

AMENDED IN SENATE APRIL 9, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL

No. 639

Introduced by Senator Hernandez

February 22, 2013

An act to amend Section 1367 of, and to add Sections 1367.006, 1367.007, ~~and~~ 1367.008, *and* 1367.009 to, the Health and Safety Code, and to add Sections 10112.28, 10112.29, 10112.295, *10112.297*, and 10112.7 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 639, as amended, Hernandez. Health care coverage.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA establishes annual limits on deductibles for employer-sponsored plans and defines bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets.

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.

This bill would prohibit the deductible under a small employer health care service plan contract or health insurance policy offered, sold, or renewed on or after January 1, 2014, from exceeding \$2,000 in the case of a plan contract or policy covering a single individual, or \$4,000 in all other cases.

The bill would require, for nongrandfathered products in the individual or small group markets, a health care service plan contract or health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2014, to provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, as defined, and would require the contract or policy, for nongrandfathered products in the large group market, to provide that limit for all covered benefits, including out-of-network emergency care.

The bill would define bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets consistent with the definitions in PPACA. The bill would prohibit a carrier that is not participating in the Exchange from offering a catastrophic plan, as defined, in the individual market.

PPACA requires a health insurance issuer offering group or individual coverage that provides or covers benefits with respect to services in the emergency department of a hospital to cover emergency services without the need for prior authorization, regardless of whether the provider is a participating provider, and subject to the same cost sharing required if the services were provided by a participating provider, as specified.

This bill would impose that requirement with respect to health insurance policies issued, amended, or renewed on or after January 1, 2014, as specified.

Because a willful violation of these 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:

- 1 SECTION 1. Section 1367 of the Health and Safety Code is
- 2 amended to read:
- 3 1367. A health care service plan and, if applicable, a specialized
- 4 health care service plan shall meet the following requirements:

1 (a) Facilities located in this state including, but not limited to,
2 clinics, hospitals, and skilled nursing facilities to be utilized by
3 the plan shall be licensed by the State Department of Public Health,
4 where licensure is required by law. Facilities not located in this
5 state shall conform to all licensing and other requirements of the
6 jurisdiction in which they are located.

7 (b) Personnel employed by or under contract to the plan shall
8 be licensed or certified by their respective board or agency, where
9 licensure or certification is required by law.

10 (c) Equipment required to be licensed or registered by law shall
11 be so licensed or registered, and the operating personnel for that
12 equipment shall be licensed or certified as required by law.

13 (d) The plan shall furnish services in a manner providing
14 continuity of care and ready referral of patients to other providers
15 at times as may be appropriate consistent with good professional
16 practice.

17 (e) (1) All services shall be readily available at reasonable
18 times to each enrollee consistent with good professional practice.
19 To the extent feasible, the plan shall make all services readily
20 accessible to all enrollees consistent with Section 1367.03.

21 (2) To the extent that telehealth services are appropriately
22 provided through telehealth, as defined in subdivision (a) of Section
23 2290.5 of the Business and Professions Code, these services shall
24 be considered in determining compliance with Section 1300.67.2
25 of Title 28 of the California Code of Regulations.

26 (3) The plan shall make all services accessible and appropriate
27 consistent with Section 1367.04.

28 (f) The plan shall employ and utilize allied health manpower
29 for the furnishing of services to the extent permitted by law and
30 consistent with good medical practice.

31 (g) The plan shall have the organizational and administrative
32 capacity to provide services to subscribers and enrollees. The plan
33 shall be able to demonstrate to the department that medical
34 decisions are rendered by qualified medical providers, unhindered
35 by fiscal and administrative management.

36 (h) (1) Contracts with subscribers and enrollees, including
37 group contracts, and contracts with providers, and other persons
38 furnishing services, equipment, or facilities to or in connection
39 with the plan, shall be fair, reasonable, and consistent with the
40 objectives of this chapter. All contracts with providers shall contain

1 provisions requiring a fast, fair, and cost-effective dispute
2 resolution mechanism under which providers may submit disputes
3 to the plan, and requiring the plan to inform its providers upon
4 contracting with the plan, or upon change to these provisions, of
5 the procedures for processing and resolving disputes, including
6 the location and telephone number where information regarding
7 disputes may be submitted.

8 (2) A health care service plan shall ensure that a dispute
9 resolution mechanism is accessible to noncontracting providers
10 for the purpose of resolving billing and claims disputes.

11 (3) On and after January 1, 2002, a health care service plan
12 shall annually submit a report to the department regarding its
13 dispute resolution mechanism. The report shall include information
14 on the number of providers who utilized the dispute resolution
15 mechanism and a summary of the disposition of those disputes.

16 (i) A health care service plan contract shall provide to
17 subscribers and enrollees all of the basic health care services
18 included in subdivision (b) of Section 1345, except that the director
19 may, for good cause, by rule or order exempt a plan contract or
20 any class of plan contracts from that requirement. The director
21 shall by rule define the scope of each basic health care service that
22 health care service plans are required to provide as a minimum for
23 licensure under this chapter. Nothing in this chapter shall prohibit
24 a health care service plan from charging subscribers or enrollees
25 a copayment or a deductible for a basic health care service
26 consistent with Section 1367.006 or 1367.007, provided that the
27 copayments, deductibles, or other cost sharing are reported to the
28 director and set forth to the subscriber or enrollee pursuant to the
29 disclosure provisions of Section 1363. Nothing in this chapter shall
30 prohibit a health care service plan from setting forth, by contract,
31 limitations on maximum coverage of basic health care services,
32 provided that the limitations are reported to, and held
33 unobjectionable by, the director and set forth to the subscriber or
34 enrollee pursuant to the disclosure provisions of Section 1363.

35 (j) A health care service plan shall not require registration under
36 the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.)
37 as a condition for participation by an optometrist certified to use
38 therapeutic pharmaceutical agents pursuant to Section 3041.3 of
39 the Business and Professions Code.

1 Nothing in this section shall be construed to permit the director
2 to establish the rates charged subscribers and enrollees for
3 contractual health care services.

4 The director's enforcement of Article 3.1 (commencing with
5 Section 1357) shall not be deemed to establish the rates charged
6 subscribers and enrollees for contractual health care services.

7 The obligation of the plan to comply with this chapter shall not
8 be waived when the plan delegates any services that it is required
9 to perform to its medical groups, independent practice associations,
10 or other contracting entities.

11 SEC. 2. Section 1367.006 is added to the Health and Safety
12 Code, to read:

13 1367.006. (a) (1) For nongrandfathered products in the
14 individual or small group markets, a health care service plan
15 contract, except a specialized health care service plan contract,
16 that is issued, amended, or renewed on or after January 1, 2014,
17 shall provide for a limit on annual out-of-pocket expenses for all
18 covered benefits that meet the definition of essential health benefits
19 in paragraph (1) of subdivision (a) of Section 1367.005.

20 (2) For nongrandfathered products in the large group market, a
21 health care service plan contract, except a specialized health care
22 service plan contract, that is issued, amended, or renewed on or
23 after January 1, 2014, shall provide for a limit on annual
24 out-of-pocket expenses for all covered benefits, including
25 out-of-network emergency care consistent with Section 1371.4.

26 *For large group products for the first plan year commencing on*
27 *or after January 1, 2014, the requirement that a product provide*
28 *for a limit on annual out-of-pocket expenses shall be satisfied if*
29 *both of the following apply:*

30 (A) *The product complies with the requirements of this*
31 *paragraph with respect to basic health care services.*

32 (B) *To the extent the product includes an out-of-pocket maximum*
33 *on coverage that does not consist solely of basic health care*
34 *services, the out-of-pocket maximum does not exceed the limit*
35 *established pursuant to this paragraph.*

36 (b) The limit described in subdivision (a) shall apply to any
37 copayment, coinsurance, deductible, incentive payment, and any
38 other form of cost sharing for all covered benefits, *including*
39 *prescription drugs covered pursuant to Section 1367.24.*

1 (c) The limit described in subdivision (a) shall not exceed the
2 limit described in Section 1302(c) of PPACA, and any subsequent
3 rules, regulations, or guidance issued under that section.

4 (d) Nothing in this section shall be construed to affect the
5 reduction in cost sharing for eligible enrollees described in Section
6 1402 of PPACA, and any subsequent rules, regulations, or guidance
7 issued under that section.

8 (e) “PPACA” means the federal Patient Protection and
9 Affordable Care Act (Public Law 111-148), as amended by the
10 federal Health Care and Education Reconciliation Act of 2010
11 (Public Law 111-152), and any rules, regulations, or guidance
12 issued thereunder.

13 SEC. 3. Section 1367.007 is added to the Health and Safety
14 Code, to read:

15 1367.007. (a) (1) For a small employer health care service
16 plan contract offered, sold, or renewed on or after January 1, 2014,
17 the deductible under the plan shall not exceed:

18 (A) Two thousand dollars (\$2,000) in the case of a plan contract
19 covering a single individual.

20 (B) Four thousand dollars (\$4,000) in the case of any other plan
21 contract.

22 (2) The dollar amounts in this section shall be indexed consistent
23 with Section 1302(c)(2) of PPACA and any federal rules or
24 guidance pursuant to that section.

25 (3) The limitation in this subdivision shall be applied in a
26 manner that does not affect the actuarial value of any small
27 employer health care service plan contract.

28 (4) For small group products at the bronze level of coverage,
29 as defined in Section 1367.008, the department may permit plans
30 to offer a higher deductible in order to meet the actuarial value
31 requirement of the bronze level. In making this determination, the
32 department shall consider affordability of cost sharing for enrollees
33 and shall also consider whether enrollees may be deterred from
34 seeking appropriate care because of higher cost sharing.

35 (b) Nothing in this section shall be construed to allow a plan
36 contract to have a deductible that applies to preventive services as
37 defined in Section 1367.002.

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

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

3 SEC. 4. Section 1367.008 is added to the Health and Safety
4 Code, to read:

5 1367.008. (a) Levels of coverage for the nongrandfathered
6 individual ~~and small group markets~~ *market* are defined as follows:

7 (1) Bronze level: A health care service plan contract in the
8 bronze level shall provide a level of coverage that is actuarially
9 equivalent to 60 percent of the full actuarial value of the benefits
10 provided under the plan contract. No product shall be offered at
11 this level of coverage unless it is a standardized product consistent
12 with Section 1366.6.

13 (2) Silver level: A health care service plan contract in the silver
14 level shall provide a level of coverage that is actuarially equivalent
15 to 70 percent of the full actuarial value of the benefits provided
16 under the plan contract. No product shall be offered at this level
17 of coverage unless it is a standardized product consistent with
18 Section 1366.6.

19 (3) Gold level: A health care service plan contract in the gold
20 level shall provide a level of coverage that is actuarially equivalent
21 to 80 percent of the full actuarial value of the benefits provided
22 under the plan contract. No product shall be offered at this level
23 of coverage unless it is a standardized product consistent with
24 Section 1366.6.

25 (4) Platinum level: A health care service plan contract in the
26 platinum level shall provide a level of coverage that is actuarially
27 equivalent to 90 percent of the full actuarial value of the benefits
28 provided under the plan contract. No product shall be offered at
29 this level of coverage unless it is a standardized product consistent
30 with Section 1366.6.

31 (b) Actuarial value for nongrandfathered individual ~~and~~
32 ~~nongrandfathered small employer~~ health care service plan contracts
33 shall be determined in accordance with the following:

34 (1) Actuarial value shall not vary by more than plus or minus
35 2 percent.

36 (2) Actuarial value shall be determined on the basis of essential
37 health benefits as defined in Section 1367.005 and as provided to
38 a standard, nonelderly population. For this purpose, a standard
39 population shall not include those receiving coverage through the
40 Medi-Cal or Medicare programs.

1 (3) The department may use the actuarial value methodology
2 developed consistent with Section 1302(d) of PPACA.

3 (4) The department, in consultation with the Department of
4 Insurance and the Exchange, shall consider whether to exercise
5 state-level flexibility with respect to the actuarial value calculator
6 in order to take into account the unique characteristics of the
7 California health care coverage market, including the prevalence
8 of health care service plans, total cost of care paid for by the plan,
9 price of care, patterns of service utilization, and relevant
10 demographic factors.

11 ~~(5) For small group products, employer contributions toward~~
12 ~~health reimbursement accounts and health savings accounts shall~~
13 ~~count toward the actuarial value of the product in the manner~~
14 ~~specified in federal rules and guidance.~~

15 (c) For all products in the nongrandfathered individual and small
16 group markets, any deductible shall apply to all services market
17 commencing January 1, 2015, any deductible shall apply to the
18 same services for any product in the same level of coverage
19 whether regulated by the department or the Department of
20 Insurance.

21 (d) (1) A catastrophic plan is a health care service plan contract
22 that provides no benefits for any plan year until the enrollee has
23 incurred cost-sharing expenses in an amount equal to the annual
24 limit on out-of-pocket costs as specified in Section 1367.006 except
25 that it shall provide coverage for at least three primary care visits.
26 A carrier that is not participating in the Exchange shall not offer,
27 market, or sell a catastrophic plan in the individual market. No
28 product shall be offered at this level of coverage unless it is a
29 standardized product consistent with Section 1366.6.

30 (2) A catastrophic plan may be offered only in the individual
31 market and only if consistent with subdivision (c) and this
32 paragraph. Catastrophic plans may be offered only if either of the
33 following apply:

34 (A) The individual purchasing the plan has not yet attained 30
35 years of age.

36 (B) The individual has a certificate of exemption from Section
37 5000(A) of the Internal Revenue Code because the individual is
38 not offered affordable coverage or because the individual faces
39 hardship.

1 (e) Nothing in this section shall prohibit a plan from offering
2 supplemental benefits for services that are not included in essential
3 health benefits as defined in Section 1367.005, including adult
4 dental, adult vision, acupuncture, or chiropractic, if the plan
5 demonstrates to the satisfaction of the director that those benefits
6 will not affect the risk adjustment scores or the reinsurance
7 amounts for the product or the plan. For a plan to continue to
8 offer a supplemental benefit, the plan shall annually provide to
9 the department information necessary to determine whether the
10 benefit has affected the risk mix in the prior plan year.

11 (e)

12 (f) “PPACA” means the federal Patient Protection and
13 Affordable Care Act (Public Law 111-148), as amended by the
14 federal Health Care and Education Reconciliation Act of 2010
15 (Public Law 111-152), and any rules, regulations, or guidance
16 issued thereunder.

17 SEC. 5. Section 1367.009 is added to the Health and Safety
18 Code, to read:

19 1367.009. (a) Levels of coverage for the nongrandfathered
20 small group market are defined as follows:

21 (1) Bronze level: A health care service plan contract in the
22 bronze level shall provide a level of coverage that is actuarially
23 equivalent to 60 percent of the full actuarial value of the benefits
24 provided under the plan contract.

25 (2) Silver level: A health care service plan contract in the silver
26 level shall provide a level of coverage that is actuarially equivalent
27 to 70 percent of the full actuarial value of the benefits provided
28 under the plan contract.

29 (3) Gold level: A health care service plan contract in the gold
30 level shall provide a level of coverage that is actuarially equivalent
31 to 80 percent of the full actuarial value of the benefits provided
32 under the plan contract.

33 (4) Platinum level: A health care service plan contract in the
34 platinum level shall provide a level of coverage that is actuarially
35 equivalent to 90 percent of the full actuarial value of the benefits
36 provided under the plan contract.

37 (b) Actuarial value for nongrandfathered small employer health
38 care service plan contracts shall be determined in accordance
39 with the following:

1 (1) Actuarial value shall not vary by more than plus or minus
 2 2 percent.

3 (2) Actuarial value shall be determined on the basis of essential
 4 health benefits as defined in Section 1367.005 and as provided to
 5 a standard, nonelderly population. For this purpose, a standard
 6 population shall not include those receiving coverage through the
 7 Medi-Cal or Medicare programs.

8 (3) The department may use the actuarial value methodology
 9 developed consistent with Section 1302(d) of PPACA.

10 (4) The department, in consultation with the Department of
 11 Insurance and the Exchange, shall consider whether to exercise
 12 state-level flexibility with respect to the actuarial value calculator
 13 in order to take into account the unique characteristics of the
 14 California health care coverage market, including the prevalence
 15 of health care service plans, total cost of care paid for by the plan,
 16 price of care, patterns of service utilization, and relevant
 17 demographic factors.

18 (5) Employer contributions toward health reimbursement
 19 accounts and health savings accounts shall count toward the
 20 actuarial value of the product in the manner specified in federal
 21 rules and guidance.

22 (c) For all products in the nongrandfathered small group market
 23 commencing January 1, 2015, any deductible shall apply to the
 24 same services for any product in the same level of coverage
 25 whether regulated by the department or the Department of
 26 Insurance.

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

32 ~~SEC. 5.~~

33 SEC. 6. Section 10112.28 is added to the Insurance Code, to
 34 read:

35 10112.28. (a) (1) For nongrandfathered products in the
 36 individual or small group markets, a health insurance policy, except
 37 a specialized health insurance policy, that is issued, amended, or
 38 renewed on or after January 1, 2014, shall provide for a limit on
 39 annual out-of-pocket expenses for all covered benefits that meet

1 the definition of essential health benefits in paragraph (1) of
2 subdivision (a) of Section 10112.27.

3 (2) For nongrandfathered products in the large group market, a
4 health insurance policy, except a specialized health insurance
5 policy, that is issued, amended, or renewed on or after January 1,
6 2014, shall provide for a limit on annual out-of-pocket expenses
7 for all covered benefits, including out-of-network emergency care.
8 *For large group products for the first plan year commencing on*
9 *or after January 1, 2014, the requirement that a product provide*
10 *for a limit on annual out-of-pocket expenses shall be satisfied if*
11 *both of the following apply:*

12 (A) *The product complies with the requirements of this*
13 *paragraph with respect to basic health care services.*

14 (B) *To the extent the product includes an out-of-pocket maximum*
15 *on coverage that does not consist solely of basic health care*
16 *services, the out-of-pocket maximum does not exceed the limit*
17 *established pursuant to this subdivision.*

18 (b) The limit described in subdivision (a) shall apply to any
19 copayment, coinsurance, deductible, incentive payment and any
20 other form of cost sharing for all covered benefits, *including*
21 *nonformulary prescription drugs that are authorized as medically*
22 *necessary.*

23 (c) The limit described in subdivision (a) shall not exceed the
24 limit described in Section 1302(c) of PPACA and any subsequent
25 rules, regulations, or guidance issued under that section.

26 (d) Nothing in this section shall be construed to affect the
27 reduction in cost sharing for eligible enrollees described in Section
28 1402 of PPACA and any subsequent rules, regulations, or guidance
29 issued under that section.

30 (e) “PPACA” means the federal Patient Protection and
31 Affordable Care Act (Public Law 111-148), as amended by the
32 federal Health Care and Education Reconciliation Act of 2010
33 (Public Law 111-152), and any rules, regulations, or guidance
34 issued thereunder.

35 ~~SEC. 6.~~

36 *SEC. 7.* Section 10112.29 is added to the Insurance Code, to
37 read:

38 10112.29. (a) (1) For a small employer health insurance policy
39 offered, sold, or renewed on or after January 1, 2014, the deductible
40 under the policy shall not exceed:

1 (A) Two thousand dollars (\$2,000) in the case of a policy
2 covering a single individual.

3 (B) Four thousand dollars (\$4,000) in the case of any other
4 policy.

5 (2) The dollar amounts in this section shall be indexed consistent
6 with Section 1302(c)(2) of PPACA and any federal rules or
7 guidance pursuant to that section.

8 (3) The limitation in this subdivision shall be applied in a
9 manner that does not affect the actuarial value of any small
10 employer health insurance policy.

11 (4) For small group products at the bronze level of coverage,
12 as defined in Section 10112.295, the department may permit
13 insurers to offer a higher deductible in order to meet the actuarial
14 value requirement of the bronze level. In making this
15 determination, the department shall consider affordability of cost
16 sharing for insureds and shall also consider whether insureds may
17 be deterred from seeking appropriate care because of higher cost
18 sharing.

19 (b) Nothing in this section shall be construed to allow a policy
20 to have a deductible that applies to preventive services as defined
21 in PPACA.

22 (c) "PPACA" means the federal Patient Protection and
23 Affordable Care Act (Public Law 111-148), as amended by the
24 federal Health Care and Education Reconciliation Act of 2010
25 (Public Law 111-152), and any rules, regulations, or guidance
26 issued thereunder.

27 ~~SEC. 7.~~

28 *SEC. 8.* Section 10112.295 is added to the Insurance Code, to
29 read:

30 10112.295. (a) Levels of coverage for the nongrandfathered
31 individual and small group markets *market* are defined as follows:

32 (1) Bronze level: A health insurance policy in the bronze level
33 shall provide a level of coverage that is actuarially equivalent to
34 60 percent of the full actuarial value of the benefits provided under
35 the policy. No product shall be offered at this level of coverage
36 unless it is a standardized product consistent with Section 10112.3.

37 (2) Silver level: A health insurance policy in the silver level
38 shall provide a level of coverage that is actuarially equivalent to
39 70 percent of the full actuarial value of the benefits provided under

1 the policy. No product shall be offered at this level of coverage
2 unless it is a standardized product consistent with Section 10112.3.

3 (3) Gold level: A health insurance policy in the gold level shall
4 provide a level of coverage that is actuarially equivalent to 80
5 percent of the full actuarial value of the benefits provided under
6 the policy. No product shall be offered at this level of coverage
7 unless it is a standardized product consistent with Section 10112.3.

8 (4) Platinum level: A health insurance policy in the platinum
9 level shall provide a level of coverage that is actuarially equivalent
10 to 90 percent of the full actuarial value of the benefits provided
11 under the policy. No product shall be offered at this level of
12 coverage unless it is a standardized product consistent with Section
13 10112.3.

14 (b) Actuarial value for nongrandfathered individual ~~and~~
15 ~~nongrandfathered small employer~~ health insurance policies shall
16 be determined in accordance with the following:

17 (1) Actuarial value shall not vary by more than plus or minus
18 2 percent.

19 (2) Actuarial value shall be determined on the basis of essential
20 health benefits as defined in Section 10112.27 and as provided to
21 a standard, nonelderly population. For this purpose, a standard
22 population shall not include those receiving coverage through the
23 Medi-Cal or Medicare programs.

24 (3) The department may use the actuarial value methodology
25 developed consistent with Section 1302(d) of PPACA.

26 (4) The department, in consultation with the Department of
27 Managed Health Care and the Exchange, shall consider whether
28 to exercise state-level flexibility with respect to the actuarial value
29 calculator in order to take into account the unique characteristics
30 of the California health care coverage market, including the
31 prevalence of health-care service plans *insurance policies*, total
32 cost of care paid for by the ~~plan~~ *health insurer*, price of care,
33 patterns of service utilization, and relevant demographic factors.

34 ~~(5) For small group products, employer contributions toward~~
35 ~~health reimbursement accounts and health savings accounts shall~~
36 ~~count toward the actuarial value of the product in the manner~~
37 ~~specified in federal rules and guidance.~~

38 (c) For all products in the nongrandfathered individual ~~and small~~
39 ~~group~~ markets, ~~any deductible shall apply to all services market~~
40 ~~commencing January 1, 2015, any deductible shall apply to the~~

1 *same services for any product in the same level of coverage*
2 *whether regulated by the department or the Department of*
3 *Managed Health Care.*

4 (d) (1) A catastrophic policy is a health insurance policy that
5 provides no benefits for any plan year until the insured has incurred
6 cost-sharing expenses in an amount equal to the annual limit on
7 out-of-pocket costs as specified in Section 10112.28 except that
8 it shall provide coverage for at least three primary care visits. No
9 product shall be offered at this level of coverage unless it is a
10 standardized product consistent with Section 10112.3. A carrier
11 that is not participating in the Exchange shall not offer, market, or
12 sell a catastrophic plan in the individual market.

13 (2) A catastrophic policy may be offered only in the individual
14 market and only if consistent with subdivision (c) and this
15 paragraph. Catastrophic policies may be offered only if either of
16 the following apply:

17 (A) The individual purchasing the policy has not yet attained
18 30 years of age.

19 (B) The individual has a certificate of exemption from Section
20 5000(A) of the Internal Revenue Code because the individual is
21 not offered affordable coverage or because the individual faces
22 hardship.

23 (e) *Nothing in this section shall prohibit an insurer from offering*
24 *supplemental benefits for services that are not included in essential*
25 *health benefits as defined in paragraph (1) of subdivision (a) of*
26 *Section 10112.27, including adult dental, adult vision, acupuncture,*
27 *or chiropractic, if the insurer demonstrates to the satisfaction of*
28 *the commissioner that those benefits will not affect the risk*
29 *adjustment scores or the reinsurance amounts for the product or*
30 *the policy. For an insurer to continue to offer a supplemental*
31 *benefit, the insurer shall annually provide to the department*
32 *information necessary to determine whether the benefit has affected*
33 *the risk mix in the prior policy year.*

34 (e)

35 (f) “PPACA” means the federal Patient Protection and
36 Affordable Care Act (Public Law 111-148), as amended by the
37 federal Health Care and Education Reconciliation Act of 2010
38 (Public Law 111-152), and any rules, regulations, or guidance
39 issued thereunder.

1 SEC. 9. Section 10112.297 is added to the Insurance Code, to
2 read:

3 10112.297. (a) Levels of coverage for the nongrandfathered
4 small group market are defined as follows:

5 (1) Bronze level: A health insurance policy in the bronze level
6 shall provide a level of coverage that is actuarially equivalent to
7 60 percent of the full actuarial value of the benefits provided under
8 the policy.

9 (2) Silver level: A health insurance policy in the silver level
10 shall provide a level of coverage that is actuarially equivalent to
11 70 percent of the full actuarial value of the benefits provided under
12 the policy.

13 (3) Gold level: A health insurance policy in the gold level shall
14 provide a level of coverage that is actuarially equivalent to 80
15 percent of the full actuarial value of the benefits provided under
16 the policy.

17 (4) Platinum level: A health insurance policy in the platinum
18 level shall provide a level of coverage that is actuarially equivalent
19 to 90 percent of the full actuarial value of the benefits provided
20 under the policy.

21 (b) Actuarial value for nongrandfathered small employer health
22 insurance policies shall be determined in accordance with the
23 following:

24 (1) Actuarial value shall not vary by more than plus or minus
25 2 percent.

26 (2) Actuarial value shall be determined on the basis of essential
27 health benefits as defined in paragraph (1) of subdivision (a) of
28 Section 10112.27 and as provided to a standard, nonelderly
29 population. For this purpose, a standard population shall not
30 include those receiving coverage through the Medi-Cal or
31 Medicare programs.

32 (3) The department may use the actuarial value methodology
33 developed consistent with Section 1302(d) of PPACA.

34 (4) The department, in consultation with the Department of
35 Managed Health Care and the Exchange, shall consider whether
36 to exercise state-level flexibility with respect to the actuarial value
37 calculator in order to take into account the unique characteristics
38 of the California health care coverage market, including the
39 prevalence of health insurance policies, total cost of care paid for

1 *by the health insurer, price of care, patterns of service utilization,*
2 *and relevant demographic factors.*

3 *(5) Employer contributions toward health reimbursement*
4 *accounts and health savings accounts shall count toward the*
5 *actuarial value of the product in the manner specified in federal*
6 *rules and guidance.*

7 *(c) For all products in the nongrandfathered small group market*
8 *commencing January 1, 2015, any deductible shall apply to the*
9 *same services for any product in the same level of coverage*
10 *whether regulated by the department or the Department of*
11 *Managed Health Care.*

12 *(e) “PPACA” means the federal Patient Protection and*
13 *Affordable Care Act (Public Law 111-148), as amended by the*
14 *federal Health Care and Education Reconciliation Act of 2010*
15 *(Public Law 111-152), and any rules, regulations, or guidance*
16 *issued thereunder.*

17 ~~SEC. 8.~~

18 *SEC. 10.* Section 10112.7 is added to the Insurance Code, to
19 read:

20 10112.7. (a) A group or individual health insurance policy
21 issued, amended, or renewed on or after January 1, 2014, that
22 provides or covers any benefits with respect to services in an
23 emergency department of a hospital shall cover emergency services
24 as follows:

25 (1) Without the need for any prior authorization determination.

26 (2) Whether the health care provider furnishing the services is
27 a participating provider with respect to those services.

28 (3) In a manner so that, if the services are provided to an insured:

29 (A) By a nonparticipating health care provider with or without
30 prior authorization; or

31 (B) (i) The services will be provided without imposing any
32 requirement under the policy for prior authorization of services or
33 any limitation on coverage where the provider of services does
34 not have a contractual relationship with the insurer for the
35 providing of services that is more restrictive than the requirements
36 or limitations that apply to emergency department services received
37 from providers who do have such a contractual relationship with
38 the insurer; and

39 (ii) If the services are provided to an insured out-of-network,
40 the cost-sharing requirement, expressed as a copayment amount

1 or coinsurance rate, is the same requirement that would apply if
2 the services were provided in-network.

3 (b) For the purposes of this section, the term “emergency
4 services” means, with respect to an emergency medical condition:

5 (1) A medical screening examination that is within the capability
6 of the emergency department of a hospital, including ancillary
7 services routinely available to the emergency department to
8 evaluate that emergency medical condition.

9 (2) Within the capabilities of the staff and facilities available at
10 the hospital, further medical examination and treatment as are
11 required under Section 1867(e)(3) of the federal Social Security
12 Act (42 U.S.C. 1395dd(e)(3)) to stabilize the patient.

13 ~~SEC. 9.~~

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