AMENDED IN ASSEMBLY AUGUST 16, 2010

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AMENDED IN SENATE APRIL 6, 2010

SENATE BILL No. 890

Introduced by Senators Alquist and Steinberg
(Coauthors: Assembly Members De La Torre, Feuer, and Jones)

January 21, 2010

~~An act to amend Sections 1363 and 1389.25 of, to add Section 1367.001 to, and to add Article 4.1 (commencing with Section 1366.10) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 10113.9, 10603, and 10604 of, to add Sections 10112.56, 10112.57, and 10604.2 to, and to add Chapter 9.6 (commencing with Section 10960) to Part 2 of Division 2 of, the~~ *An act to amend Section 1389.5 of, and to add Sections 1366.5 and 1367.001 to, the Health and Safety Code, and to amend Section 10119.1 of, to add Sections 10112.56, 10112.57, and 10112.58 to, the* Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 890, as amended, Alquist. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, on and after January 1, 2014, requires a health insurance issuer offering

health insurance coverage in the individual or group market to accept every employer and individual in the state that applies for that coverage, as specified, and requires issuers in the individual and small group markets to ensure that the coverage includes a specified essential benefits package. ~~Among other things, the act allows premiums for that individual or small group coverage to vary only by rating area, age, tobacco use, and whether the coverage is for an individual or family, as specified.~~ *The act requires an essential health benefits package to provide coverage in one of 5 levels based on actuarial value, as specified.*

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 imposes various requirements with respect to individual contracts and policies issued by health care service plans and health insurers. Existing law requires a health care service plan to permit, at least once each year, an individual who has been covered for at least 18 months under an individual plan contract issued by the health care service plan to transfer, without medical underwriting, as defined, to another individual plan contract offered by the health care service plan having equal or lesser benefits, as specified. Existing law imposes a parallel requirement with respect to individual policies issued by health insurers.

~~This bill would, commencing July 1, 2011, require plans and insurers issuing individual coverage to make certain standard benefit plan designs available to individuals, would require that these designs be offered in 6 different coverage choice categories, as specified, and would require a plan or insurer to market one standard benefit plan design in each category. The bill would require plans to, on and after July 1, 2011, discontinue offering and selling benefit plan designs other than the standard benefit plan designs, but would require plans and insurers to renew benefit plan designs issued prior to that date. The bill would, commencing July 1, 2011, allow a subscriber or policyholder of an individual contract or policy, on the annual renewal date of that contract or policy, to transfer on a guarantee issue basis to another benefit plan design issued by his or her plan or insurer or a benefit plan design issued by another plan or insurer, provided that the new plan design is in the same or a lower coverage choice category or has an equal or lower~~

~~actuarial value, as specified. The bill would require plans and insurers to provide notice of these transfer rights in their evidence of coverage and in notices regarding changes to premiums or coverage.~~

~~The bill would, commencing July 1, 2011, create the Individual Insurance Market Reform Commission, which would consist of 9 voting members, appointed by the Legislature and the Governor, as specified, and 3 specified nonvoting members. The bill would require the commission to review and suggest changes to the standard benefit plan designs described above and would require the Department of Managed Health Care and the Department of Insurance to jointly adopt regulations based on those suggestions. The bill would require the commission to develop a standardized enrollment questionnaire to be used by all plans and insurers when offering and selling individual coverage, but would prohibit plans and insurers from requesting or obtaining health information from applicants eligible for guaranteed issuance of coverage on and after January 1, 2014. The bill would also require the commission to establish a methodology for the graduation of risk into 3 specified categories and would require plans and insurers in the individual market to set rates consistent with this methodology. The bill would place limits on the annualized premium rate increase for a contract and the variation between the highest standard premium rate and the lowest standard premium rate and would enact other related provisions.~~

This bill would eliminate the 18-month requirement and would require plans and insurers to allow an individual to transfer to another individual contract or policy without medical underwriting on the annual renewal date of his or her contract or policy. Commencing July 1, 2011, the bill would require plans and insurers to categorize all products offered in the individual market into 5 tiers according to actuarial value, as specified, and would require plans and insurers to disclose this value and other information in certain disclosure forms.

Existing law requires health care service plan contracts and health insurance policies to provide coverage for certain benefits. Under existing law, health care service plan contracts are required, subject to certain exemptions, to provide basic health care services, as defined, among other benefits.

This bill would require health insurance policies issued, amended, or renewed on or after July 1, 2011, to provide coverage for medically necessary basic health care services, as defined.

Existing law prohibits a health care service plan from expending for administrative costs, as defined, an excessive amount of the payments

the plan receives for providing health care services to its subscribers and enrollees. The Insurance Commissioner is required to withdraw approval of an individual or mass-marketed policy of disability insurance if the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged, as specified.

The federal Patient Protection and Affordable Care Act prohibits a health insurance issuer issuing health insurance coverage from establishing lifetime limits or unreasonable annual limits on the dollar value of benefits for any participant or beneficiary, as specified. The act also requires a health insurance issuer issuing health insurance coverage to provide an annual rebate to each enrollee if the ratio of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified.

This bill would require health care service plans and health insurers to comply with the ~~applicable~~ requirements imposed under those provisions *to the extent required under federal law*.

~~Existing law requires health care service plans and health insurers to use disclosure forms containing certain information in order to provide a full and fair disclosure of the provisions of a contract or policy, as specified.~~

~~This bill would require that this disclosure be made available on the plan's or insurer's Internet Web site. With respect to individual plan contracts or policies, the bill would require the form to include provisions relating to an individual's right to apply for any benefit plan design issued by the plan or insurer at the time of application for a new contract or policy and at the time of renewal of a contract or policy and information concerning the availability of a listing of all the contracts or policies and benefit designs offered to individuals by the plan or insurer, as specified. The bill would make these provisions apply as of July 1, 2011.~~

~~Existing law requires each health care service plan offering a contract to an individual or small group to provide a uniform health plan benefits and coverage matrix containing the plan's major provisions, as specified.~~

~~This bill would, commencing July 1, 2011, also impose that requirement on health insurers offering policies to individual or small groups and would, with respect to both plans and insurers, require that the matrix be made available on the plan's or insurer's Internet Web site.~~

Because a willful violation of the bill's requirements with respect to health care service plans 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.

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

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

SECTION 1. Section 1366.5 is added to the Health and Safety Code, to read:

1366.5. (a) Effective July 1, 2011, a health care service plan shall categorize all products offered or renewed in the individual market in accordance with this section.

(b) From July 1, 2011, to December 31, 2013, inclusive, each product offered or renewed in the individual market shall be categorized on the basis of actuarial value into one of the following tiers:

(1) Bronze level for products with an actuarial value of 60 to 69 percent, inclusive.

(2) Silver level for products with an actuarial value of 70 to 79 percent, inclusive.

(3) Gold level for products with an actuarial value of 80 to 89 percent, inclusive.

(4) Platinum level for products with an actuarial value of 90 percent or greater.

(5) Catastrophic coverage for products with an actuarial value less than 60 percent.

(c) On and after January 1, 2014, each product offered or renewed in the individual market shall be categorized on the basis of actuarial value into one of the following tiers:

(1) Bronze level for products with an actuarial value equal to 60 percent.

(2) Silver level for products with an actuarial value equal to 70 percent.

(3) Gold level for products with an actuarial value equal to 80 percent.

(4) Platinum level for products with an actuarial value equal to 90 percent.

(5) Catastrophic coverage for products with an actuarial value less than 60 percent.

(d) In establishing the actuarial value of products for purposes of this section, a health care service plan shall use the method of calculating actuarial value contained in subdivision (d) of Section 1302 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and the regulations adopted under that section. The plan shall also use a qualified actuary to certify the accuracy of the required categorization.

(e) The department may review the categorization of any product under this section for accuracy, including, but not limited to, the methodology used by the plan to establish actuarial value.

(f) As part of the disclosure form required by Section 1363 for an individual plan contract, a health care service plan shall include the actuarial value of the particular product reflected in the contract, as determined under this section, along with an explanation of actuarial value in easily understood language expressed as a percentage of expenses paid by insurance versus out-of-pocket. In addition, the disclosure shall include an estimate of the annual out-of-pocket expenses of an individual in average health who is enrolled in the product, and the total annual cost (the sum of the premium plus out-of-pocket costs) of an individual of average health who is enrolled in the product. The disclosure shall also state that an individual's share of cost may be more or less depending on his or her illness or health condition. The disclosure shall also include the following statement:

"Please examine the other features of this product carefully, including prescription drug coverage, exclusion of specific conditions, and other costs such as copayments and deductibles."

(g) This section shall not apply to Medicare supplement contracts or to specialized health care service plan contracts.

SEC. 2. Section 1367.001 is added to the Health and Safety Code, to read:

1367.001. (a) To the extent required by federal law, every health care service plan that issues, sells, renews, or offers contracts for health care coverage in this state shall comply with

the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.

(b) To the extent required by federal law, every health care service plan that issues, sells, renews, or offers contracts for health care coverage in this state shall comply with the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under that section.

SEC. 3. Section 1389.5 of the Health and Safety Code is amended to read:

1389.5. (a) This section shall apply to a health care service plan that provides coverage under an individual plan contract that is issued, amended, delivered, or renewed on or after January 1, ~~2007~~ *2011*.

(b) ~~At least once each year,~~ *Upon the annual renewal date of an individual health care service plan contract,* the health care service plan shall permit an individual ~~who has been~~ covered ~~for at least 18 months under an individual plan~~ *under the* contract to transfer, without medical underwriting, to any other individual plan contract offered by that same health care service plan that provides equal or lesser benefits, as determined by the plan.

"Without medical underwriting" means that the health care service plan shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who transfers to another individual plan contract pursuant to this section.

(c) The plan shall establish, for the purposes of subdivision (b), a ranking of the individual plan contracts it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The plan shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The plan shall notify in writing all enrollees of the right to transfer to another individual plan contract pursuant to this section, at a minimum, when the plan changes the enrollee's premium rate. Posting this information on the plan's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall

adequately inform enrollees of the transfer rights provided under this section, including information on the process to obtain details about the individual plan contracts available to that enrollee and advising that the enrollee may be unable to return to his or her current individual plan contract if the enrollee transfers to another individual plan contract.

(e) The requirements of this section shall not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (c) of Section 1399.801, who is enrolled in an individual health benefit plan contract offered pursuant to Section 1366.35.

(2) An individual offered conversion coverage pursuant to Section 1373.6.

(3) Individual coverage under a specialized health care service plan contract.

(4) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Division 9 of Part 3 of the Welfare and Institutions Code.

(5) An individual enrolled in the Access for Infants and Mothers Program pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

(6) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(f) It is the intent of the Legislature that individuals shall have more choice in their health coverage when health care service plans guarantee the right of an individual to transfer to another product based on the plan's own ranking system. ~~The Legislature does not intend for the department to review or verify the plan's ranking for actuarial or other purposes.~~

SEC. 4. Section 10112.56 is added to the Insurance Code, to read:

10112.56. (a) For purposes of this section, "basic health care services" has the same meaning as that set forth in Section 1345 of the Health and Safety Code and in Section 1300.67 of Title 28 of the California Code of Regulations.

(b) A health insurance policy issued, amended, or renewed on or after July 1, 2011, shall provide coverage for medically necessary basic health care services.

(c) Nothing in this section shall prohibit a health insurer from charging policyholders or insureds a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the commissioner and set forth to the policyholder or insured pursuant to the disclosure provisions of Section 10604.

(d) 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. 5. Section 10112.57 is added to the Insurance Code, to read:

10112.57. (a) To the extent required by federal law, every health insurer that issues, sells, renews, or offers policies for health care coverage in this state shall comply with the requirements of Section 2711 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued under that section, in addition to any state laws or regulations that do not prevent the application of those requirements.

(b) To the extent required by federal law, every health insurer that issues, sells, renews, or offers policies for health care coverage in this state shall comply with the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under that section.

SEC. 6. Section 10112.58 is added to the Health and Safety Code, to read:

10112.58. (a) Effective July 1, 2011, a health insurer shall categorize all products offered or renewed in the individual market in accordance with this section.

(b) From July 1, 2011, to December 31, 2013, inclusive, each product offered or renewed in the individual market shall be categorized on the basis of actuarial value into one of the following tiers:

(1) Bronze level for products with an actuarial value of 60 to 69 percent, inclusive.

(2) Silver level for products an actuarial value of 70 to 79 percent, inclusive.

(3) Gold level for products with an actuarial value of 80 to 89 percent, inclusive.

(4) Platinum level for products with an actuarial value of 90 percent or greater.

(5) Catastrophic coverage for products with an actuarial value less than 60 percent.

(c) On and after January 1, 2014, each product offered or renewed in the individual market shall be categorized on the basis of actuarial value into one of the following tiers:

(1) Bronze level for products with an actuarial value equal to 60 percent.

(2) Silver level for products with an actuarial value equal to 70 percent.

(3) Gold level for products with an actuarial value equal to 80 percent.

(4) Platinum level for products with an actuarial value equal to 90 percent.

(5) Catastrophic coverage for products with an actuarial value less than 60 percent.

(d) In establishing the actuarial value of products for purposes of this section, a health insurer shall use the method of calculating actuarial value contained in subdivision (d) of Section 1302 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and any regulations adopted under that section. The insurer shall also use a qualified actuary to certify the accuracy of the required categorization.

(e) The department may review the categorization of any product under this section for accuracy, including, but not limited to, the methodology used by the insurer to establish actuarial value.

(f) As part of the disclosure form required by Section 10603 for an individual health insurance policy, a health insurer shall include the actuarial value of the particular product reflected in the policy, as determined under this section, along with an explanation of actuarial value in easily understood language expressed as a percentage of expenses paid by insurance versus out-of-pocket. In addition, the disclosure shall include an estimate of the annual out-of-pocket expenses of an individual in average health who is enrolled in the product, and the total annual cost (the sum of the

premium plus out-of-pocket costs) of an individual of average health who is enrolled in the product. The disclosure shall also state that an individual's share of cost may be more or less depending on his or her illness or health condition. The disclosure shall also include the following statement:

"Please examine the other features of this product carefully, including prescription drug coverage, exclusion of specific conditions, and other costs such as copayments and deductibles."

(g) This section shall not apply to Medicare supplement policies or to specialized health insurance.

SEC. 7. Section 10119.1 of the Insurance Code is amended to read:

10119.1. (a) This section shall apply to a health insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, that is issued, amended, renewed, or delivered on or after January 1, ~~2007~~ *2011*.

(b) ~~At least once each year,~~ *Upon the annual renewal date of an individual health benefit plan,* a health insurer shall permit an individual ~~who has been~~ covered ~~for at least 18 months under an individual~~ *under the* health benefit plan to transfer, without medical underwriting, to any other individual health benefit plan offered by that same health insurer that provides equal or lesser benefits as determined by the insurer.

"Without medical underwriting" means that the health insurer shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who transfers to another individual health benefit plan pursuant to this section.

(c) The insurer shall establish, for the purposes of subdivision (b), a ranking of the individual health benefit plans it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The insurer shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The insurer shall notify in writing all insureds of the right to transfer to another individual health benefit plan pursuant to this section, at a minimum, when the insurer changes the insured's premium rate. Posting this information on the insurer's Internet Web site shall not constitute notice for purposes of this subdivision.

The notice shall adequately inform insureds of the transfer rights provided under this section including information on the process to obtain details about the individual health benefit plans available to that insured and advising that the insured may be unable to return to his or her current individual health benefit plan if the insured transfers to another individual health benefit plan.

(e) The requirements of this section shall not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (e) of Section 10900, who purchases individual coverage pursuant to Section 10785.

(2) An individual offered conversion coverage pursuant to Sections 12672 and 12682.1.

(3) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(4) An individual enrolled in the Access for Infants and Mothers Program, pursuant to Part 6.3 (commencing with Section 12695).

(5) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693).

(f) It is the intent of the Legislature that individuals shall have more choice in their health care coverage when health insurers guarantee the right of an individual to transfer to another product based on the insurer's own ranking system. ~~The Legislature does not intend for the department to review or verify the insurer's ranking for actuarial or other purposes.~~

SEC. 8. 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.

All matter omitted in this version of the bill appears in the bill as amended in the Assembly, August 2, 2010. (JR11)

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