

AMENDED IN ASSEMBLY SEPTEMBER 3, 2013

AMENDED IN ASSEMBLY AUGUST 6, 2013

AMENDED IN SENATE MAY 28, 2013

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, 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 covered benefits, including out-of-network emergency care, to the extent that the limit does not conflict with federal law or guidance, as specified. The bill would, effective January 1, 2015, ~~apply the above-described provisions to~~ *would prohibit the total annual out-of-pocket maximum for all essential benefits from exceeding that limit for a specialized plan or specialized health insurance policy that offers or provides an essential health benefit, as specified, in plan or policy years beginning on or after January 1, 2015.*

The bill would provide that in the first plan year or policy year commencing on or after January 1, 2014, to the extent allowed by federal law, for nongrandfathered products in the individual and small group markets, when a plan or insurer uses a separate service provider to administer pediatric oral care benefits, the limit on annual out-of-pocket expenses would be satisfied if the plan or policy complies with a specified out-of-pocket maximum for all other essential health benefits and the separate out-of-pocket maximum for the pediatric oral care benefits does not exceed the out-of-pocket maximum requirements for pediatric dental benefits established for stand-alone dental plans by the California Health Benefit Exchange. The bill would also prohibit a plan or insurer from applying a separate out-of-pocket maximum to mental health or substance use disorder benefits.

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:

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

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

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

17 (d) The plan shall furnish services in a manner providing
18 continuity of care and ready referral of patients to other providers

1 at times as may be appropriate consistent with good professional
2 practice.

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

7 (2) To the extent that telehealth services are appropriately
8 provided through telehealth, as defined in subdivision (a) of Section
9 2290.5 of the Business and Professions Code, these services shall
10 be considered in determining compliance with Section 1300.67.2
11 of Title 28 of the California Code of Regulations.

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

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

17 (g) The plan shall have the organizational and administrative
18 capacity to provide services to subscribers and enrollees. The plan
19 shall be able to demonstrate to the department that medical
20 decisions are rendered by qualified medical providers, unhindered
21 by fiscal and administrative management.

22 (h) (1) Contracts with subscribers and enrollees, including
23 group contracts, and contracts with providers, and other persons
24 furnishing services, equipment, or facilities to or in connection
25 with the plan, shall be fair, reasonable, and consistent with the
26 objectives of this chapter. All contracts with providers shall contain
27 provisions requiring a fast, fair, and cost-effective dispute
28 resolution mechanism under which providers may submit disputes
29 to the plan, and requiring the plan to inform its providers upon
30 contracting with the plan, or upon change to these provisions, of
31 the procedures for processing and resolving disputes, including
32 the location and telephone number where information regarding
33 disputes may be submitted.

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

37 (3) On and after January 1, 2002, a health care service plan shall
38 annually submit a report to the department regarding its dispute
39 resolution mechanism. The report shall include information on the

1 number of providers who utilized the dispute resolution mechanism
2 and a summary of the disposition of those disputes.

3 (i) A health care service plan contract shall provide to
4 subscribers and enrollees all of the basic health care services
5 included in subdivision (b) of Section 1345, except that the director
6 may, for good cause, by rule or order exempt a plan contract or
7 any class of plan contracts from that requirement. The director
8 shall by rule define the scope of each basic health care service that
9 health care service plans are required to provide as a minimum for
10 licensure under this chapter. Nothing in this chapter shall prohibit
11 a health care service plan from charging subscribers or enrollees
12 a copayment or a deductible for a basic health care service
13 consistent with Section 1367.006 or 1367.007, provided that the
14 copayments, deductibles, or other cost sharing are reported to the
15 director and set forth to the subscriber or enrollee pursuant to the
16 disclosure provisions of Section 1363. Nothing in this chapter shall
17 prohibit a health care service plan from setting forth, by contract,
18 limitations on maximum coverage of basic health care services,
19 provided that the limitations are reported to, and held
20 unobjectionable by, the director and set forth to the subscriber or
21 enrollee pursuant to the disclosure provisions of Section 1363.

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

27 Nothing in this section shall be construed to permit the director
28 to establish the rates charged subscribers and enrollees for
29 contractual health care services.

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

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

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

39 1367.006. (a) (1) For nongrandfathered products in the
40 individual or small group markets, a health care service plan

1 contract, except a specialized health care service plan contract,
2 that is issued, amended, or renewed on or after January 1, 2014,
3 shall provide for a limit on annual out-of-pocket expenses for all
4 covered benefits that meet the definition of essential health benefits
5 in ~~paragraph (1) of subdivision (a) of Section 1367.005.~~

6 *(A) In the first plan year commencing on or after January 1,*
7 *2014, to the extent allowed by federal law, for nongrandfathered*
8 *products in the individual and small group markets, when a health*
9 *care service plan uses a separate service provider to administer*
10 *the pediatric oral care benefits required by Section 1367.005, the*
11 *limit on annual out-of-pocket expenses shall be satisfied if both of*
12 *the following conditions are met:*

13 *(i) With respect to all essential health benefits except for the*
14 *pediatric oral care benefit, the health care service plan complies*
15 *with the out-of-pocket maximum requirements in Section 1302(c)(1)*
16 *of PPACA and any federal rules, regulations, and guidance*
17 *implementing that section.*

18 *(ii) The separate out-of-pocket maximum for pediatric oral care*
19 *benefits does not exceed the out-of-pocket maximum requirements*
20 *for pediatric dental benefits established for stand-alone dental*
21 *plans by the California Health Benefit Exchange.*

22 *(B) The health care service plan shall not apply a separate*
23 *out-of-pocket maximum to mental health or substance use disorder*
24 *benefits.*

25 (2) For nongrandfathered products in the large group market, a
26 health care service plan contract, except a specialized health care
27 service plan contract, that is issued, amended, or renewed on or
28 after January 1, 2014, shall provide for a limit on annual
29 out-of-pocket expenses for covered benefits, including
30 out-of-network emergency care consistent with Section 1371.4.
31 This limit shall apply to essential health benefits, *as defined in*
32 *Section 1367.005, that are covered under the plan to the extent*
33 *that this provision does not conflict with federal law or guidance*
34 *on out-of-pocket maximums for nongrandfathered products in the*
35 *large group market. For large group products for the first plan year*
36 *commencing on or after January 1, 2014, the requirement that a*
37 *product provide for a limit on annual out-of-pocket expenses shall*
38 *be satisfied if both of the following apply:*

39 (A) The product complies with the requirements of this
40 paragraph with respect to basic health care services, *as defined in*

1 *subdivision (b) of Section 1345, services required under Sections*
2 *1374.72 and 1374.73, and any requirements of the Paul Wellstone*
3 *and Pete Domenci Mental Health Parity and Addiction Equity Act*
4 *of 2008 (Public Law 110-343).*

5 (B) To the extent the product includes an out-of-pocket
6 maximum on coverage other than ~~basic health care services~~ *the*
7 *coverage described in subparagraph (A), that out-of-pocket*
8 maximum also does not exceed the limit established pursuant to
9 this paragraph.

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

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

17 (d) Nothing in this section shall be construed to affect the
18 reduction in cost sharing for eligible enrollees described in Section
19 1402 of PPACA, and any subsequent rules, regulations, or guidance
20 issued under that section.

21 (e) ~~Effective~~ *For plan years beginning on or after January 1,*
22 *2015, if an essential health benefit is offered or provided by a*
23 *specialized plan, this section shall apply so that the total annual*
24 *out-of-pocket maximum for all essential benefits does shall not*
25 *exceed the limit in this section. This section shall not apply to a*
26 *specialized plan that does not offer an essential health benefit as*
27 *defined in Section 1367.005.*

28 (f) *For nongrandfathered health plan contracts in the group*
29 *market, “plan year” has the meaning set forth in Section 144.103*
30 *of Title 45 of the Code of Federal Regulations. For*
31 *nongrandfathered health plan contracts sold in the individual*
32 *market, “plan year” means the calendar year.*

33 (f)

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

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

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

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

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

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

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

14 (4) For small group products at the bronze level of coverage,
15 as defined in Section 1367.008, the department may permit plans
16 to offer a higher deductible in order to meet the actuarial value
17 requirement of the bronze level. In making this determination, the
18 department shall consider affordability of cost sharing for enrollees
19 and shall also consider whether enrollees may be deterred from
20 seeking appropriate care because of higher cost sharing.

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

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

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

31 1367.008. (a) Levels of coverage for the nongrandfathered
32 individual market are defined as follows:

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

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

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

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

9 (b) Actuarial value for nongrandfathered individual health care
10 service plan contracts shall be determined in accordance with the
11 following:

12 (1) Actuarial value shall not vary by more than plus or minus
13 2 percent.

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

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

21 (4) The actuarial value for pediatric dental benefits, whether
22 offered by a full service plan or a specialized plan, shall be
23 consistent with federal law and guidance *applicable to the plan*
24 *type*.

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

33 ~~(e) For all products in the nongrandfathered individual market~~
34 ~~commencing January 1, 2015, any deductible shall apply to the~~
35 ~~same services for any product in the same level of coverage~~
36 ~~whether regulated by the department or the Department of~~
37 ~~Insurance.~~

38 ~~(d)~~

39 (c) (1) A catastrophic plan is a health care service plan contract
40 that provides no benefits for any plan year until the enrollee has

1 incurred cost-sharing expenses in an amount equal to the annual
2 limit on out-of-pocket costs as specified in Section 1367.006 except
3 that it shall provide coverage for at least three primary care visits.
4 A carrier that is not participating in the Exchange shall not offer,
5 market, or sell a catastrophic plan in the individual market.

6 (2) A catastrophic plan may be offered only in the individual
7 market and only if consistent with ~~subdivision (e)~~ and this
8 paragraph. Catastrophic plans may be offered only if either of the
9 following apply:

10 (A) The individual purchasing the plan has not yet attained 30
11 years of age *before the beginning of the plan year*.

12 (B) The individual has a certificate of exemption from Section
13 5000(A) of the Internal Revenue Code because the individual is
14 not offered affordable coverage or because the individual faces
15 hardship.

16 ~~(e) (1) Nongrandfathered products in the individual market that
17 are not standardized products as provided under Section 1366.1
18 shall be subject to review by the department consistent with this
19 subdivision prior to product approval. This section shall also apply
20 to carriers offering specialized plans that provide coverage of an
21 essential health benefit as defined in Section 1367.005.~~

22 ~~(2) The department shall publicly post information on
23 nonstandardized products no less than 60 days prior to the date on
24 which the product is approved by the department. For purposes of
25 products offered by the Exchange, the department shall post
26 nonstandardized products for review 60 days prior to the
27 finalization of any contract between the Exchange and the health
28 care service plan.~~

29 ~~(3) For each proposed product, the plan shall provide to the
30 department all of the following:~~

31 ~~(A) Information as to whether the product was proposed to the
32 Exchange and any written information from the Exchange as to
33 whether the product was approved, denied, or modified.~~

34 ~~(B) The estimated actuarial value of the proposed product and
35 the actuarial value tier of the proposed product.~~

36 ~~(C) The anticipated impact on risk mix of plan enrollees
37 purchasing the proposed product, including information on the
38 risk mix of enrollees purchasing the same or similar products in
39 prior years.~~

1 ~~(D) Any benefit to consumers, including the anticipated impacts~~
2 ~~on premiums.~~

3 ~~(4) The department shall review and take public comment on~~
4 ~~the nonstandardized products with regard to all of the following:~~

5 ~~(A) Whether the proposed product is likely to affect the risk~~
6 ~~adjustment scores or reinsurance amounts for the product or health~~
7 ~~care service plan.~~

8 ~~(B) Whether the consumer will be provided additional or more~~
9 ~~comprehensive benefits.~~

10 ~~(C) Whether the proposed product has a disproportional impact~~
11 ~~on individuals with high health care needs.~~

12 ~~(D) The anticipated impact on premiums.~~

13 ~~(E) Whether the proposed product is otherwise consistent with~~
14 ~~this chapter.~~

15 ~~(5) If this product is approved or modified, the approved product~~
16 ~~shall be posted.~~

17 ~~(f) Nothing in this section shall prohibit a plan from offering~~
18 ~~supplemental benefits for services that are not included in essential~~
19 ~~health benefits as defined in Section 1367.005, including adult~~
20 ~~dental, adult vision, acupuncture, or chiropractic, if the plan~~
21 ~~demonstrates to the satisfaction of the director that those benefits~~
22 ~~will not affect the risk adjustment scores or the reinsurance amounts~~
23 ~~for the product or the plan. For a plan to continue to offer a~~
24 ~~supplemental benefit, the plan shall annually provide to the~~
25 ~~department information necessary to determine whether the benefit~~
26 ~~has affected the risk mix in the prior plan year.~~

27 ~~(g)~~

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

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

35 1367.009. (a) Levels of coverage for the nongrandfathered
36 small group market are defined as follows:

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

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

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

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

13 (b) Actuarial value for nongrandfathered small employer health
14 care service plan contracts shall be determined in accordance with
15 the following:

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

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

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

25 (4) The actuarial value for pediatric dental benefits, whether
26 offered by a full service plan or a specialized plan, shall be
27 consistent with federal law and guidance *applicable to the plan*
28 *type*.

29 (5) The department, in consultation with the Department of
30 Insurance and the Exchange, shall consider whether to exercise
31 state-level flexibility with respect to the actuarial value calculator
32 in order to take into account the unique characteristics of the
33 California health care coverage market, including the prevalence
34 of health care service plans, total cost of care paid for by the plan,
35 price of care, patterns of service utilization, and relevant
36 demographic factors.

37 (6) Employer contributions toward health reimbursement
38 accounts and health savings accounts shall count toward the
39 actuarial value of the product in the manner specified in federal
40 rules and guidance.

1 ~~(e) For all products in the nongrandfathered small group market~~
2 ~~commencing January 1, 2015, any deductible shall apply to the~~
3 ~~same services for any product in the same level of coverage~~
4 ~~whether regulated by the department or the Department of~~
5 ~~Insurance.~~

6 ~~(d)~~

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

12 SEC. 6. Section 10112.28 is added to the Insurance Code, to
13 read:

14 10112.28. (a) (1) For nongrandfathered products in the
15 individual or small group markets, a health insurance policy, except
16 a specialized health insurance policy, that is issued, amended, or
17 renewed on or after January 1, 2014, shall provide for a limit on
18 annual out-of-pocket expenses for all covered benefits that meet
19 the definition of essential health benefits in ~~paragraph (1) of~~
20 ~~subdivision (a) of~~ Section 10112.27.

21 *(A) In the first policy year commencing on or after January 1,*
22 *2014, to the extent allowed by federal law, for nongrandfathered*
23 *health insurance policies in the individual and small group*
24 *markets, when an insurer uses a separate service provider to*
25 *administer the pediatric oral care benefits required by Section*
26 *10112.27, the limit on annual out-of-pocket expenses shall be*
27 *satisfied if both of the following conditions are met:*

28 *(i) With respect to all essential health benefits except for the*
29 *pediatric oral care benefit, the insurer complies with the*
30 *out-of-pocket maximum requirements in Section 1302(c)(1) of*
31 *PPACA and any federal rules, regulations, and guidance*
32 *implementing that section.*

33 *(ii) The separate out-of-pocket maximum for pediatric oral care*
34 *benefits does not exceed the out-of-pocket maximum requirements*
35 *for pediatric dental benefits established for stand-alone dental*
36 *policies by the California Health Benefit Exchange.*

37 *(B) The insurer shall not apply a separate out-of-pocket*
38 *maximum to mental health or substance use disorder benefits.*

39 (2) For nongrandfathered products in the large group market, a
40 health insurance policy, except a specialized health insurance

1 policy, that is issued, amended, or renewed on or after January 1,
 2 2014, shall provide for a limit on annual out-of-pocket expenses
 3 for covered benefits, including out-of-network emergency care.
 4 This limit shall apply to essential health benefits, *as defined in*
 5 *Section 10112.27, that are covered under the policy to the extent*
 6 *that this provision does not conflict with federal law or guidance*
 7 *on out-of-pocket maximums for nongrandfathered products in the*
 8 *large group market. For large group products for the first plan year*
 9 *commencing on or after January 1, 2014, the requirement that a*
 10 *product provide for a limit on annual out-of-pocket expenses shall*
 11 *be satisfied if both of the following apply:*

12 (A) The product complies with the requirements of this
 13 paragraph with respect to basic health care services, *as defined in*
 14 *Sections 10112.27, 10144.05, 10144.51, and any requirements of*
 15 *the Paul Wellstone and Pete Domenci Mental Health Parity and*
 16 *Addiction Equity Act of 2008 (Public Law 110-343).*

17 (B) To the extent the product includes an out-of-pocket
 18 maximum on coverage other than ~~basic health care services~~ *the*
 19 *coverage described in subparagraph (A), that out-of-pocket*
 20 *maximum also does not exceed the limit established pursuant to*
 21 *this paragraph.*

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

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

30 (d) Nothing in this section shall be construed to affect the
 31 reduction in cost sharing for eligible enrollees described in Section
 32 1402 of PPACA and any subsequent rules, regulations, or guidance
 33 issued under that section.

34 (e) ~~Effective~~ *For policy years beginning on or after January 1,*
 35 *2015, if an essential health benefit is offered or provided by a*
 36 *specialized health insurance policy, this section shall apply so that*
 37 *the total annual out-of-pocket maximum for all essential benefits*
 38 *does shall not exceed the limit in this section. This section shall*
 39 *not apply to a specialized policy that does not offer an essential*
 40 *health benefit as defined in Section ~~1367.005~~ 10112.28.*

1 (f) For nongrandfathered health insurance policies in the group
2 market, “policy year” has the meaning set forth in Section 144.103
3 of Title 45 of the Code of Federal Regulations. For
4 nongrandfathered health insurance policies sold in the individual
5 market, “policy year” means the calendar year.

6 ~~(f)~~

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

12 SEC. 7. Section 10112.29 is added to the Insurance Code, to
13 read:

14 10112.29. (a) (1) For a small employer health insurance policy
15 offered, sold, or renewed on or after January 1, 2014, the deductible
16 under the policy shall not exceed:

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

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

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

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

27 (4) For small group products at the bronze level of coverage,
28 as defined in Section 10112.295, the department may permit
29 insurers to offer a higher deductible in order to meet the actuarial
30 value requirement of the bronze level. In making this
31 determination, the department shall consider affordability of cost
32 sharing for insureds and shall also consider whether insureds may
33 be deterred from seeking appropriate care because of higher cost
34 sharing.

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

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. 8. Section 10112.295 is added to the Insurance Code, to
4 read:

5 10112.295. (a) Levels of coverage for the nongrandfathered
6 individual market are defined as follows:

7 (1) Bronze level: A health insurance policy in the bronze level
8 shall provide a level of coverage that is actuarially equivalent to
9 60 percent of the full actuarial value of the benefits provided under
10 the policy.

11 (2) Silver level: A health insurance policy in the silver level
12 shall provide a level of coverage that is actuarially equivalent to
13 70 percent of the full actuarial value of the benefits provided under
14 the policy.

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

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

23 (b) Actuarial value for nongrandfathered individual health
24 insurance policies shall be determined in accordance with the
25 following:

26 (1) Actuarial value shall not vary by more than plus or minus
27 2 percent.

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

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

35 (4) The actuarial value for pediatric dental benefits, whether
36 offered by a major medical policy or a specialized health insurance
37 policy, shall be consistent with federal law and guidance *applicable*
38 *to the policy type*.

39 (5) The department, in consultation with the Department of
40 Managed Health Care and the Exchange, shall consider whether

1 to exercise state-level flexibility with respect to the actuarial value
2 calculator in order to take into account the unique characteristics
3 of the California health care coverage market, including the
4 prevalence of health insurance policies, total cost of care paid for
5 by the health insurer, price of care, patterns of service utilization,
6 and relevant demographic factors.

7 ~~(e) For all products in the nongrandfathered individual 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 Managed~~
11 ~~Health Care.~~

12 ~~(d)~~

13 (c) (1) A catastrophic policy is a health insurance policy that
14 provides no benefits for any plan year until the insured has incurred
15 cost-sharing expenses in an amount equal to the annual limit on
16 out-of-pocket costs as specified in Section 10112.28 except that
17 it shall provide coverage for at least three primary care visits. A
18 carrier that is not participating in the Exchange shall not offer,
19 market, or sell a catastrophic plan in the individual market.

20 (2) A catastrophic policy may be offered only in the individual
21 market and only if consistent with ~~subdivision (e)~~ and this
22 paragraph. Catastrophic policies may be offered only if either of
23 the following apply:

24 (A) The individual purchasing the policy has not yet attained
25 30 years of age *before the beginning of the plan year*.

26 (B) The individual has a certificate of exemption from Section
27 5000(A) of the Internal Revenue Code because the individual is
28 not offered affordable coverage or because the individual faces
29 hardship.

30 ~~(e) (1) Nongrandfathered products in the individual market that~~
31 ~~are not standardized products as provided under Section 10112.3~~
32 ~~shall be subject to review by the department consistent with this~~
33 ~~subdivision prior to product approval. This section shall also apply~~
34 ~~to carriers offering specialized health insurance policies that~~
35 ~~provide coverage of an essential health benefit as defined in Section~~
36 ~~10112.27.~~

37 ~~(2) The department shall publicly post information on~~
38 ~~nonstandardized products no less than 60 days prior to the date on~~
39 ~~which the product is approved by the department. For purposes of~~
40 ~~products offered by the Exchange, the department shall post~~

1 nonstandardized products for review 60 days prior to the
2 finalization of any contract between the Exchange and the health
3 insurer or carrier offering a specialized health insurance policy.
4 (3) For each proposed product, the insurer shall provide to the
5 department all of the following:
6 (A) Information as to whether the product was proposed to the
7 Exchange and any written information from the Exchange as to
8 whether the product was approved, denied, or modified.
9 (B) The estimated actuarial value of the proposed product and
10 the actuarial value tier of the proposed product.
11 (C) The anticipated impact on risk mix of insureds purchasing
12 the proposed product, including information on the risk mix of
13 insureds purchasing the same or similar products in prior years.
14 (D) Any benefit to consumers, including the anticipated impacts
15 on premiums.
16 (4) The department shall review and take public comment on
17 the nonstandardized products with regard to all of the following:
18 (A) Whether the proposed product is likely to affect the risk
19 adjustment scores or reinsurance amounts for the product or the
20 health insurance policy.
21 (B) Whether the consumer will be provided additional or more
22 comprehensive benefits.
23 (C) Whether the proposed product has a disproportional impact
24 on individuals with high health care needs.
25 (D) The anticipated impact on premiums.
26 (E) Whether the proposed product is otherwise consistent with
27 this chapter.
28 (5) If this product is approved or modified, the approved product
29 shall be posted.
30 (f) Nothing in this section shall prohibit an insurer under a health
31 insurance policy from offering supplemental benefits for services
32 that are not included in essential health benefits as defined in
33 paragraph (1) of subdivision (a) of Section 10112.27, including
34 adult dental, adult vision, acupuncture, or chiropractic, if the insurer
35 demonstrates to the satisfaction of the commissioner that those
36 benefits will not affect the risk adjustment scores or the reinsurance
37 amounts for the product or the policy. For an insurer to continue
38 to offer a supplemental benefit, the insurer shall annually provide
39 to the department information necessary to determine whether the
40 benefit has affected the risk mix in the prior policy year.

1 (g)

2 (d) “PPACA” means the federal Patient Protection and
3 Affordable Care Act (Public Law 111-148), as amended by the
4 federal Health Care and Education Reconciliation Act of 2010
5 (Public Law 111-152), and any rules, regulations, or guidance
6 issued thereunder.

7 SEC. 9. Section 10112.297 is added to the Insurance Code, to
8 read:

9 10112.297. (a) Levels of coverage for the nongrandfathered
10 small group market are defined as follows:

11 (1) Bronze level: A health insurance policy in the bronze level
12 shall provide a level of coverage that is actuarially equivalent to
13 60 percent of the full actuarial value of the benefits provided under
14 the policy.

15 (2) Silver level: A health insurance policy in the silver level
16 shall provide a level of coverage that is actuarially equivalent to
17 70 percent of the full actuarial value of the benefits provided under
18 the policy.

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

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

27 (b) Actuarial value for nongrandfathered small employer health
28 insurance policies shall be determined in accordance with the
29 following:

30 (1) Actuarial value shall not vary by more than plus or minus
31 2 percent.

32 (2) Actuarial value shall be determined on the basis of essential
33 health benefits as defined in paragraph (1) of subdivision (a) of
34 Section 10112.27 and as provided to a standard, nonelderly
35 population. For this purpose, a standard population shall not include
36 those receiving coverage through the Medi-Cal or Medicare
37 programs.

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

1 (4) The actuarial value for pediatric dental benefits, whether
 2 offered by a major medical policy or a specialized health insurance
 3 policy, shall be consistent with federal law and guidance *applicable*
 4 *to the policy type*.

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

13 (6) Employer contributions toward health reimbursement
 14 accounts and health savings accounts shall count toward the
 15 actuarial value of the product in the manner specified in federal
 16 rules and guidance.

17 ~~(e) For all products in the nongrandfathered small group market~~
 18 ~~commencing January 1, 2015, any deductible shall apply to the~~
 19 ~~same services for any product in the same level of coverage~~
 20 ~~whether regulated by the department or the Department of Managed~~
 21 ~~Health Care.~~

22 ~~(d)~~

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

28 SEC. 10. Section 10112.7 is added to the Insurance Code, to
 29 read:

30 10112.7. (a) A group or individual health insurance policy
 31 issued, amended, or renewed on or after January 1, 2014, that
 32 provides or covers any benefits with respect to services in an
 33 emergency department of a hospital shall cover emergency services
 34 as follows:

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

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

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

39 (A) By a nonparticipating health care provider with or without
 40 prior authorization; or

1 (B) (i) The services will be provided without imposing any
2 requirement under the policy for prior authorization of services or
3 any limitation on coverage where the provider of services does
4 not have a contractual relationship with the insurer for the
5 providing of services that is more restrictive than the requirements
6 or limitations that apply to emergency department services received
7 from providers who do have such a contractual relationship with
8 the insurer; and

9 (ii) If the services are provided to an insured out-of-network,
10 the cost-sharing requirement, expressed as a copayment amount
11 or coinsurance rate, is the same requirement that would apply if
12 the services were provided in-network.

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

15 (1) A medical screening examination that is within the capability
16 of the emergency department of a hospital, including ancillary
17 services routinely available to the emergency department to
18 evaluate that emergency medical condition.

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

23 SEC. 11. No reimbursement is required by this act pursuant
24 to Section 6 of Article XIII B of the California Constitution because
25 the only costs that may be incurred by a local agency or school
26 district will be incurred because this act creates a new crime or
27 infraction, eliminates a crime or infraction, or changes the penalty
28 for a crime or infraction, within the meaning of Section 17556 of
29 the Government Code, or changes the definition of a crime within
30 the meaning of Section 6 of Article XIII B of the California
31 Constitution.