AMENDED IN SENATE JUNE 16, 2010

AMENDED IN ASSEMBLY APRIL 22, 2010

AMENDED IN ASSEMBLY APRIL 8, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2345

Introduced by Assembly Member De La Torre

February 19, 2010

~~An act to amend Section 10113.95 of the Insurance Code, relating to health care coverage.~~ *An act to add Section 1367.001 to the Health and Safety Code, and to add Section 10112.1 to the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2345, as amended, De La Torre. ~~Individual health care coverage: health insurers.~~ *Health care coverage: federal health care reform.*

Existing law, the federal Patient Protection and Affordable Care Act, enacts various health care coverage market reforms. With respect to plan years beginning on and after September 23, 2010, the act requires health insurance issuers to provide coverage, and not impose cost-sharing requirements, for certain preventive services.

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 that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would require health care service plan contracts and health insurance policies issued, amended, renewed, or delivered on or after September 23, 2010, to provide coverage, and not impose cost-sharing

requirements, for certain preventive services. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The bill would also state the intent of the Legislature to enact legislation that would implement other provisions of the federal Patient Protection and Affordable Care Act, including, among other things, requiring plans and insurers to provide an internal claims and appeals process that complies with the federal act and requiring plans and insurers to comply with certain patient protections specified in the federal act.

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 and requires a health insurer to have written policies, procedures, and underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to individuals who apply for coverage and sets the rate for that coverage. Existing law requires an insurer to annually file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, as specified.~~

~~This bill would additionally require an insurer to annually post on its Internet Web site that information the insurer uses for rating and underwriting decisions related to individual health insurance policies, as specified.~~

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

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

SECTION 1. Section 1367.001 is added to the Health and Safety Code, to read:

1367.001. (a) (1) Subject to the minimum interval established by the United States Secretary of Health and Human Services pursuant to subsection (b) of Section 2713 of the federal Public

Health Service Act, as added by Section 1001 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), a group or individual health care service plan contract that is issued, amended, renewed, or delivered on or after September 23, 2010, shall, at a minimum, provide coverage for, and shall not impose any cost-sharing requirements for, all of the following:

(A) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

(B) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(C) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration.

(D) With respect to women, any additional preventive care and screenings not described in subparagraph (A) as provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration.

(2) For purposes of this subdivision, the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current, other than recommendations issued by the task force in November of 2009, or within 30 days of that month.

(3) Nothing in this subdivision shall be construed to prohibit a plan from providing coverage for services in addition to those recommended by the United States Preventive Services Task Force or to deny coverage for services that are not recommended by the task force.

(b) This section shall not apply to Medicare supplement plans or to coverage offered by specialized health care service plans, including, but not limited to, ambulance, dental, vision, behavioral health, chiropractic, and naturopathic.

SEC. 2. Section 10112.1 is added to the Insurance Code, to read:

10112.1. (a) (1) Subject to the minimum interval established by the United States Secretary of Health and Human Services

pursuant to subsection (b) of Section 2713 of the federal Public Health Service Act, as added by Section 1001 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), a group or individual health insurance policy that is issued, amended, renewed, or delivered on or after September 23, 2010, shall, at a minimum, provide coverage for, and shall not impose any cost-sharing requirements for, all of the following:

(A) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

(B) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(C) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration.

(D) With respect to women, any additional preventive care and screenings not described in subparagraph (A) as provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration.

(2) For purposes of this subdivision, the current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current, other than recommendations issued by the task force in November of 2009, or within 30 days of that month.

(3) Nothing in this subdivision shall be construed to prohibit a health insurer from providing coverage for services in addition to those recommended by the United States Preventive Services Task Force or to deny coverage for services that are not recommended by the task force.

(b) This section shall not apply to specialized health insurance policies, Medicare supplement policies, CHAMPUS-supplement insurance policies, TRICARE supplement insurance policies, accident-only insurance policies, or insurance policies excluded from the definition of "health insurance" under subdivision (b) of Section 106.

SEC. 3. It is the intent of the Legislature to enact legislation that would do all of the following:

(a) Prohibit group health plans, other than self-insured plans, from discriminating in favor of highly compensated individuals as to eligibility to participate in the plan and benefits included in the plan in a manner consistent with Section 2716 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-16), as added by Section 1001 of, and amended by Section 10101 of, the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(b) Require health care service plans and health insurers to provide an internal claims and appeals process that complies with Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19), as added by Section 1001 of, and amended by Section 10101 of, the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(c) Require health care service plans and health insurers to comply with the patient protections set forth in Section 2719A of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19a), as added by Section 10101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(d) Require the Department of Managed Health Care and the Department of Insurance to post a link on their respective Internet Web sites to the Internet Web site of the federal Department of Health and Human Services where consumers may easily obtain information about affordable and comprehensive health care coverage options under the federal Patient Protection and Affordable Care Act (Public Law 111-148).

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

~~SECTION 1. Section 10113.95 of the Insurance Code is amended to read:~~

~~10113.95. (a) A health insurer that issues, renews, or amends individual health insurance policies shall be subject to this section.~~

~~(b) An insurer subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall ensure that the plan rating and underwriting criteria comply with Sections 10140 and 10291.5 and all other applicable provisions.~~

~~(c) (1) On or before June 1, 2006, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which they would be eligible.~~

~~(2) An insurer may comply with this section by submitting to the department underwriting materials or resource guides provided to agents and brokers, provided that those materials include the information required to be submitted by this section.~~

~~(3) January 1, 2011, and annually thereafter, every insurer shall post on its Internet Web site the information specified in paragraph (1).~~

~~(d) Commencing September 1, 2006, the commissioner shall post on the department's Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the Major Risk Medical Insurance Program. The commissioner shall develop the information for the Web site in consultation with the Department of Managed Health Care to enhance the consistency of information provided to consumers. Information about individual health insurance shall also include the following notification:~~

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~~"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your~~

~~medical history that could result in a higher premium or you could be denied coverage entirely.”~~

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~~(e) Nothing in this section shall authorize public disclosure of company-specific rating and underwriting criteria and practices submitted to the commissioner.~~

~~(f) This section shall not apply to a closed block of business, as defined in Section 10176.10.~~

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