance services, including oral interpretation services in the top 15 languages as determined by the Department of Health Care Services. Requires interpreters to meet specified requirements, requires specified disclosures to the public and Medi-Cal beneficiaries and applies these and existing Medi-Cal provisions on language assistance to Medi-Cal mental health plans. ***(Chapter 771, Statutes of 2017).***

SB 374 (Newman) -- Health insurance: discriminatory practices: mental health. Requires large group, small group, and individual health insurance policies to provide all covered mental health and substance use disorder benefits in compliance with the federal Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all rules, regulations, and guidance issued pursuant to MHPAEA. ***(Chapter 162, Statutes of 2017).***

SB 910 (Hernandez) -- Short-term limited duration health insurance. Prohibits a health insurer from issuing, amending, selling, renewing, or offering a policy of short-term limited duration health insurance in California commencing January 1, 2019. ***(Chapter 687, Statutes of 2018).***

SB 1245 (Leyva) -- Covered California. Extends existing Covered California Executive Board emergency regulation authority until January 1, 2022, with two readoptions until January 1, 2027, and requires any rule or regulation to be discussed by the Covered California Executive Board during at least one properly noticed board meeting prior to the board meeting at which the board adopts the rule or regulation**.** (***Chapter 417, Statutes of 2018).***

SB 1375 (Hernandez) -- Health insurance: small employer groups. Prohibits employer group health benefit plans from being issued, marketed, or sold to a sole proprietorship or partnership without employees. Requires only individual health benefit plans to be sold to any entity without employees. Revises the definition of "eligible employee" for purposes of all small employer health plan contracts and health insurance policies to exclude sole proprietors or their spouses, and partners or their spouses. ***(Chapter 700, Statutes of 2018).***

SR 26 (Hernandez, De León) -- The Patient Protection and Affordable Care Act. Affirms the California State Senate's strong support for the ACA, calls upon Congress to reject any effort to repeal the ACA unless it is simultaneously replaced with an alternative program that meets the standards articulated by President Trump that no American will lose coverage, and that coverage will be more affordable and of higher quality for all Americans. Urges Congress to not vote on any measure that would repeal and replace the ACA without first allowing a comprehensive public review, including evaluations by the Congressional Budget Office and relevant policy committees. Makes legislative findings on the impact of the ACA in reducing the number of uninsured, the number of people receiving coverage under the provisions of the ACA, and the impact of the proposed American Health Care Act on the state and the number of Californians receiving health coverage. ***(Adopted).***

AB 156 (Wood) -- Individual market: enrollment periods. Deletes a reference in existing law to the ACA reinsurance program related to individual and small group health insurance policy single risk pool index rate adjustments, and revises for 2019 and after the open enrollment periods under which people

may purchase health insurance through Covered California and the individual insurance market outside of Covered California. ***(Chapter 468, Statutes of 2017).***

AB 2893 (Waldron) -- California Health Benefit Review Program: financial impacts. Adds to the financial impact analysis requested of the California Health Benefit Review Program (CHBRP) related to CHBRP's assessment of health plan or health insurance mandate legislation, the impact of the coverage or repeal of coverage on anticipated costs or savings estimated upon implementation for one subsequent calendar year, or, if applicable, two subsequent calendar years through a long-range estimate. ***(Chapter 326, Statutes of 2018).***

2019-20

SB-129 (Pan) -- Health care coverage reporting. Requires annual health plan and insurer enrollment reporting to include enrollment data for products sold inside and outside of Covered California, any other business lines, and multiple employer welfare arrangements; and requires the California Department of Insurance and the Department of Managed Health Care to publicly report annual enrollment data no later than April 15th of each year. ***(Chapter 241, Statutes of 2019).***

SB-260 (Hurtado) -- Automatic health care coverage enrollment. Requires Covered California, commencing July 1, 2021, to enroll an individual or individuals using electronic information from Medi-Cal or the Children's Health Insurance Program in the lowest cost silver Covered California plan. Requires a health plan or insurer to annually notify an individual that when he or she ceases to be enrolled in coverage, his or her contact information will be provided to Covered California to assist him or her in obtaining other coverage, or that he or she may opt out of this transfer of information. (***Chapter 845, Statutes of 2019).***

SB-406 (Pan) -- Health care omnibus bill. Contains a number of changes to law related to health care coverage, vital records, food safety, adult health, and recovery facilities. Delinks requirements on health plans and health insurers related to preventive services without cost sharing and annual and lifetime benefit limits from the ACA, extends the California Health Benefits Review Program and other operational authority to 2022, and makes other technical and conforming changes to existing law. (***Chapter 302, Statutes of 2020*****).**

SB-583 (Jackson) -- Clinical trials. Conforms California law with respect to health plan and insurer coverage requirements for participants in clinical trials to incorporate federal requirements enacted as part of the ACA, which includes expanding the type of clinical trials to include life-threatening diseases or conditions***. (Chapter 482, Statutes of 2019).***

AB-174 (Wood) -- Health care coverage: financial assistance. Requires Covered California to develop and prepare biannual public reports to inform the California Health and Human Services Agency, the Legislature, and the public about state individual market financial assistance established in the 2019-2020 Budget Act. Corrects an incorrect cross reference contained in AB 651 (Muratsuchi, Chapter 782, Statutes of 2017) related to nonprofit health facilities. ***(Chapter 795, Statutes of 2019).***

AB-414 (Bonta) -- Health care coverage: minimum essential coverage. Directs the Franchise Tax Board to report to the Legislature regarding specific information resulting from California's minimum essential health coverage requirement and individual shared responsibility penalty. ***(Chapter 801, Statutes of 2019).***

AB-731 (Kalra) -- Health care coverage: rate review. Requires large group health insurance products to be reviewed by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) similar to individual and small group products based on methodology, and benefit and cost-sharing variations. Requires new reporting for all health plans and insurers on specified fees, reclassification of services, comparisons to Medicare on prices paid, and variations in medical trend by geographic region. Requires, upon request, DMHC and CDI to determine if large group experience rated changes are unreasonable or unjustified, and if so, requires health plans and insurers to notify the purchaser of an unreasonable or unjustified rate determination**.** ***(Chapter 807, Statutes of 2019).***

AB-929 (Luz Rivas) -- California Health Benefit Exchange: data collection. Requires a Covered California qualified health plan to report on cost reduction efforts, quality improvements, or disparity reductions. Requires Covered California to post annually on its website plan-specific data and information on cost reduction efforts, quality improvements, and disparity reductions in a manner that protects the personal information of enrollees***. (Chapter 812, Statutes of 2019).***

AB-1309 (Bauer-Kahan) -- Health care coverage: enrollment periods. Makes the annual health insurance open enrollment period the beginning of November 1 of the preceding calendar year to January 31 of the benefit year, for individual market policies available on or after January 1, 2020. ***(Chapter 828, Statutes of 2019).***

AB-2118 (Kalra) -- Health care service plans and health insurers: reporting requirements. Establishes new reporting requirements for health plans and insurers with respect to premium rates, cost sharing, benefits and benefit designs of products offered and sold in the individual and small group markets. (***Chapter 277, Statutes of 2020).***