

ASSEMBLY BILL

No. 786

Introduced by Assembly Member Jones

February 26, 2009

An act to add Sections 1399.819 and 127664.5 to the Health and Safety Code, and to add Section 10903 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 786, as introduced, Jones. Individual health care coverage: coverage choice categories.

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 also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers that offer contracts or policies to individuals to comply with specified requirements.

This bill would require, by September 1, 2010, the Department of Managed Health Care and the Department of Insurance to jointly, by regulation, develop a system to categorize all health care service plan contracts and health insurance policies offered and sold to individuals into 5 coverage choice categories that meet specified requirements. The bill would require individual health care service plan contracts and individual health insurance policies offered or sold on or after January 1, 2011, to contain a maximum dollar limit on out-of-pocket costs for covered benefits. The bill would authorize health care service plans and health insurers to offer plan contracts in any coverage choice category subject to specified restrictions. The bill would also require health care

service plans and health insurers to establish prices for the products offered to individuals that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. The bill would require the Department of Managed Health Care and the Department of Insurance to develop a notice providing information on the coverage choice categories and would require this notice to be provided with the marketing, purchase, and renewal of individual contracts and policies, as specified. The bill would require the Director of Managed Health Care and the Insurance Commissioner to annually report on the contracts and policies offered in each coverage choice category and on the enrollment in those contracts and policies. The bill would also require, commencing January 1, 2013, and every 3 years thereafter, the director and the commissioner to jointly determine whether the coverage choice categories should be revised to meet the needs of consumers. The bill would enact other related provisions.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

Existing law requests the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate or repeal a benefit or service, as defined, and to prepare a written analysis in accordance with specified criteria.

This bill would request the University of California, as part of that program, to prepare a written analysis with relevant data on, among other things, the health insurance and health care service plan products sold in the individual market. The bill would request the University of California to provide this report 3 months prior to the implementation of the bill's other provisions and would authorize the Department of Managed Health Care or the Insurance Commissioner to request that analysis prior to specified annual reports and triennial reviews. The bill would also require those departments to require data from health care service plans and health insurers in order to assist the University of California in fulfilling these responsibilities.

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.

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

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

1 SECTION 1. Section 1399.819 is added to the Health and
2 Safety Code, to read:
3 1399.819. (a) On or before September 1, 2010, the department
4 and the Department of Insurance shall jointly, by regulation,
5 develop a system to categorize all health care service plan contracts
6 and health insurance policies offered and sold to individuals
7 pursuant to this chapter and Part 2 (commencing with Section
8 10110) of Division 2 of the Insurance Code into five coverage
9 choice categories. These coverage choice categories shall do all
10 of the following:
11 (1) Reflect a reasonable continuum between the coverage choice
12 category with the lowest level of health care benefits and the
13 coverage choice category with the highest level of health care
14 benefits based on the actuarial value of each product.
15 (2) Permit reasonable benefit variation within each coverage
16 choice category.
17 (3) Be enforced consistently between health care service plans
18 and health insurers in the same marketplace regardless of licensure.
19 (4) Within each coverage choice category, include one standard
20 health maintenance organization (HMO) contract and one standard
21 preferred provider organization (PPO) contract, as defined by
22 regulation. For the coverage choice category with the highest cost
23 sharing and the least comprehensive benefit, the standard HMO
24 contract and the standard PPO contract shall not be the lowest
25 benefit level in that category.
26 (5) Within each coverage choice category, have a maximum
27 dollar limit on out-of-pocket costs, including, but not limited to,
28 copayments, coinsurance, and deductibles, for covered benefits.
29 (6) Use standard definitions and terminology for covered
30 benefits and cost sharing between health care service plans and
31 health insurers in the same marketplace regardless of licensure.
32 (7) Be developed by taking into account any written analysis
33 provided by the University of California pursuant to Section
34 127664.5.

1 (b) The regulations developed by the department and the
 2 Department of Insurance pursuant to this section shall identify and
 3 require the submission of any information needed to categorize
 4 each health care service plan contract and health insurance policy
 5 subject to this section.

6 (c) All health care service plan contracts offered or sold to
 7 individuals on or after January 1, 2011, shall contain a maximum
 8 dollar limit on out-of-pocket costs, including, but not limited to,
 9 copayments, coinsurance, and deductibles, for covered benefits.

10 (d) All health care service plans shall submit filings no later
 11 than April 1, 2011, for all individual health care service plan
 12 contracts to be offered or sold on or after that date, and thereafter
 13 any additional individual health care plan contracts shall be filed
 14 with the department. The director shall categorize each individual
 15 health care service plan contract offered by a plan into the
 16 appropriate coverage choice category within 90 days of the date
 17 the contract is filed pursuant to this section. A health care service
 18 plan shall not offer or sell an individual health care service plan
 19 contract until the director has categorized the contract pursuant to
 20 this subdivision.

21 (e) To facilitate accurate information about consumer choices,
 22 a health care service plan may offer plan contracts in any coverage
 23 choice category. However, if a plan offers a plan contract in the
 24 least comprehensive category, it shall also offer the standard
 25 contract the least comprehensive category, the standard contract
 26 in one of the two most comprehensive categories, and the standard
 27 contract in the middle category. Every plan shall offer at least the
 28 standard contract in the middle category, except that a plan that
 29 offers the standard contract in one of the two most comprehensive
 30 categories shall not be required to offer contracts in the less
 31 comprehensive categories. For purposes of this subdivision,
 32 “standard contract” means the contract developed pursuant to
 33 paragraph (4) of subdivision (a). A plan may meet its obligations
 34 under this subdivision with products filed with and approved by
 35 the department as well as products filed with and approved by the
 36 Department of Insurance.

37 (f) To facilitate consumer comparison shopping, the department
 38 and the Department of Insurance shall develop a notice that
 39 provides information about the coverage choice categories
 40 developed pursuant to this section, including the range of cost

1 sharing and the benefits and services provided in each category,
2 including any variation in those benefits and services. For each
3 product, the notice shall include the percentage of expense paid
4 by the coverage, the estimated annual out-of-pocket cost and the
5 estimated total annual cost, including both premium and
6 out-of-pocket costs for persons with average health care costs and
7 persons with high health care needs. A health care service plan,
8 solicitor, or solicitor firm shall provide this notice when marketing
9 any individual health care service plan contract. The notice shall
10 also accompany the purchase and renewal of an individual health
11 care service plan contract. With the agreement of the consumer,
12 the notice may be provided electronically.

13 (g) A health care service plan shall establish prices for its
14 products that reflect a reasonable continuum between the products
15 offered in the coverage choice category with the lowest level of
16 benefits and the products offered in the coverage choice category
17 with the highest level of benefits. A health care service plan shall
18 not establish a standard risk rate for a product in a coverage choice
19 category at a lower rate than a product offered in a lower coverage
20 choice category for a consumer of the same age and the same risk
21 rate living in the same geographic region. For purposes of this
22 subdivision, "geographic region" shall mean the geographic regions
23 established pursuant to paragraph (3) of subdivision (k) of Section
24 1357.

25 (h) The director shall annually report on the health care service
26 plan contracts offered by plans in each coverage choice category
27 pursuant to this section and on the enrollment in those contracts
28 within each coverage choice category. Commencing January 1,
29 2013, and every three years thereafter, the director and the
30 Insurance Commissioner shall jointly determine whether the
31 coverage choice categories should be revised to meet the needs of
32 consumers.

33 (i) The department shall require data from health care service
34 plans in order to assist the University of California in fulfilling the
35 responsibilities of Section 127664.5 and shall promptly provide
36 that data to the University of California.

37 (j) This section shall not apply to Medicare supplement plans
38 or to coverage offered by specialized health care service plans or
39 government-sponsored programs.

1 SEC. 2. Section 127664.5 is added to the Health and Safety
2 Code, to read:

3 127664.5. (a) In order to assist the Department of Managed
4 Health Care and the Insurance Commissioner with the
5 implementation of Section 1399.819 of this code and Section 10903
6 of the Insurance Code, the Legislature requests the University of
7 California, as part of the California Health Benefit Review Program
8 established pursuant to Section 127660, to prepare a written
9 analysis with relevant data on all of the following:

10 (1) The health care service plan and health insurance products
11 that are sold in the individual market.

12 (2) The benefits and services covered by the products described
13 in paragraph (1), including any limitations or exclusions.

14 (3) The cost sharing applicable to the products described in
15 paragraph (1), including deductibles, copayments, coinsurance,
16 maximum out-of-pocket limits, and other limits or exclusions that
17 require individual consumers to pay for basic health care services
18 in whole or in part.

19 (4) The distribution of health care service plan and health
20 insurance products purchased by individuals in terms of the benefits
21 and services included and the cost sharing involved.

22 (5) The share of the individual health care coverage market that
23 is short-term coverage, conversion coverage, renewal of existing
24 coverage, or coverage sold to a person not previously covered by
25 individual health care coverage.

26 (b) In providing the data described in subdivision (a), the
27 University of California is requested to distinguish between
28 products provided by entities regulated by the Department of
29 Managed Health Care and those provided by entities regulated by
30 the Insurance Commissioner.

31 (c) The Legislature requests that the written analysis described
32 in subdivision (a) be provided three months prior to the
33 implementation of Section 1399.819 of this code and Section 10903
34 of the Insurance Code.

35 (d) The Department of Managed Health Care in consultation
36 with the Insurance Commissioner shall request the University of
37 California to provide the written analysis described in subdivision
38 (a) prior to the annual reports and triennial reviews required by
39 Section 1399.819 of this code and Section 10903 of the Insurance
40 Code.

1 (e) The Department of Managed Health Care and the Department
2 of Insurance shall assist the University of California by requiring
3 and collecting data from health care service plans and health
4 insurers in order to fulfill the responsibilities of this section and
5 of Section 1399.819 of this code and Section 10903 of the
6 Insurance Code.

7 (f) The work of the University of California in providing the
8 written analyses specified in this section shall be supported by
9 moneys in the fund established pursuant to Section 127662.

10 SEC. 3. Section 10903 is added to the Insurance Code, to read:

11 10903. (a) On or before September 1, 2010, the department
12 and the Department of Managed Health Care shall jointly, by
13 regulation, develop a system to categorize all health insurance
14 policies and health care service plan contracts offered and sold to
15 individuals pursuant to this part and Chapter 2.2 (commencing
16 with Section 1340) of Division 2 of the Health and Safety Code
17 into five coverage choice categories. These coverage choice
18 categories shall do all of the following:

19 (1) Reflect a reasonable continuum between the coverage choice
20 category with the lowest level of health care benefits and the
21 coverage choice category with the highest level of health care
22 benefits based upon the actuarial value of each product.

23 (2) Permit reasonable benefit variation within each coverage
24 choice category.

25 (3) Be enforced consistently between health insurers and health
26 care service plans in the same marketplace regardless of licensure.

27 (4) Within each coverage choice category, include one standard
28 preferred provider organization (PPO) policy, as defined by
29 regulation. For the coverage choice category with the highest cost
30 sharing and the least comprehensive benefit, the standard PPO
31 policy shall not be the lowest benefit level in that category.

32 (5) Within each coverage choice category, have a maximum
33 dollar limit on out-of-pocket costs, including, but not limited to,
34 copayments, coinsurance, and deductibles, for covered benefits.

35 (6) Use standard definitions and terminology for covered
36 benefits and cost sharing between health insurers and health care
37 service plans in the same marketplace regardless of licensure.

38 (7) Be developed by taking into account any written analysis
39 provided by the University of California pursuant to Section
40 127664.5 of the Health and Safety Code.

1 (b) The regulations developed by the department and the
2 Department of Managed Health Care pursuant to this section shall
3 identify and require the submission of any information needed to
4 categorize each health insurance policy and health care service
5 plan contract subject to this section.

6 (c) All health insurance policies offered or sold to individuals
7 on or after January 1, 2011, shall contain a maximum dollar limit
8 on out-of-pocket costs, including, but not limited to, copayments,
9 coinsurance, and deductibles, for covered benefits.

10 (d) All health insurers shall submit the filings no later than April
11 1, 2011, for all individual health insurance policies to be offered
12 or sold on or after that date, and thereafter any additional individual
13 health insurance policies shall be filed with the commissioner. The
14 commissioner shall categorize each individual health insurance
15 policy offered by a health insurer into the appropriate coverage
16 choice category within 90 days of the date the policy is filed
17 pursuant to this section. A health insurer shall not offer or sell an
18 individual health insurance policy until the commissioner has
19 categorized the policy pursuant to this subdivision.

20 (e) To facilitate accurate information about consumer choices,
21 a health insurer may offer health insurance policies in any coverage
22 choice category. However, if a health insurer offers a health
23 insurance policy in the least comprehensive category, it shall also
24 offer the standard policy in the least comprehensive category, the
25 standard policy in one of the two most comprehensive categories,
26 and the standard policy in the middle category. Every insurer shall
27 offer at least the standard policy in the middle category, except
28 that an insurer that offers the standard policy in one of the two
29 most comprehensive categories shall not be required to offer
30 policies in the less comprehensive categories. For purposes of this
31 subdivision, “standard policy” means the policy developed pursuant
32 to paragraph (4) of subdivision (a). An insurer may meet its
33 obligations under this subdivision with products filed with and
34 approved by the department as well as products filed with and
35 approved by the Department of Managed Health Care.

36 (f) To facilitate consumer comparison shopping, the department
37 and the Department of Managed Health Care shall develop a notice
38 that provides information about the coverage choice categories
39 developed pursuant to this section, including the range of cost
40 sharing and the benefits and services provided in each category,

1 including any variation in those benefits and services. For each
2 product, the notice shall include the percentage of expense paid
3 by the coverage, the estimated annual out-of-pocket cost and the
4 estimated total annual cost, including both premium and
5 out-of-pocket costs for persons with average health care costs and
6 persons with high health care needs. A health insurer, broker, or
7 agent shall provide this notice when marketing any individual
8 health insurance policy. The notice shall also accompany the
9 purchase and renewal of an individual health insurance policy.
10 With the agreement of the consumer, the notice may be provided
11 electronically.

12 (g) A health insurer shall establish prices for its products that
13 reflect a reasonable continuum between the products offered in
14 the coverage choice category with the lowest level of benefits and
15 the products offered in the coverage choice category with the
16 highest level of benefits. A health insurer shall not establish a
17 standard risk rate for a product in a coverage choice category at a
18 lower rate than a product offered in a lower coverage choice
19 category for a consumer of the same age and the same risk rate
20 living in the same geographic region. For purposes of this
21 subdivision, “geographic region” shall mean the geographic regions
22 established pursuant to paragraph (3) of subdivision (v) of Section
23 10700.

24 (h) The commissioner shall annually report on the health
25 insurance policies offered by health insurers in each coverage
26 choice category pursuant to this section and on the enrollment in
27 those policies within each coverage choice category. Commencing
28 January 1, 2013, and every three years thereafter, the commissioner
29 and the Director of the Department of Managed Health Care shall
30 jointly determine whether the coverage choice categories should
31 be revised to meet the needs of consumers.

32 (i) All health insurance policies offered and sold to individuals
33 on or after January 1, 2011, shall contain a maximum dollar limit
34 on out-of-pocket costs, shall cover physician services, hospitals,
35 and preventive services, and shall, at a minimum, meet existing
36 coverage requirements.

37 (j) The department shall require data from health insurers in
38 order to assist the University of California in fulfilling the
39 responsibilities of Section 127664.5 of the Health and Safety Code
40 and shall promptly provide that data to the University of California.

1 (k) Nothing in this section shall be construed to limit disability
2 insurance, including, but not limited to, hospital indemnity,
3 accident only, and specified disease insurance that pays benefits
4 on a fixed benefit, cash payment only basis, from being sold as
5 supplemental insurance.

6 (l) This section shall not apply to Medicare supplement, Tricare
7 supplement, or CHAMPUS supplement insurance, to specialized
8 health insurance policies, as defined in subdivision (c) of Section
9 106, or to coverage offered by government-sponsored programs.

10 SEC. 4. No reimbursement is required by this act pursuant to
11 Section 6 of Article XIII B of the California Constitution because
12 the only costs that may be incurred by a local agency or school
13 district will be incurred because this act creates a new crime or
14 infraction, eliminates a crime or infraction, or changes the penalty
15 for a crime or infraction, within the meaning of Section 17556 of
16 the Government Code, or changes the definition of a crime within
17 the meaning of Section 6 of Article XIII B of the California
18 Constitution.