

AMENDED IN ASSEMBLY MARCH 29, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 1453

Introduced by Assembly Member Monning

January 5, 2012

An act to add Section ~~100509~~ to the Government Code ~~1367.005~~ to the Health and Safety Code, and to add Section 10112.27 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1453, as amended, Monning. Essential health benefits.

Commencing January 1, 2014, existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides the essential health benefits package. Existing state law creates the California Health Benefit Exchange (*the Exchange*) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.

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 plan contracts and health insurance policies to cover various benefits.

This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the benefits and services covered by particular plans. The bill would specify that this provision applies regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that it does not apply to grandfathered plans or plans that offer excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, issuing, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill.

Because a willful violation of the bill's provisions 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.

~~This bill would require the board of the California Health Benefit Exchange to, by March 1, 2013, submit to the Assembly Committee on Health and the Senate Committee on Health a recommendation for an existing health plan to set the benchmark for items and services to be included in the definition of essential health benefits as contemplated under PPACA and a specified federal bulletin. In developing this recommendation, the bill would require the board to collaborate with the Department of Managed Health Care, the Department of Insurance, and other interested stakeholders and to take into consideration the benefits required to be covered by health care service plans. The bill would require the board to compare and contrast the options presented in a specified federal bulletin and would authorize the board to convene an advisory council to aid in its deliberations.~~

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

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

1 *SECTION 1. The Legislature hereby finds and declares the*
2 *following:*

3 *(a) Commencing January 1, 2014, the federal Patient Protection*
4 *and Affordable Care Act (PPACA) requires a health insurance*
5 *issuer that offers coverage to small employers or individuals, both*
6 *inside and outside of an American Health Benefit Exchange, with*
7 *the exception of grandfathered plans, to provide minimum coverage*
8 *that includes essential health benefits, as defined.*

9 *(b) It is the intent of the Legislature to comply with federal law*
10 *and consistently implement the essential health benefits provisions*
11 *of PPACA and related federal guidance and regulations, by*
12 *adopting the uniform minimum essential benefits requirement in*
13 *state-regulated health care coverage regardless of whether the*
14 *policy or contract is regulated by the Department of Managed*
15 *Health Care or the Department of Insurance and regardless of*
16 *whether the policy or contract is offered to individuals or small*
17 *employers inside or outside of the California Health Benefit*
18 *Exchange.*

19 *SEC. 2. Section 1367.005 is added to the Health and Safety*
20 *Code, to read:*

21 1367.005. *(a) An individual or small group health care service*
22 *plan contract issued, amended, or renewed on or after January 1,*
23 *2014, shall, at a minimum, include coverage for essential health*
24 *benefits. For purposes of this section, “essential health benefits”*
25 *means all of the following:*

26 *(1) (A) The benefits and services covered by the Kaiser Small*
27 *Group HMO plan contract (product number 40513CA035) as of*
28 *December 31, 2011, including, but not limited to, all of the*
29 *following:*

30 *(i) The items and services covered by the plan contract within*
31 *the categories identified in subsection (b) of Section 1302 of*
32 *PPACA, including, but not limited to, ambulatory patient services,*
33 *emergency services, hospitalization, maternity and newborn care,*
34 *mental health and substance use disorder services, including*
35 *behavioral health treatment, prescription drugs, rehabilitative and*
36 *habilitative services and devices, laboratory services, preventive*
37 *and wellness services and chronic disease management, and*
38 *pediatric vision care.*

1 (ii) *The items and services covered by the plan contract within*
2 *the following categories: acupuncture services, chiropractic*
3 *services, skilled nursing facility services, hospice care, bariatric*
4 *surgery, nonsevere mental illness services, substance abuse*
5 *services, smoking cessation counseling, alcoholism treatment,*
6 *applied behavior analysis therapy for autism, smoking cessation*
7 *drugs, pain medication for terminally ill patients, rehabilitative*
8 *services, habilitative, physical, and occupational therapy, speech*
9 *therapy, orthotics and prosthetics, prosthetic devices for*
10 *laryngectomy, special footwear for persons suffering from foot*
11 *disfigurement, surgically implanted hearing devices, home health*
12 *services, HIV/AIDS services, osteoporosis services, and diabetes*
13 *education.*

14 (B) *The services and benefits described in this paragraph shall*
15 *be covered to the extent they are medically necessary. Scope and*
16 *duration limits imposed on the services and benefits described in*
17 *this paragraph shall be no greater than the scope and duration*
18 *limits imposed on those services and benefits by the plan contract*
19 *identified in subparagraph (A).*

20 (2) *With respect to habilitative services, in addition to any*
21 *habilitative services identified in paragraph (1), the same services*
22 *as the plan contract covers for rehabilitative services. Habilitative*
23 *services shall be covered under the same terms and conditions*
24 *applied to rehabilitative services under the plan contract.*

25 (3) *With respect to pediatric oral care, the same services and*
26 *benefits for pediatric oral care covered under the federal Blue*
27 *Cross and Blue Shield Standard Option Service Benefit Plan*
28 *available to enrollees through the Federal Employees Health*
29 *Benefit Plan (FEHB) as of December 31, 2011. Scope and duration*
30 *limits imposed on the services and benefits described in this*
31 *paragraph shall be no greater than the scope and duration*
32 *limitations imposed on those benefits by the federal Blue Cross*
33 *and Blue Shield Standard Option Service Benefit Plan available*
34 *to enrollees through the FEHB as of December 31, 2011.*

35 (4) *Any other benefits required to be covered under this chapter.*

36 (b) *When offering, issuing, selling, or marketing a health care*
37 *service plan contract, a health care service plan shall not indicate*
38 *or imply that the plan contract covers essential health benefits*
39 *unless the plan contract covers essential health benefits as defined*
40 *in this section.*

1 (c) *This section shall apply regardless of whether the plan*
2 *contract is offered inside or outside the California Health Benefit*
3 *Exchange created by Section 100500 of the Government Code.*

4 (d) *A plan contract subject to this section shall also comply with*
5 *Section 1367.001.*

6 (e) *This section shall not be construed to prohibit a plan contract*
7 *from covering additional benefits, including, but not limited to,*
8 *spiritual care services that are tax deductible under Section 213*
9 *of the Internal Revenue Code.*

10 (f) *Subdivision (a) shall not apply to any of the following:*

11 (1) *A plan contract that provides excepted benefits as described*
12 *in Section 2722 of the federal Public Health Service Act (42 U.S.C.*
13 *Sec. 300gg-21).*

14 (2) *A plan contract that qualifies as a grandfathered health plan*
15 *under Section 1251 of PPACA.*

16 (g) *This section shall be implemented only to the extent that*
17 *federal law or policy does not require the state to defray the costs*
18 *of benefits included within the definition of essential health benefits*
19 *under this section.*

20 (h) *For purposes of this section, the following definitions shall*
21 *apply:*

22 (1) *“Habilitative services” means health care services that help*
23 *a person keep, learn, or improve skills and functioning for daily*
24 *living.*

25 (2) *“PPACA” means the federal Patient Protection and*
26 *Affordable Care Act (Public Law 111-148), as amended by the*
27 *federal Health Care and Education Reconciliation Act of 2010*
28 *(Public Law 111-152), and any rules, regulations, or guidance*
29 *issued thereunder.*

30 (3) *“Small group health care service plan contract” means a*
31 *group health care service plan contract issued to a small employer,*
32 *as defined in Section 1357.*

33 *SEC. 3. Section 10112.27 is added to the Insurance Code, to*
34 *read:*

35 10112.27. (a) *An individual or small group health insurance*
36 *policy issued, amended, or renewed on or after January 1, 2014,*
37 *shall, at a minimum, include coverage for essential health benefits.*
38 *For purposes of this section, “essential health benefits” means all*
39 *of the following:*

1 (1) (A) *The benefits and services covered by the Kaiser Small*
2 *Group HMO plan contract (product number 40513CA035) as of*
3 *December 31, 2011, including, but not limited to, all of the*
4 *following:*

5 (i) *The items and services covered by the plan contract within*
6 *the categories identified in subsection (b) of Section 1302 of*
7 *PPACA, including, but not limited to, ambulatory patient services,*
8 *emergency services, hospitalization, maternity and newborn care,*
9 *mental health and substance use disorder services, including*
10 *behavioral health treatment, prescription drugs, rehabilitative and*
11 *habilitative services and devices, laboratory services, preventive*
12 *and wellness services and chronic disease management, and*
13 *pediatric vision care.*

14 (ii) *The items and services covered by the plan contract within*
15 *the following categories: acupuncture services, chiropractic*
16 *services, skilled nursing facility services, hospice care, bariatric*
17 *surgery, nonsevere mental illness services, substance abuse*
18 *services, smoking cessation counseling, alcoholism treatment,*
19 *applied behavior analysis therapy for autism, smoking cessation*
20 *drugs, pain medication for terminally ill patients, rehabilitative*
21 *services, habilitative, physical, and occupational therapy, speech*
22 *therapy, orthotics and prosthetics, prosthetic devices for*
23 *laryngectomy, special footwear for persons suffering from foot*
24 *disfigurement, surgically implanted hearing devices, home health*
25 *services, HIV/AIDS services, osteoporosis services, and diabetes*
26 *education.*

27 (B) *The services and benefits described in this paragraph shall*
28 *be covered to the extent they are medically necessary. Scope and*
29 *duration limits imposed on the services and benefits described in*
30 *this paragraph shall be no greater than the scope and duration*
31 *limits imposed on those services and benefits by the health care*
32 *service plan contract identified in subparagraph (A).*

33 (2) *With respect to habilitative services, in addition to any*
34 *habilitative services identified in paragraph (1), the same services*
35 *as the policy covers for rehabilitative services. Habilitative services*
36 *shall be covered under the same terms and conditions applied to*
37 *rehabilitative services under the policy.*

38 (3) *With respect to pediatric oral care, the same services and*
39 *benefits for pediatric oral care covered under the federal Blue*
40 *Cross and Blue Shield Standard Option Service Benefit Plan*

1 available to enrollees through the Federal Employees Health
2 Benefit Plan (FEHB) as of December 31, 2011. Scope and duration
3 limits imposed on the services and benefits described in this
4 paragraph shall be no greater than the scope and duration
5 limitations imposed on those benefits by the federal Blue Cross
6 and Blue Shield Standard Option Service Benefit Plan available
7 to enrollees through the FEHB as of December 31, 2011.

8 (4) Any other benefits required to be covered under this part.

9 (b) When offering, issuing, selling, or marketing a health
10 insurance policy, a health insurer shall not indicate or imply that
11 the policy covers essential health benefits unless the policy covers
12 essential health benefits as defined in this section.

13 (c) This section shall apply regardless of whether the policy is
14 offered inside or outside the California Health Benefit Exchange
15 created by Section 100500 of the Government Code.

16 (d) A health insurance policy subject to this section shall also
17 comply with Section 10112.1.

18 (e) This section shall not be construed to prohibit a policy from
19 covering additional benefits, including, but not limited to, spiritual
20 care services that are tax deductible under Section 213 of the
21 Internal Revenue Code.

22 (f) Subdivision (a) shall not apply to any of the following:

23 (1) A policy that provides excepted benefits as described in
24 Section 2722 of the federal Public Health Service Act (42 U.S.C.
25 Sec. 300gg-21).

26 (2) A health insurance policy that qualifies as a grandfathered
27 health plan under Section 1251 of PPACA.

28 (g) This section shall be implemented only to the extent that
29 federal law or policy does not require the state to defray the costs
30 of benefits included within the definition of essential health benefits
31 under this section.

32 (h) For purposes of this section, the following definitions shall
33 apply:

34 (1) "Habilitative services" means health care services that help
35 a person keep, learn, or improve skills and functioning for daily
36 living.

37 (2) "PPACA" means the federal Patient Protection and
38 Affordable Care Act (Public Law 111-148), as amended by the
39 federal Health Care and Education Reconciliation Act of 2010

1 (Public Law 111-152), and any rules, regulations, or guidance
2 issued thereunder.

3 (3) “Small group health insurance policy” means a group health
4 insurance policy issued to a small employer, as defined in Section
5 10700.

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

15 SECTION 1. ~~Section 100509 is added to the Government Code,~~
16 ~~to read:~~

17 ~~100509. (a) By March 1, 2013, the board shall submit to the~~
18 ~~Assembly Committee on Health and the Senate Committee on~~
19 ~~Health a recommendation for an existing health plan to set the~~
20 ~~benchmark for items and services to be included in the definition~~
21 ~~of essential health benefits, as contemplated under Section 1302~~
22 ~~of the federal Patient Protection and Affordable Care Act (42~~
23 ~~U.S.C. Sec. 18022) and the Essential Health Benefits Bulletin~~
24 ~~issued on December 16, 2011, by the Center for Consumer~~
25 ~~Information and Insurance Oversight within the federal Centers~~
26 ~~for Medicare and Medicaid Services.~~

27 ~~(b) (1) In developing the recommendation under subdivision~~
28 ~~(a), the board shall collaborate with the Department of Managed~~
29 ~~Health Care, the Department of Insurance, and other interested~~
30 ~~stakeholder organizations. The board may convene an advisory~~
31 ~~council to aid in its deliberations. The board shall compare and~~
32 ~~contrast the options presented in the bulletin referred to in~~
33 ~~subdivision (a), including use of any of the following as the~~
34 ~~benchmark plan:~~

35 ~~(A) One of the three largest small employer plans in the state.~~

36 ~~(B) One of the three largest state employee health plans.~~

37 ~~(C) One of the three largest federal employee health plan~~
38 ~~options:~~

39 ~~(D) The largest HMO plan offered in the state’s commercial~~
40 ~~market.~~

1 ~~(2) In developing the recommendation under subdivision (a);~~
2 ~~the board shall take into consideration all of the benefits required~~
3 ~~to be covered by health care service plans under the Knox-Keene~~
4 ~~Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing~~
5 ~~with Section 1340) of Division 2 of the Health and Safety Code),~~
6 ~~including, but not limited to, basic health care services, as defined~~
7 ~~in subdivision (b) of Section 1345 of the Health and Safety Code~~
8 ~~and Section 1300.67 of Title 28 of the California Code of~~
9 ~~Regulations. The board shall propose statutory amendments~~
10 ~~necessary to implement its recommendation and other conforming~~
11 ~~amendments necessary to comply with the requirements of the~~
12 ~~federal Patient Protection and Affordable Care Act, and the rules~~
13 ~~and regulations issued thereunder, relating to essential health~~
14 ~~benefits.~~

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