



Abbreviated Analysis

California Assembly Bill 570: Dependent Parent Health Care Coverage

Summary to the 2021–2022
California State Legislature
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Prepared by
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SUMMARY

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP) conduct a cost assessment of California Assembly Bill (AB) 570. AB 570 would expand the definition of “dependent coverage” for enrollees in group and individual plans and policies regulated by the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), respectively. The health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to the bill, as these beneficiaries are not enrolled in either group or individual plans. Current law Health and Safety Code 1357(a) and 1357.600(a); Insurance Code 1399.845(b) and 10700(e) defines dependents as “spouses, registered domestic partners or children.” The updated language would expand the definition to include eligible parents or stepparents.

Projected Enrollment Impacts

AB 570 would impose specific requirements for enrollment of dependent parents and stepparents, thereby limiting the eligibility of such individuals. In particular, the individual must meet IRS requirements, including that the head of household provided more than 50% of the person’s total support.

CHBRP projects that the enrollees in CDI- and DMHC-regulated plans and policies would increase by 20,000 to 80,000, as dependent parents and stepparents became newly enrolled or switched from other plans or policies (those not regulated by the CDI and DMHC).

Projected Impacts on Expenditures

For AB 570, CHBRP has presented a low enrollment and a high enrollment scenario.

Under the low enrollment scenario, AB 570 would increase total net annual expenditures by \$234,075,000, or 0.17%, for enrollees with health insurance subject to state-level benefit mandates. This is due to a \$207,339,000 increase in total health insurance premiums and a \$26,736,000 increase in enrollee cost sharing (for the new enrollees).

Under the high enrollment scenario, AB 570 would increase total net annual expenditures by \$936,304,000, or 0.69%, for enrollees with health insurance subject to state-level benefit

mandates. This is due to an \$829,360,000 increase in total health insurance premiums and a \$106,944,000 increase in enrollee cost sharing (for the new enrollees).

CHBRP recognizes that new enrollees may have previously had health insurance or may have been previously uninsured. The choice to gain or switch coverage as a dependent parent or stepparent is an individualized decision that may be driven by consideration of a number of factors: a comparison of premium costs, health insurance plan design, provider networks, formulary design, and other considerations. CHBRP cannot estimate what coverage (if any) dependent parents and stepparents many have had previously.

Policy Context

For health insurance, a dependent is typically a child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.

Plans and policies regulated by DMHC and CDI do not currently include parents or stepparents as eligible dependents. Enrollment is almost uniformly limited to the employee or policyholder, any spouse/domestic partner, and any children under age 26 years. However, at least 30 states have extended the eligibility for dependent coverage. Most states require that a young adult be unmarried and financially dependent on their parents in order to qualify for extended dependent coverage.

POLICY CONTEXT

The Assembly Committee on Health requested on March 1, 2021, that CHBRP provide a limited fiscal analysis of AB 570. This abbreviated analysis fulfills that request with some supporting policy context.

Assembly Bill 570 would expand the current law¹ definition of “dependent coverage” for enrollees in group and individual plans and policies regulated by the California Department of Managed Health care (DMHC) and the California Department of Insurance (CDI). This bill would not impact Medi-Cal Managed Care Plans. Current state law defines dependents as “spouses, registered domestic partners, or children.” The updated language would expand the definition to include eligible dependent parents or stepparents.

For health insurance, a dependent is typically a child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents (IRS, 2021). (For adult children under the age of 26 years, the child does not have to be claimed as a dependent for income tax purposes to maintain eligibility.)

Expanding Eligible Dependents

Enrollees in plans and policies regulated by DMHC and CDI cannot currently include parents or stepparents as eligible dependents. Eligibility is almost uniformly limited to the employee or policyholder, any spouse/domestic partner, and any children under age 26 years.²

There has been a recent precedent of expanding eligibility of eligible dependents. The extension of coverage for young adults under their parents’ or guardians’ health insurance, like many of the Affordable Care Act’s (ACA’s) provisions, originated in state legislatures. Prior to the implementation of the ACA, at least 31 states required, for health insurance purposes, that employees or policyholder be able to treat young adults (the specific age varied by state) as eligible dependents (NCSL, 2016). Additionally, some states required certain conditions to be met by young adults in order to be eligible for enrollment in their guardians’ plans. For example, a number of states required that young adults be unmarried in order to qualify.

States may continue with current state law requirements for extended dependent coverage unless they prevent the application of the ACA. As with other state health insurance statutes, the state mandate language enables the state insurance departments to educate the public and to implement and enforce those laws directly, including use of state courts and state-specific penalties.

State and local governments, as employers and sponsors of coverage plans, are required to notify those under the age of 26 whose coverage has ended or were denied coverage under their plans before turning 26, of enrollment opportunities.

State Actions

The federal ACA law applies to young adults in all states. As of 2012 (before the ACA was fully in effect), 37 states had already extended the age that young adults can remain on their parents’ health insurance plan.³ There is considerable variation among state laws in terms of eligibility requirements. At

¹ Health and Safety Code 1357(a) and 1357.600(a); Insurance Code 1399.845(b) and 10700(e).

² Children include natural children, step-children, foster children, adopted children, and children placed with the employee for adoption. Some plans/policies will also extend dependent eligibility to children under age 26 years for whom the employee is a legal guardian, or beyond in some select states.

³ Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New

least 30 states have extended dependent coverage, regardless of student status. Most states require that a young adult be unmarried and financially dependent on their parents in order to qualify for extended dependent coverage.

Several states have more generous allowances for dependents staying on health insurance policies, and a few others have special provisions or allow for other dependent definitions. Florida⁴ allows for dependent children up to 25 years of age, who live with their parent or are a student, and up to 30 years old, who are also unmarried and have no dependent child of their own, to remain on their parents' insurance. Illinois has an exemption for veterans. Parents with dependents who are veterans can keep them on their plans up to age 30.⁵ Missouri defines dependent as an unmarried child up to age 26. However, Missouri provides an exemption for continuing coverage of a dependent child if "the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance."⁶ New Jersey allows, at the option of the insured person, that a dependent may be covered up to the age of 31, as long as they are unmarried and have no dependents of their own.⁷ Similarly, New York allows an unmarried adult child to remain on their parent's insurance through age 29 (up to age 30) if they are a resident of New York.^{8,9}

Oregon defines dependent as an unmarried child up to 23, elderly parents, and disabled adult children for the purpose of insurance coverage.¹⁰ Pennsylvania allows for an unmarried child to remain on parent's insurance up to age 30 if they have no dependents and are residents of PA or are enrolled as full-time students.^{11,12} South Dakota allows for dependent full-time students up to the age of 29.¹³ Wisconsin allows for continued coverage for full-time students, regardless of age.¹⁴

Rhode Island allows for continuation of insurance coverage if the dependent child is mentally or physically impaired,¹⁵ as does South Dakota¹⁶ and South Carolina.¹⁷

Costs

The cost of notifying families about new enrollment opportunities is shared between insurance providers and employers. The cost of covering the young adults who take advantage of the extension is shared between employers and the families of newly covered young adults. For families with no employer health coverage, the cost may fall on the parents. A qualified young adult cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to the loss of dependent status. We assume that notification costs will be handled similarly for dependent parents.

IRS Notice 2010-38¹⁸ provides guidance to extend the general exclusion from gross income for the reimbursements for medical care under an employer provided accident or health plan to any employee's

York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

⁴ [Florida 627.6562.](#)

⁵ [215 ILCS 5/356z.12.](#)

⁶ [Mo. Rev. Stat. § 354-536.](#)

⁷ [N.J.S.A. 17B:27-30.5](#)

⁸ [2009 AB 9038\).](#)

⁹ McKinney's Insurance Law § 3216.

¹⁰ [O.R.S. § 735.720.](#)

¹¹ [2009 SB 189.](#)

¹² Pennsylvania also allows for full-time students whose studies are interrupted by service in the reserves or National Guard to extend their eligibility beyond the normal terminating age to the length of their deployment.

¹³ [SD Codified Laws § 58-17-2.3.](#)

¹⁴ Wis. Stat. § 632.885.

¹⁵ [R.I. Gen. Laws § 27-20-45](#) and [Gen. Laws § 27-41-61.](#)

¹⁶ [SD Codified Laws Ann. § 3-12A-1.](#)

¹⁷ S.C. Code Ann. § 38-71-350 requires that a dependent child who is not capable of self-sustaining employment be allowed to remain on his or her parent's insurance, without regard to age.

¹⁸ IRS Notice 2010-38 may be accessed at: <https://www.irs.gov/pub/irs-drop/n-10-38.pdf>.

child who has not yet attained age 27 years as of the end of the taxable year, making the benefit tax-free. A similar guidance should apply with implementation of AB 570, because the criteria for eligible dependent parents/step-parents is required to meet IRS criteria.

TRICARE

CHBRP is aware of a limited primary care program for “secondary dependents” in the TRICARE program. TRICARE Plus is a primary care program that may offer primary care and prescription drugs to eligible parents and parent-in-law(s) who are dependent on an active service member/sponsor. In such scenarios, the law requires the parents to be "in fact" dependent on the service member/sponsor, and the service member's contribution must be more than one-half of monthly living expenses of the parental dependents. Documentation to prove living expenses and the service member's contribution must be provided.¹⁹

¹⁹ If these requirements are met and the parents do qualify as secondary dependents, their TRICARE options are limited. The parents/parents-in-law are eligible for care only in military hospitals and clinics through the program known as TRICARE Plus. They may enroll at military hospitals and clinics based on space/resource availability. Dependent parents are not eligible for any other TRICARE program. TRICARE Plus doesn't cover specialty care. In addition, TRICARE does not pay for care by civilian providers, even if the military hospital or clinic refers for care.

IMPACTS

Table 1. AB 570 Impacts on Benefit Coverage, Utilization, and Cost, 2022

	Baseline (2022)	Postmandate Year 1 (2022)	Increase/ Decrease	Change	Postmandate Year 1 (2022)	Increase/ Decrease	Change
		Low Scenario			High Scenario		
Benefit Coverage							
Total enrollees with health insurance subject to state-level benefit mandates (a)	21,946,000	21,946,000	0	0.00%	21,946,000	0	0.00%
Total enrollees with health insurance subject to AB 570	13,941,000	13,961,000	20,000	0.14%	14,021,000	80,000	0.57%
Total percentage of enrollees with health insurance compliant with AB 570	0%	0%	0%	0.00%	0%	0%	0.00%
Utilization and Cost — Existing Enrollees & Dependents							
Enrollees & other dependents	13,941,000	13,941,000	—	0.00%	13,941,000	—	0.00%
Average covered benefits (PMPM)	\$485.93	\$485.93	\$0.00	0.00%	\$485.93	\$0.00	0.00%
Utilization and Cost — Newly Covered Dependents							
Dependent parents & stepparents	0	20,000	20,000	0.00%	80,000	80,000	0.00%
Average covered benefits (PMPM)	N/A	\$830.38	—	0.00%	\$830.38	—	0.00%
Utilization and Cost — Total Enrollees & Dependents							
Enrollees & all dependents	13,941,000	13,961,000	20,000	0.14%	14,021,000	80,000	0.57%
Average covered benefits for all enrollees (PMPM)	\$485.93	\$486.43	\$0.49	0.10%	\$487.90	\$1.97	0.40%
Expenditures							
<i>Premium (expenditures) by payer</i>							
Private employers for group insurance	\$55,036,808,000	\$55,166,871,000	\$130,063,000	0.24%	\$55,557,059,000	\$520,251,000	0.95%
CalPERS HMO employer expenditures (b) (c)	\$5,765,017,000	\$5,782,254,000	\$17,237,000	0.30%	\$5,833,968,000	\$68,951,000	1.20%
Medi-Cal Managed Care Plan expenditures	\$24,150,529,000	\$24,150,529,000	\$0	0.00%	\$24,150,529,000	\$0	0.00%
<i>Enrollee premiums (expenditures)</i>							
Enrollees for individually purchased insurance	\$15,847,507,000	\$15,859,547,000	\$12,040,000	0.08%	\$15,895,667,000	\$48,160,000	0.30%
Individually purchased – outside exchange	\$4,890,852,000	\$4,894,119,000	\$3,267,000	0.07%	\$4,903,920,000	\$13,068,000	0.27%
Individually purchased – Covered California	\$10,956,655,000	\$10,965,428,000	\$8,773,000	0.08%	\$10,991,747,000	\$35,092,000	0.32%

Enrollees with group insurance, CalPERS HMOs, Covered California, and Medi-Cal Managed Care (c)	\$20,755,165,000	\$20,803,164,000	\$47,999,000	0.23%	\$20,947,163,000	\$191,998,000	0.93%
<i>Enrollee out-of-pocket expenses</i>							
Cost-sharing for covered benefits (deductibles, copayments, etc.)	\$13,169,503,000	\$13,196,239,000	\$26,736,000	0.20%	\$13,276,447,000	\$106,944,000	0.81%
Expenses for noncovered benefits (d)	\$0	\$0	\$0	0.00%	\$0	\$0	0.00%
Total Expenditures	\$134,724,529,000	\$134,958,604,000	\$234,075,000	0.17%	\$135,660,833,000	\$936,304,000	0.69%

Source: California Health Benefits Review Program, 2021.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI aged 0 to 64 years as well as enrollees 65 years or older in employer-sponsored health insurance. This group includes commercial enrollees (including those associated with Covered California or CalPERS) and Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

(b) Of the increase in CalPERS employer expenditures, about 54.1% would be state expenditures for CalPERS members who are state employees or their dependents.

About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(c) Enrollee premium expenditures include contributions by employees to employer-sponsored health insurance, health insurance purchased through Covered California, and contributions to Medi-Cal Managed Care

(d) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

Key: CalPERS HMOs = California Public Employees' Retirement System Health Maintenance Organizations; CDI = California Department of Insurance; DMHC = Department of Managed Health.

This section reports the estimated incremental impacts of AB 570 on covered benefits.

Baseline and Postmandate Benefit Coverage

Currently, there are 13,941,000 enrollees with health insurance that would be subject to AB 570. If enacted, the law would affect the health insurance of commercial/CalPERS enrollees in DMHC-regulated plans and CDI-regulated policies.

Baseline and Postmandate Enrollment

CHBRP projects that the number of members covered by CDI- and DMHC-regulated plans and policies would increase by between 20,000 and 80,000 individuals who have newly gained coverage or who switched coverage from policies not regulated by the CDI and DMHC.

For Tax Year 2017, IRS data indicate that 3.37 million exemptions were claimed on tax returns for dependent parents nationally.²⁰ Assuming that the demographics of California are similar to the United States, this would indicate that roughly 400,000 individuals were reported as dependent parents.

For AB 570, CHBRP has presented a low enrollment and a high enrollment scenario.

CHBRP's **low enrollment scenario** is informed by the following considerations:

- AB 570 would impose specific requirements for dependent parents and stepparents, thereby limiting the eligibility of such individuals. In particular, the individual must meet IRS requirements, including that the head of household provided more than 50% of the person's total support.
- For dependent parents and stepparents, CHBRP's analysis considers that there are a number of programs currently available to many individuals who could receive coverage under AB 570. The availability of these programs would limit the potential impact of AB 570.
- Generally, Medicare is available for people age 65 years and older, and for younger people with disabilities. For the low enrollment scenario, CHBRP assumes that, generally, Medicare-eligible beneficiaries would continue coverage with Medicare. Although there are no current guidelines on coordination of benefits for Medicare and coverage as a dependent parent, the low enrollment scenario assumes that Medicare would be the primary payer. The low enrollment scenario also assumes that most dependents would favor Medicare coverage compared to coverage as a dependent parent. CHBRP anticipates that the challenge of comparing policies with different premium structures, copays, deductibles, and maximum out-of-pocket amounts would be challenging to many enrollees.
- For those not eligible for Medicare and individuals meeting specified income requirements, Medi-Cal coverage may be available. Also, many individuals requiring 50% support would potentially be dual eligible for Medicare and Medi-Cal. Medi-Cal policies typically have minimal cost sharing and provide richer financial benefits than small-group, individual, and large-group coverage.
- Therefore, CHBRP has assumed that current programs such as Medicare and Medi-Cal would continue to provide coverage for dependent parents and stepparents.

CHBRP's **high enrollment scenario** is informed by the following considerations:

- Many dependent parents who are eligible for Medicare may prefer coverage through the dependent-as-parent option.

²⁰ <https://www.irs.gov/pub/irs-soi/17in23ar.xls>.

- Medicare eligible enrollees could cancel or postpone Part B coverage,²¹ which would be less expensive in terms of monthly premiums than adding another family member, especially if the family is already in the maximum family tier.²² For those with Original Medicare only, there is a Part A deductible and a Part B deductible. There are many policies available through the individual, small-group, and large-group markets with no deductible.
- Medicare Advantage policies are available with a \$0 premium (after paying the Part B premium); however, these policies have a maximum out-of-pocket amount of roughly \$3,400 in many cases.
- There are many large-group and also small-group policies with a lower maximum out-of-pocket amount, so the dependent-as-parent option could be more appealing.
- Also, CHBRP considered in developing this scenario that it could make financial sense to add a parent to a family policy, thereby limiting the total maximum out-of-pocket costs for the family.
- Some parents will compare the dependent-as-parent option to Medigap policies. Although Medigap policies have low out-of-pocket costs, they also have premiums. Coverage under parent-as-dependent is likely more affordable in many cases, especially for parents who cannot be underwritten (that is, those who have pre-existing conditions or a tobacco history).

Other drivers for the high enrollment scenario may include the following:

- Parents eligible for Medi-Cal may prefer the dependent-as-parent option if they have broader network choices or a broader formulary.
- Having one insurance policy in a household would also simplify communication with the insurer to understand issues such as network, coverage, benefits, etc.
- Some eligible for the dependent-as-parent option may use this as secondary insurance.
- And finally, there is a risk of medical tourism, which is discussed below.

Baseline and Postmandate Premiums

Baseline premiums were determined from a survey of the largest (by enrollment) plans and insurers regulate by DMHC and CDI. The average cost of covered benefits was estimated to be \$485.93 (see Table 1).

Postmandate, CHBRP assumed an increase in premiums and cost sharing for newly enrolled parents and stepparents. CHBRP assumed that utilization of covered services would be driven by the demographics and corresponding risk status of newly enrolled dependent parents and stepparents. CHBRP assumed that these new enrollees would be, on average, older than other enrollees. CHBRP assumed that newly covered members would have similar demographics to those of similar ages currently enrolled in the individual market. Utilization of covered services for existing and new enrollees was estimated using the age factors in the Milliman Health Cost Guidelines. The average cost of covered services for these new enrollees was estimated to be \$830.38 (see Table 1).

Baseline and Postmandate Expenditures

For AB 570, CHBRP has presented a low enrollment and a high enrollment scenario.

Under the low enrollment scenario, AB 570 would increase total net annual expenditures by \$234,075,000, or 0.17%, for enrollees with health insurance subject to state-level benefit mandates. This

²¹ Medicare Part B (medical insurance) helps pay for services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services.

²² CHBRP recognizes that there are administrative hurdles to canceling Part B coverage, and there is a risk of a late enrollment penalty for postponing Part B coverage. However, it may be possible to avoid the late enrollment penalty for Part B coverage if dependent-as-parent coverage meets alternative coverage requirements.

is due to a \$207,339,000 increase in total health insurance premiums and a \$26,736,000 increase in enrollee share of cost for services for newly covered members.

Under the high enrollment scenario, AB 570 would increase total net annual expenditures by \$936,304,000, or 0.69%, for enrollees with health insurance subject to state-level benefit mandates. This is due to a \$829,360,000 increase in total health insurance premiums and a \$106,944,000 increase in enrollee share of cost for services for newly covered members.

CHBRP recognizes that new enrollees may have previously had health insurance or may have been previously uninsured. The choice to gain or switch coverage as a dependent parent or stepparent is an individualized decision that would be driven by a comparison of premium costs, cost sharing, provider network, formulary design, and other considerations. CHBRP cannot estimate how many may have previously had health insurance and so cannot project whether there would be a decrease in such enrollment, though such a decrease could occur. CHBRP has provided this analysis to illustrate the potential impact of AB 570.

Other Cost Considerations With Respect to AB 570

For large-group plans and policies, premiums are typically community rated using the composite experience of the group. This rating basis has the effect of cross-subsidizing the premiums of older enrollees. For small-group and individual plans and policies, premiums are typically rated using a composite on an individual basis. The individual rating basis restricts premiums of individual members to a 3:1 age curve. Similar to large-group policies, rating basis has the effect of cross-subsidizing the premiums of older enrollees. Because AB 570 seems likely to attract older enrollees, it is reasonable to conclude that AB 570 would result in increased premiums for enrollees currently with coverage.

For employer-sponsored coverage, premiums are typically subsidized by the employer, who pays a percentage of the total premiums. The premium subsidies generally vary by family tier (i.e., single, two-party, family). It is possible that employers may consider modifications or additions to family tiers in response to AB 570; however, CHBRP does not assume any such changes in the first year of postmandate.

Costs stemming from medical tourism may be a risk to payers. In some cases, dependent parents may meet IRS requirements and live outside the United States. Insurance availability through AB 570 would provide an opportunity for the dependent to seek treatment in the United States. Although there are administrative hurdles relating to receiving care in the United States for a dependent parent residing in Mexico or Canada, the opportunity to receive care in the United States would be very attractive, especially for those with high-risk conditions. The administrative hurdles include: (a) meeting IRS requirements for dependent status; and (b) typical plan provisions that limit risk exposure such as annual enrollment periods, prior authorization, and referral requirements. For AB 570, we have not explicitly modeled costs related to medical tourism risk; however, the broad range between the low enrollment and high enrollment scenarios is intended to capture this risk.

Analysis-Specific Caveats and Assumptions

Assumptions for Baseline Benefit Coverage

- CHBRP assumed 0% of the enrollees with health insurance subject to AB 570 currently have insurance that offers enrollment to dependent parents and stepparents.
- CHBRP did not conduct carrier surveys to determine the percentage of enrollees that currently have coverage for parents and stepparents.

Assumptions for Postmandate Utilization

- Based on the discussion above, CHBRP assumed that the number of enrollees would increase by the amounts in the following table:

<u>Market Segment</u>	<u>Demographics</u>	<u>Increase in Members From Baseline</u>	
		<u>Low Scenario</u>	<u>High Scenario</u>
Large Group	17 and Under	0.00%	0.00%
	18 to 64	0.20%	0.81%
	65 and Older	2.03%	8.11%
Small Group	17 and Under	0.00%	0.00%
	18 to 64	0.10%	0.41%
	65 and Older	1.22%	4.86%
Individual	17 and Under	0.00%	0.00%
	18 to 64	0.10%	0.41%
	65 and Older	0.10%	0.41%
CalPERS HMO	17 and Under	0.00%	0.00%
	18 to 64	0.23%	0.93%
	65 and Older	2.33%	9.32%

- CHBRP assumed that the increase in covered lives for CalPERS HMO would be 15% higher compared to the large group market. This is due to the rich cost-sharing plan design of CalPERS plans.

Assumptions for Postmandate Cost

- CHBRP assumed an increase in the cost of services for newly covered members, driven by the demographics and corresponding risk status of newly covered members.
- CHBRP assumed that newly covered members would be age 40 years or older and have similar demographics to those currently covered by the individual market.
- The risk status of existing and newly covered enrollees was calculated using the Milliman Health Cost Guidelines.

Assumptions for Postmandate Cost Sharing

- CHBRP assumed that applicable cost sharing would be unchanged, postmandate. There is an increase in cost sharing driven by higher utilization.
- As a simplifying assumption, CHBRP did not make any adjustment to the percentage of cost sharing relative to all covered benefits to account for the tendency of an individual from a high-cost population being more likely to reach their deductible or out-of-pocket maximum.
- As a simplifying assumption, CHBRP did not make any adjustment to the portion of premium covered by employers postmandate.

APPENDIX A TEXT OF BILL ANALYZED

On March 1, 2021, the California Assembly Committee on Health requested that CHBRP analyze AB 570.

ASSEMBLY BILL

NO. 570

Introduced by Assembly Member Santiago

(Coauthors: Assembly Members Carrillo, Cristina Garcia, Eduardo Garcia, Stone, Ting, Villapudua, and Wicks)

(Coauthors: Senators Hurtado, Laird, and Wiener)

February 11, 2021

An act to amend ~~Section 10112.28~~ of Sections 1357, 1357.500, 1357.600, and 1399.845 of, and to add Section 1374.1 to, the Health and Safety Code, and to amend Sections 10700, 10753, 10755, and 10965 of, and to add Section 10278.1 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 570, as amended, Santiago. ~~Nongrandfathered health insurance policies.~~ *Dependent parent health care coverage.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes an individual or eligible employee to add a dependent to their health care service plan contract or health insurance policy, including adding a dependent outside of an initial enrollment period if certain criteria are met. Existing law defines "dependent" for these purposes to mean the spouse, registered domestic partner, or child of an individual with an individual contract or policy or an eligible employee with a small employer contract or policy.

This bill would require a group or individual health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, that provides dependent coverage to make that coverage available to a qualified dependent parent or stepparent. The bill would expand the definition of "dependent" for an individual or small employer health care service plan contract or health insurance policy to include a qualified dependent parent or stepparent. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a nongrandfathered health insurance policy issued, amended, or renewed on or after January 1, 2015, to provide for a limit on the annual out-of-pocket expenses for covered essential health benefits.~~

~~This bill would make technical, nonsubstantive changes to that provision.~~

Vote: majority Appropriation: no Fiscal Committee: ~~no~~yes Local Program: ~~no~~yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Section 1357 of the Health and Safety Code is amended to read:*

1357. As used in this article:

(a) “Dependent” means ~~the spouse or child~~ *spouse, child, or parent or stepparent pursuant to Section 1374.1*, of an eligible employee, subject to applicable terms of the health care plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (o).

(b) “Eligible employee” means either of the following:

(1) 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 small employer’s regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term does not include sole proprietors or the spouses of those sole proprietors, partners of a partnership or the spouses of those partners, or employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association are eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employees health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health benefit plan.

(D) The employee shall have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

(2) Any member of a guaranteed association as defined in subdivision (o).

(c) “In force business” means an existing health benefit plan contract issued by the plan to a small employer.

(d) “Late enrollee” means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association’s plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (o), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) ~~He or she~~ *The individual* was covered under another employer health benefit plan, the Healthy Families Program, the Access for Infants and Mothers (AIM) Program, or the Medi-Cal program at the time the individual was eligible to enroll.

(B) ~~He or she~~ *The individual* certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the AIM Program, or the Medi-Cal program was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) ~~He or she~~ *The individual* has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan’s coverage, cessation of an employer’s contribution toward an employee or dependent’s coverage, death of the person through whom the individual was covered as a dependent, legal separation, or

divorce; or ~~he or she~~ *the individual* has lost or will lose coverage under the Healthy Families Program, the AIM Program, or the Medi-Cal program.

(D) ~~He or she~~ *The individual* requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or Healthy Families Program coverage.

(2) The employer offers multiple health benefit plans and the employee elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4) (A) In the case of an eligible employee, as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(B) In the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the association stating that the association sent a written notice in boldface type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that ~~he or she~~ *the member* meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or meets the requirements of paragraph (2) or (3).

(C) In the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that ~~he or she~~ *the employer or person* meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or meets the requirements of paragraph (2) or (3), or that ~~he or she~~ *the employer or person* recently had a change in status that would make ~~him or her~~ *them* eligible and that application for enrollment was made within 30 days of the change.

For the complete bill language version that CHBRP analyzed (AB 570 is more than forty pages long), please go to CHBRP's website at https://www.chbrp.org/completed_analyses/index.php.

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org.