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:

SECTION 1. Section 1367 of the Health and Safety Code is amended to read:

1367. A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) In the first plan 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 health care service plan uses a separate service provider to administer the pediatric oral care benefits required by Section 1367.005, the limit on annual out-of-pocket expenses shall be satisfied if both of the following conditions are met:

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

(ii) The separate out-of-pocket maximum for 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.

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

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

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

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

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

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

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

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

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

(f) For nongrandfathered health plan contracts in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health plan contracts sold in the individual market, "plan year" means the calendar year.

~~(f)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(d)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(g)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(d)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(f)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c) For all products in the nongrandfathered individual market commencing January 1, 2015, any deductible shall apply to the same services for any product in the same level of coverage whether regulated by the department or the Department of Managed Health Care.~~

~~(d)~~

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

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

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

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

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

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

~~nonstandardized products for review 60 days prior to the finalization of any contract between the Exchange and the health insurer or carrier offering a specialized health insurance policy.~~

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

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

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

~~(C) The anticipated impact on risk mix of insureds purchasing the proposed product, including information on the risk mix of insureds purchasing the same or similar products in prior years.~~

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

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

~~(A) Whether the proposed product is likely to affect the risk adjustment scores or reinsurance amounts for the product or the health insurance policy.~~

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

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

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

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

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

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

~~(g)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(d)~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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