Date of Hearing: April 27, 2021

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 570 (Santiago) – As Amended March 18, 2021

SUBJECT: Dependent parent health care coverage.

SUMMARY: Requires a group or individual health care service plan (health 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. Expands the definition of "dependent" for an individual or small employer health plan contract or health insurance policy to include a qualified dependent parent or stepparent. Specifically, **this bill**:

1) Requires a group or individual health 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 parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code.

2) Expands the definition of dependent to include parent or stepparent in specified sections of existing law as it relates to small group access to contracts for health care services, nongrandfathered small employer plans or insurance, grandfathered small employer plans or insurance, and individual access to health care coverage.

EXISTING FEDERAL LAW:

1) Establishes the Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms, including the availability of health insurance exchanges, coverage of essential health benefits (EHBs), a prohibition against imposing a preexisting condition provision, a requirement to maintain minimum essential coverage (MEC), imposing a shared responsibility penalty (individual mandate) on an applicable individual who does not maintain MEC, and to fairly and affirmatively offer, market, and sell all of the health plan's health benefit plans that are sold in the individual and small group market, as specified. Requires health insurance carriers that offer coverage for dependents to extend coverage until the dependent is 26 years of age.

2) Defines a qualifying relative as an individual who depends on a taxpaying relative for over one-half of the individual's support for the calendar year.

EXISTING STATE LAW:

1) Establishes in state government, the California Health Benefits Exchange, referred to as Covered California, as an independent public entity not affiliated with an agency or department, and requires Covered California to compare and make available through selective contracting health insurance for individuals and small business purchasers as authorized under the ACA.

2) Provides for the regulation of health plans by the Department of Managed Health Care (DMHC) and health insurers by the California Department of Insurance (CDI).

3) Requires health plans and insurers, to the extent EHBs are required by federal law, providing health coverage in the individual and small group markets to cover, at a minimum, EHBs, including the ten EHB benefit categories in the ACA, and consistent with California's EHB benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan (Kaiser benchmark), as specified.

4) Defines dependent as the spouse or child of an eligible employee, subject to the applicable terms of the health plan contract or health benefit plan covering the employee.

5) Requires for plan years for plan years beginning before January 1, 2014, a group health care service plan contract that qualifies as a grandfathered health plan under Section 1251 of the federal Patient Protection and Affordable Care Act ((ACA) Public Law 111-148) and that makes available dependent coverage of children may exclude from coverage an adult child who has not attained 26 years of age only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in Section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent. Prohibits the limiting age be less than 26 years of age with respect to plan years beginning on or after September 23, 2010.

FISCAL EFFECT: Unknown. This bill has not yet been heard by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, healthcare access for seniors was already an issue pre COVID-19, but now we see an even more urgent need. Prior to COVID-19, an estimated 3 million Californians did not have healthcare insurance. Now, millions of Californians have lost healthcare coverage due to historic unemployment rates. The author states that this bill will provide health coverage to more Californians by ensuring dependent parents, including undocumented immigrants, are covered. The author concludes that by allowing adult children to add their dependent parents to their healthcare plan, working families will save a significant amount each year on healthcare costs.

2) BACKGROUND.

a) ACA. Enacted in March 2010, the ACA provides the framework, policies, regulations and guidelines for the implementation of comprehensive health care reform by the states. The ACA expands access to quality, affordable insurance and health care. As of January 1, 2014, insurers are no longer able to deny coverage or charge higher premiums based on preexisting conditions (under rules referred to as guaranteed issue and modified community rating, respectively). These aspects of the ACA, along with tax credits for low and middle income people buying insurance on their own in new health benefit exchanges, make it easier for people with preexisting conditions to gain insurance coverage.

Before the ACA, many health plans and issuers could remove adult children from their parents' coverage because of their age, whether or not they were a student or where they lived. The ACA requires plans and issuers that offer dependent child coverage to make the coverage available until the adult child reaches the age of 26. Many parents and their children who worried about losing health coverage after they graduated from college no longer have to worry.

According to the California Health Benefits Review Program (CHBRP), 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.

b) California coverage. According to a recent University of California (UC) Berkeley Labor Center publication, even after the American Rescue Plan (ARP) substantially increased premium subsidies for health insurance coverage purchased through Covered California, large inequities remain in who has access to affordable coverage. Nearly 3.2 million Californians will remain uninsured in 2022, or about 9.5% of the population age 0-64 years, according to their projections. The highest uninsured rates will be among undocumented Californians (65%) and those eligible only for insurance through Covered California (28%). These projections, using the California Simulation of Insurance Markets model, take into account the projected economy in 2022 as the state recovers from the pandemic and recession and the associated impacts on coverage eligibility. Undocumented Californians make up the largest group of the uninsured, with nearly 1.3 million individuals under the age of 65 projected to be uninsured, plus an additional 30,000 undocumented seniors age 65+ not included in our modeling. Although fewer than one out of 10 of all Californians are projected to lack insurance in 2022, nearly two out of three (65%) undocumented Californians age 0-64 will be uninsured. Undocumented residents are excluded from federal ACA subsidy and Medicaid eligibility as well as the additional help available through the ARP. Additionally, non-citizens without a green card have much lower rates of job-based coverage than their citizen counterparts because they are more likely to work in industries and occupations that do not offer health insurance. (In California, low-income undocumented children and young adults are eligible for Medi-Cal under state policy, and those who have not enrolled are included in the Medi-Cal eligible uninsured group.) The other eligibility group with a particularly high uninsured rate (28%) are the 800,000 Californians who are not eligible for Medi-Cal or employer-sponsored insurance but are eligible to purchase coverage through Covered California.

c) Employer coverage in California. In 2019, roughly 12.4 million Californians got their coverage from employers. According to the 2020 Kaiser Family Foundation Employer Health Benefits Survey, for job-based coverage, the average annual premium for single coverage rose 4%, to $7,470, and the average annual premium for family coverage also rose 4%, to $21,342. Covered workers, on average, contributed 17% of the cost for single coverage and 27% of the cost for family coverage. The average premium for family coverage has increased 22% over the last five years and 55% over the last 10 years. In California, the Getting to Affordability report states that the average cost of family health insurance plan is $20,000 per year, or almost one-third of the state's median family income. Premiums for the average family health plan in the employer market increased by 133% since 2002.

3) CHBRP analysis. AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the UC to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB

1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP states the following in its analysis of this bill:

a) Enrollees covered. This bill 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).

b) Impact on expenditures. For this bill, CHBPR presented a low enrollment and a high enrollment scenario (details discussed below). Under the low enrollment scenario, this bill 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, this bill 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 would be driven by a comparison of premium costs, cost sharing, provider network, formulary design, and other considerations. CHBRP cannot estimate what coverage (if any) dependent parents and stepparents many have had previously.

i) 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. According to CHBRP, this bill seems likely to attract older enrollees, and it is reasonable to conclude that this bill 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, 2-party, family). It is possible that employers may consider modifications or additions to family tiers in response to this bill, however, CHBRP does not assume any such changes in the first year of postmandate.

ii) 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 this bill would provide an opportunity for the dependent to seek treatment in the United States. While there are administrative hurdles relating to receiving care in the US for a dependent parent residing in Mexico or Canada, the opportunity to receive care in the US 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 this bill, CHBRP did not explicitly modele costs related to medical

tourism risk, however, the broad range between the low enrollment and high enrollment scenario is intended to capture this risk.

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

i) This bill 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.

ii) 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 this bill. The availability of these programs would limit the potential impact of this bill.

iii) Generally, Medicare is available for people age 65 and older and younger people with disabilities. For the low enrollment scenario, CHBRP assumes that generally Medicare eligible beneficiaries would continue coverage with Medicare. While 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.

iv) 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.

v) Therefore, CHBRP has assumed that current programs such as Medicare and Medi-Cal would continue to provide coverage for dependent parents and stepparents.

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

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

ii) Medicare eligible enrollees could cancel or postpone Part B coverage, 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. 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.

iii) 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.

iv) 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.

v) 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.

vi) Some parents will compare the dependent-as-parent option to Medigap policies. While 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, have pre-existing conditions or a tobacco history).

e) Other drivers for the high-enrollment scenario may include the following:
- **i)** Parents eligible for Medi-Cal may prefer the dependent-as-parent option if they have broader network choices or a broader formulary.
- **ii)** Having one insurance policy in a household would also simplify communication with the insurer to understand issues like network, coverage, and benefits.
- **iii)** Some eligible for the dependent-as-parent option may use this as secondary insurance.
- **iv)** There is a risk of medical tourism.

f) **Dependent coverage in other states.** The ACA 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. There is considerable variation among state laws in terms of eligibility requirements. At 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. Florida allows for dependent children up to 25, 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. 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." 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. 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. Oregon defines dependent as an unmarried child up to 23, elderly parents, and disabled adult children for the purpose of insurance coverage. 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. South Dakota allows for dependent full-time students up to the age of 29. Wisconsin allows for continued coverage for full-time students, regardless of age.
Additionally, CHBRP is aware of a limited primary care program for "secondary dependents" in the Tricare. 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 of 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.

4) **SUPPORT.** CDI, the sponsor of this bill, states that this bill would increase health insurance access and affordability for older adults by enabling individuals to enroll their dependent parent(s) in their health insurance coverage. Currently, in the individual and group markets, children can be added as dependents to their parents' health insurance coverage. But, this

protection does not extend to dependent parents. Under existing law today, dependent parents of adult children are not allowed to be included in the same health insurance policy, resulting in the purchase of separate policies with separate deductibles and maximum out-of-pocket limits for the adult child and their dependent parents. According to CDI, allowing dependent parents of adult children to be covered in the same health insurance policy would reduce overall health care costs for the family by pooling these costs and making coverage more affordable, especially during this COVID-19 pandemic. It also represents a measure of equity among different types of dependent individuals for purposes of health insurance. Families that obtain coverage under a single health insurance policy or certificate enjoy the economic protection of a combined family maximum out-of-pocket (MOOP) cost limit. This means that their medical expenses are aggregated towards a maximum amount, rather than each family member having to meet a separate MOOP. In addition, families typically have a combined family deductible, rather than a single deductible that each family member must meet. Requiring health insurance companies to offer dependent coverage to older adults would allow families with dependent parents to include those parents on their health insurance policy. This will, in turn, enable the family to utilize a family deductible and cap their maximum out-of-pocket costs, thus reducing overall health care costs for working families and make it more likely that the dependent parents will be covered. This solution would not be based on an age requirement for the dependent parent but, rather, that the parent meets the federal definition of being a "qualifying relative." CDI writes that as California works to improve the health and well-being of older adults, this bill will continue this effort by providing increased health coverage access. Health Access California states that this bill will provide increased financial security for many older Californians by helping to bridge the gap for those who do not qualify for Medi-Cal. The unprecedented job loss associated with the COVID-19 pandemic has underscored the need to ensure affordable coverage options for that those who lose employer sponsored insurance. The California Pan-Ethnic Health Network writes that even despite the ACA, communities of color are most likely to be uninsured. This is especially true for adults who are undocumented, who are excluded from Medi-Cal. This bill would give adults a much-needed tool to ensure their dependent parent(s) have health insurance especially at a time when their health needs change and increase.

5) **OPPOSITION.** The California Chamber of Commerce (CCC), along with other organizations, write that it is anticipated this bill will cause health care costs to increase. Employer group health plans are already difficult for employers to afford. Typically, employer plans, particularly in the small group market, include employers that contribute an apportioned payment towards dependent premiums in addition to employee premium contributions. This bill would introduce older and higher premium dependents to already strained employer budgets and potentially discourage any dependent contributions or encourage lower contributions to all dependents. This is not a trend that should be encouraged as it could lead to more uncovered Californians. Additionally, this bill must be considered in context as state lawmakers have introduced at least 14 benefit mandate bills this year that could increase premiums for employers and enrollees. According to the California Health Care Foundation, 18 million of 32.7 million insured Californians had health care coverage through an employer sponsored health plan in 2019. The average premium for family coverage has increased 22% over the last five years and 55% over the last 10 years. Since 2002, premiums for the average family health plan in the employer market have increased 133%. The 2020 Kaiser Family Foundation Employer Health Benefits Survey indicated that, for job-based coverage, the average annual premium for single coverage rose 4%, to $7,470. The average annual premium for family coverage also rose 4%,

to $21,342, which is nearly one-third of the state's median family income. According to the CCC, California should not increase costs of health care coverage for employers and employees with another mandate.

6) RELATED LEGISLATION.

a) AB 1400 (Kalra) establishes the California Guaranteed Health Care for All Act, and creates the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. AB 1400 was made a 2-year bill by the author.

b) AB 4 (Arambula) extends, effective January 1, 2022, eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status, pursuant to an eligibility and enrollment plan. AB 4 is pending in the Assembly Appropriations Committee.

7) PREVIOUS LEGISLATION.

a) ABX1 2 (Pan), Chapter 1, Statutes of 2013-14 First Extraordinary Session, and SBX1 2 (Hernandez), Chapter 2, Statutes of 2013-14 First Extraordinary Session, established the health insurance market reforms contained in the ACA specific to individual purchasers, such as prohibiting insurers from denying coverage based on preexisting conditions; and, make conforming changes to small employer health insurance laws resulting from final federal regulations.

b) SB 1088 (Price), Chapter 660, Statutes of 2010, prohibits, with specified exceptions, the limiting age for dependents covered by health plan contracts and health insurance policies from being less than 26 years of age beginning on or after September 23, 2010, and prohibits health plan contracts and health insurance policies from being required to cover a child of a child receiving dependent coverage.

8) COMMENT. In the fall of 2020, CalPERS approved steep rate hikes of up to 51% for its cheapest health insurance plans, favored by young, healthy workers, in an effort to save its most expensive plans from collapse. Since this bill seems likely to attract older enrollees, as mentioned above, it is reasonable to conclude that this bill 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. With premiums in California growing faster than wages, how will this bill impact coverage provided by employers for California workers? Because the definition of dependents will now include dependent parent or stepparent, how much increase in the premiums and out of pocket costs will employees now incur?

REGISTERED SUPPORT / OPPOSITION:

Support

California Department of Insurance (sponsor)
California Access Coalition
California Pan - Ethnic Health Network

Estrategia LLC
Health Access California
Justice in Aging
Western Center on Law & Poverty, Inc.

Opposition

California Chamber of Commerce
Chino Valley Chamber of Commerce
Corona Chamber of Commerce
El Dorado Hills Chamber of Commerce
Gilroy Chamber of Commerce
Greater High Desert Chamber of Commerce
National Federation of Independent Business
North Orange County Chamber
San Gabriel Valley Economic Partnership
Santa Maria Valley Chamber of Commerce
Southwest California Legislative Council
Torrance Area Chamber of Commerce
Tulare Chamber of Commerce

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