Senate Bill No. 639

Passed the Senate September 12, 2013

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Secretary of the Senate

Passed the Assembly September 12, 2013

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2013, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 1357.503 and 1367 of, to add Sections 1367.006, 1367.007, 1367.008, and 1367.009 to, and to add and repeal Section 1367.0065 of, the Health and Safety Code, and to amend Section 10753.05 of, and to add Sections 10112.28, 10112.29, 10112.295, 10112.297, and 10112.7 to, and to add and repeal Section 10112.285 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 639, 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. That provision would not apply to multiple employer welfare arrangements, as specified.

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 set the limit at $6,500 for individual coverage and $12,700 for family coverage for the 2014 plan and policy years, and would set a specified limit for pediatric oral care benefits. For later years, those limits would be set using a specified provision of federal law. The bill would prohibit the total annual out-of-pocket maximum for all covered 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 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.

Existing law requires a health care service plan and carrier providing coverage to small employers each calendar year to establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits within a single risk pool, as specified.

This bill would require that index rate to be established at least each calendar year and no more frequently than each calendar quarter.

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.

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

SECTION 1. Section 1357.503 of the Health and Safety Code, as amended by Chapter 2 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

1357.503. (a) (1) On and after October 1, 2013, a plan shall fairly and affirmatively offer, market, and sell all of the plan's small employer health care service plan contracts for plan years on or after January 1, 2014, to all small employers in each service area in which the plan provides or arranges for the provision of health care services.

(2) On and after October 1, 2013, a plan shall make available to each small employer all small employer health care service plan contracts that the plan offers and sells to small employers or to associations that include small employers in this state for plan years on or after January 1, 2014. Health coverage through an association that is not related to employment shall be considered individual coverage pursuant to Section 144.102(c) of Title 45 of the Code of Federal Regulations.

(3) A plan that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraphs (1) and (2) with respect to small employer health care service plan contracts offered through the Exchange in those geographic regions in which the plan offers plan contracts through the Exchange.

(b) A plan shall provide enrollment periods consistent with PPACA and described in Section 155.725 of Title 45 of the Code of Federal Regulations. Commencing January 1, 2014, a plan shall provide special enrollment periods consistent with the special enrollment periods described in Section 1399.849, to the extent permitted by PPACA, except for the triggering events identified

in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of the Code of Federal Regulations with respect to plan contracts offered through the Exchange.

(c) No plan or solicitor shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health care service plan contract that is provided in connection with employee's employment or membership in a guaranteed association.

(d) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in Section 1357.500 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage under subdivision (m) of Section 1357.500, but not electing any health coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

(e) The plan shall not reject an application from a small employer for a small employer health care service plan contract if all of the following conditions are met:

(1) The small employer offers health benefits to 100 percent of its eligible employees. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(3) The small employer agrees to inform the small employer's employees of the availability of coverage and the provision that

those not electing coverage must wait until the next open enrollment or a special enrollment period to obtain coverage through the group if they later decide they would like to have coverage.

(4) The employees and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(f) No plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(2) Encourage or direct small employers to seek coverage from another plan because of the health status, claims experience, industry, occupation of the small employer, or geographic location provided that it is within the plan's approved service area.

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(g) A plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(h) (1) A policy or contract that covers a small employer, as defined in Section 1304(b) of PPACA and in Section 1357.500, shall not establish rules for eligibility, including continued

eligibility, of an individual, or dependent of an individual, to enroll under the terms of the policy or contract based on any of the following health status-related factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 1389.1, a health care service plan shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire prior to enrollment under a small employer health care service plan contract. A health care service plan shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(i) (1) A health care service plan shall consider as a single risk pool for rating purposes in the small employer market the claims experience of all enrollees in all nongrandfathered small employer health benefit plans offered by the health care service plan in this state, whether offered as health care service plan contracts or health insurance policies, including those insureds and enrollees who enroll in coverage through the Exchange and insureds and enrollees covered by the health care service plan outside of the Exchange.

(2) At least each calendar year, and no more frequently than each calendar quarter, a health care service plan shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 1367.005, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state

pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the health care service plan's nongrandfathered small employer health care service plan contracts shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A health care service plan may vary premium rates for a particular nongrandfathered small employer health care service plan contract from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the plan contract.

(B) The plan contract's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the plan contract that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for plan contracts that offer those benefits in addition to essential health benefits.

(D) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(E) Administrative costs, excluding any user fees required by the Exchange.

(j) A plan shall comply with the requirements of Section 1374.3.

(k) (1) Except as provided in paragraph (2), if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, this section shall become inoperative 12 months after the repeal date, in which case health care service plans subject to this section shall instead be governed by Section 1357.03 to the extent permitted by federal law, and all references in this article to this section shall instead refer to Section 1357.03 except for purposes of paragraph (2).

(2) Subdivision (b) shall remain operative with respect to health care service plan contracts offered through the Exchange.

SEC. 2. 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. 3. Section 1367.006 is added to the Health and Safety Code, to read:

1367.006. (a) This section shall apply to nongrandfathered individual and group health care service plan contracts that provide coverage for essential health benefits, as defined in Section 1367.005, and that are issued, amended, or renewed on or after January 1, 2015.

(b) (1) For nongrandfathered health care service plan contracts 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, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 1367.005, including out-of-network emergency care consistent with Section 1317.4.

(2) For nongrandfathered health care service plan contracts 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, 2015, 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 only 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 health care service plan contracts in the large group market.

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

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(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) If an essential health benefit is offered or provided by a specialized health care service plan, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits in Section 1367.005.

(g) 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.

(h) "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 1367.0065 is added to the Health and Safety Code, to read:

1367.0065. (a) This section shall apply to nongrandfathered individual and group health care service plan contracts that provide coverage for essential health benefits defined in Section 1367.005 and that are issued, amended, or renewed for the 2014 plan year.

(b) (1) For nongrandfathered health care service plan contracts in the individual market, and to the extent allowed by federal law, regulations, and guidance, a health care service plan contract, except a specialized health care service plan contract, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits as defined in Section 1367.005, including out-of-network emergency care consistent with Section 1371.4. The total out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars ($6,350) for individual coverage and twelve thousand seven hundred dollars ($12,700) for family coverage.

(2) For nongrandfathered specialized health care service plan contracts in the individual market that provide the pediatric oral care benefit meeting the definition in Section 1302(b)(1)(j) of PPACA, the out-of-pocket maximum for the pediatric oral care benefit shall not exceed one thousand dollars ($1,000) for one child and two thousand dollars ($2,000) for more than one child.

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

(c) For nongrandfathered health care service plan contracts in the small group markets, and to the extent allowed by federal law, regulations, and guidance, a health care service plan contract, except a specialized health care service plan contract, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, as defined in Section 1367.005, including out-of-network emergency care consistent with Section 1371.4, as follows:

(1) With respect to all essential health benefits, except for the pediatric oral care benefit, the total out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars ($6,350) for individual coverage and twelve thousand seven hundred dollars ($12,700) for family coverage. For small group health plan contracts the total out-of-pocket maximum limit in this paragraph may be split between prescription drug services and all other essential health benefits.

(2) The separate out-of-pocket maximum for pediatric oral care benefits meeting the definition in Section 1302(b)(1)(j) of PPACA shall not exceed one thousand dollars ($1,000) for one child or two thousand dollars ($2,000) for more than one child.

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

(d) For nongrandfathered health care service plan contracts in the large group market, a health care service plan contract, except a specialized health care service plan contract, 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 only to essential health benefits, as defined in Section 1367.005, that are covered under the plan contract. This limit shall be as follows:

(1) The total out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars ($6,350) for individual coverage or twelve thousand seven hundred dollars ($12,700) for family coverage with respect to basic health care services as defined in subdivision (b) of Section 1345, and services, except for prescription drugs, required under Sections 1374.72 and 1374.73.

(2) To the extent the plan contract includes an out-of-pocket maximum on coverage other than the coverage defined in paragraph (1), that out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars ($6,350) for individual coverage or twelve thousand seven hundred dollars ($12,700) for family coverage.

(3) An enrollee in a large group plan contract shall not be subject to more than two limits on annual out-of-pocket expenses for covered benefits that meet the definition of essential health benefits.

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

(5) This subdivision shall apply only to the extent that it does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health plan contracts in the large group market.

(e) 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.

(f) The limits described in this section shall apply to any copayment, coinsurance, deductible, and any other form of cost

sharing for all covered services that meet the definition of essential health benefits.

(g) 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.

(h) "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.

(i) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

SEC. 5. 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. 6. 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) (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 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.

(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. 7. 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) "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 10753.05 of the Insurance Code, as amended by Chapter 1 of the First Extraordinary Session of the Statutes of 2013, is amended to read:

10753.05. (a) No group or individual policy or contract or certificate of group insurance or statement of group coverage providing benefits to employees of small employers as defined in this chapter shall be issued or delivered by a carrier subject to the jurisdiction of the commissioner regardless of the situs of the contract or master policyholder or of the domicile of the carrier nor, except as otherwise provided in Sections 10270.91 and 10270.92, shall a carrier provide coverage subject to this chapter until a copy of the form of the policy, contract, certificate, or statement of coverage is filed with and approved by the commissioner in accordance with Sections 10290 and 10291, and the carrier has complied with the requirements of Section 10753.17.

(b) (1) On and after October 1, 2013, each carrier shall fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are sold to, offered through, or sponsored by, small employers or associations that include small employers for plan years on or after January 1, 2014, to all small employers in each geographic region in which the carrier makes coverage available or provides benefits.

(2) A carrier that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraph (1) with respect to health benefit plans offered through the Exchange in those geographic regions in which the carrier offers plans through the Exchange.

(3) A carrier shall provide enrollment periods consistent with PPACA and described in Section 155.725 of Title 45 of the Code of Federal Regulations. Commencing January 1, 2014, a carrier shall provide special enrollment periods consistent with the special enrollment periods described in Section 10965.3, to the extent permitted by PPACA, except for the triggering events identified in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of

the Code of Federal Regulations with respect to health benefit plans offered through the Exchange.

(4) Nothing in this section shall be construed to require an association, or a trust established and maintained by an association to receive a master insurance policy issued by an admitted insurer and to administer the benefits thereof solely for association members, to offer, market or sell a benefit plan design to those who are not members of the association. However, if the association markets, offers or sells a benefit plan design to those who are not members of the association it is subject to the requirements of this section. This shall apply to an association that otherwise meets the requirements of paragraph (8) formed by merger of two or more associations after January 1, 1992, if the predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and met the requirements of paragraph (5).

(5) A carrier which (A) effective January 1, 1992, and at least 20 years prior to that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer or sell any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers or sells any benefit plan design or any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits to those who are not members of the association it is subject to the requirements of this section.

(6) Each carrier that sells health benefit plans to members of one association pursuant to paragraph (5) shall submit an annual statement to the commissioner which states that the carrier is selling health benefit plans pursuant to paragraph (5) and which, for the one association, lists all the information required by paragraph (7).

(7) Each carrier that sells health benefit plans to members of any association shall submit an annual statement to the commissioner which lists each association to which the carrier sells health benefit plans, the industry or profession which is served by the association, the association’s membership criteria, a list of officers, the state in which the association is organized, and the site of its principal office.

(8) For purposes of paragraphs (4) and (6), an association is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to that date, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state. Health coverage through an association that is not related to employment shall be considered individual coverage pursuant to Section 144.102(c) of Title 45 of the Code of Federal Regulations.

(c) On and after October 1, 2013, each carrier shall make available to each small employer all health benefit plans that the carrier offers or sells to small employers or to associations that include small employers for plan years on or after January 1, 2014. Notwithstanding subdivision (d) of Section 10753, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(d) Each carrier shall do all of the following:

(1) Prepare a brochure that summarizes all of its health benefit plans and make this summary available to small employers, agents, and brokers upon request. The summary shall include for each plan information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, an explanation of how creditable coverage is calculated if a waiting period is imposed, and a telephone number that can be called for more detailed benefit information. Carriers are

required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send copies to agents and brokers representing the carrier. Any entity that provides administrative services only with regard to a health benefit plan written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan.

(2) For each health benefit plan, prepare a more detailed evidence of coverage and make it available to small employers, agents and brokers upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making selections of benefit plan designs. An entity that provides administrative services only with regard to a health benefit plan written or issued by another carrier shall not be required to prepare an evidence of coverage for that health benefit plan.

(3) Provide copies of the current summary brochure to all agents or brokers who represent the carrier and, upon updating the brochure, send copies of the updated brochure to agents and brokers representing the carrier for the purpose of selling health benefit plans.

(4) Notwithstanding subdivision (c) of Section 10753, for purposes of this subdivision, companies that are affiliated companies or that are eligible to file a consolidated income tax return shall be treated as one carrier.

(e) Every agent or broker representing one or more carriers for the purpose of selling health benefit plans to small employers shall do all of the following:

(1) When providing information on a health benefit plan to a small employer but making no specific recommendations on particular benefit plan designs:

(A) Advise the small employer of the carrier's obligation to sell to any small employer any of the health benefit plans it offers to small employers, consistent with PPACA, and provide them, upon request, with the actual rates that would be charged to that employer for a given health benefit plan.

(B) Notify the small employer that the agent or broker will procure rate and benefit information for the small employer on any health benefit plan offered by a carrier for whom the agent or broker sells health benefit plans.

(C) Notify the small employer that, upon request, the agent or broker will provide the small employer with the summary brochure

required in paragraph (1) of subdivision (d) for any benefit plan design offered by a carrier whom the agent or broker represents.

(D) Notify the small employer of the availability of coverage and the availability of tax credits for certain employers consistent with PPACA and state law, including any rules, regulations, or guidance issued in connection therewith.

(2) When recommending a particular benefit plan design or designs, advise the small employer that, upon request, the agent will provide the small employer with the brochure required by paragraph (1) of subdivision (d) containing the benefit plan design or designs being recommended by the agent or broker.

(3) Prior to filing an application for a small employer for a particular health benefit plan:

(A) For each of the health benefit plans offered by the carrier whose health benefit plan the agent or broker is presenting, provide the small employer with the benefit summary required in paragraph (1) of subdivision (d) and the premium for that particular employer.

(B) Notify the small employer that, upon request, the agent or broker will provide the small employer with an evidence of coverage brochure for each health benefit plan the carrier offers.

(C) Obtain a signed statement from the small employer acknowledging that the small employer has received the disclosures required by this paragraph and Section 10753.16.

(f) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10753, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section 10753, is provided in connection with a guaranteed association.

(g) No carrier shall reject an application from a small employer for a health benefit plan provided:

(1) The small employer as defined by subparagraph (A) of paragraph (1) of subdivision (q) of Section 10753 offers health benefits to 100 percent of its eligible employees as defined in paragraph (1) of subdivision (f) of Section 10753. Employees who waive coverage on the grounds that they have other group coverage shall not be counted as eligible employees.

(2) The small employer agrees to make the required premium payments.

(h) No carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct small employers to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(2) Encourage or direct small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location within the carrier's approved service area of the small employer or the small employer's employees.

(3) Employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on the individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

This subdivision shall be enforced in the same manner as Section 790.03, including through Sections 790.035 and 790.05.

(i) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer or the small employer's employees. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(j) (1) A health benefit plan offered to a small employer, as defined in Section 1304(b) of PPACA and in Section 10753, shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability, including conditions arising out of acts of domestic violence.

(H) Disability.

(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.

(2) Notwithstanding Section 10291.5, a carrier shall not require an eligible employee or dependent to fill out a health assessment or medical questionnaire prior to enrollment under a health benefit plan. A carrier shall not acquire or request information that relates to a health status-related factor from the applicant or his or her dependent or any other source prior to enrollment of the individual.

(k) (1) A carrier shall consider as a single risk pool for rating purposes in the small employer market the claims experience of all insureds in all nongrandfathered small employer health benefit plans offered by the carrier in this state, whether offered as health care service plan contracts or health insurance policies, including those insureds and enrollees who enroll in coverage through the Exchange and insureds and enrollees covered by the carrier outside of the Exchange.

(2) At least each calendar year, and no more frequently than each calendar quarter, a carrier shall establish an index rate for the small employer market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA and Section 10112.27, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of PPACA. The premium rate for all of the carrier's nongrandfathered health benefit plans shall use the applicable index rate, as adjusted for total expected marketwide payments and charges under the risk adjustment and reinsurance programs established for the state pursuant to Sections 1343 and 1341 of

PPACA, subject only to the adjustments permitted under paragraph (3).

(3) A carrier may vary premium rates for a particular nongrandfathered health benefit plan from its index rate based only on the following actuarially justified plan-specific factors:

(A) The actuarial value and cost-sharing design of the health benefit plan.

(B) The health benefit plan's provider network, delivery system characteristics, and utilization management practices.

(C) The benefits provided under the health benefit plan that are in addition to the essential health benefits, as defined pursuant to Section 1302 of PPACA. These additional benefits shall be pooled with similar benefits within the single risk pool required under paragraph (1) and the claims experience from those benefits shall be utilized to determine rate variations for health benefit plans that offer those benefits in addition to essential health benefits.

(D) Administrative costs, excluding any user fees required by the Exchange.

(E) With respect to catastrophic plans, as described in subsection (e) of Section 1302 of PPACA, the expected impact of the specific eligibility categories for those plans.

(*l*) If a carrier enters into a contract, agreement, or other arrangement with a third-party administrator or other entity to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this chapter.

(m) (1) Except as provided in paragraph (2), this section shall become inoperative if Section 2702 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201 of PPACA, is repealed, in which case, 12 months after the repeal, carriers subject to this section shall instead be governed by Section 10705 to the extent permitted by federal law, and all references in this chapter to this section shall instead refer to Section 10705, except for purposes of paragraph (2).

(2) Paragraph (3) of subdivision (b) of this section shall remain operative as it relates to health benefit plans offered through the Exchange.

SEC. 9. Section 10112.28 is added to the Insurance Code, to read:

10112.28. (a) This section shall apply to nongrandfathered individual and group health insurance policies that provide coverage for essential health benefits, as defined in Section 10112.27, and that are issued, amended, or renewed on or after January 1, 2015.

(b) (1) For nongrandfathered health insurance policies 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, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 10112.27, including out-of-network emergency care.

(2) For nongrandfathered health insurance policies 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, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care. This limit shall apply only 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 health insurance policies in the large group market.

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

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits that shall equal the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

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

(e) If an essential health benefit is offered or provided by a specialized health insurance policy, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized

health insurance policy that does not offer an essential health benefit as defined in Section 10112.28.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.28.

(g) 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.

(h) "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 10112.285 is added to the Insurance Code, to read:

10112.285. (a) This section shall apply to nongrandfathered individual and group health insurance policies that provide coverage for essential health benefits defined in Section 10112.27 and that are issued, amended, or renewed for the 2014 policy year.

(b) (1) For nongrandfathered health insurance policies in the individual market, and to the extent allowed by federal law, regulations, and guidance, a health insurance policy, except a specialized health insurance policy, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.27, including out-of-network emergency care. The total out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars ($6,350) for individual coverage and twelve thousand seven hundred dollars ($12,700) for family coverage.

(2) For nongrandfathered specialized health insurance policies in the individual market that provide the pediatric oral care benefit meeting the definition in Section 1302(b)(1)(j) of PPACA, the out-of-pocket maximum for the pediatric oral care benefit shall not exceed one thousand dollars ($1,000) for one child and two thousand dollars ($2,000) for more than one child.

(3) A health insurance policy shall not apply a separate out-of-pocket maximum to mental health or substance use disorder benefits.

(c) For nongrandfathered health insurance policies in the small group markets, and to the extent allowed by federal law, regulations, and guidance, a health insurance policy, except a specialized health insurance policy, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.27, including out-of-network emergency care, as follows:

(1) With respect to all essential health benefits, except for the pediatric oral care benefit, the total out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars ($6,350) for individual coverage and twelve thousand seven hundred dollars ($12,700) for family coverage. For small group health insurance policies the total out-of-pocket maximum limit in this paragraph may be split between prescription drug services and all other essential health benefits.

(2) The separate out-of-pocket maximum for pediatric oral care benefits meeting the definition in Section 1302(b)(1) of PPACA shall not exceed one thousand dollars ($1,000) for one child and two thousand dollars ($2,000) for more than one child.

(3) A health insurance policy shall not apply a separate out-of-pocket maximum to mental health or substance use disorder benefits.

(d) For nongrandfathered health insurance policies in the large group market, a health insurance policy, except a specialized health insurance policy, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care. This limit shall apply only to essential health benefits, as defined in Section 10112.27, that are covered under the policy. This limit shall be as follows:

(1) The total out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars ($6,350) for individual coverage or twelve thousand seven hundred dollars ($12,700) for family coverage with respect to basic health care services described in Section 10112.27, and services, except for prescription drugs, required under Sections 10144.5 and 10144.51.

(2) To the extent the policy includes an out-of-pocket maximum on coverage other than the coverage described in paragraph (1),

that out-of-pocket maximum shall not exceed six thousand three hundred fifty dollars ($6,350) for individual coverage or twelve thousand seven hundred dollars ($12,700) for family coverage.

(3) An insured in a large group policy shall not be subject to more than two limits on annual out-of-pocket expenses for covered benefits that meet the definition of essential health benefits.

(4) A health insurance policy shall not apply a separate out-of-pocket maximum to mental health or substance use disorder benefits.

(5) This subdivision shall apply only to the extent that it does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered policies in the large group market.

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

(f) The limits described in this section shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered services that meet the definition of essential health benefits.

(g) 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.

(h) "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.

(i) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.

SEC. 11. 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) This section shall not apply to multiple employer welfare arrangements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 that provide health care benefits to their members and that comply with small group health reforms unless otherwise required by federal law or guidance.

(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. 12. 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) (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 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.

(d) This section shall apply to a policy of health insurance, as defined in subdivision (b) of Section 106, that covers any essential health benefit as defined in Section 10112.27. This section shall not apply to a specialized health insurance policy that does not cover any of the essential health benefits.

(e) "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. 13. 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) "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. 14. 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. 15. 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.

Approved _____, 2013

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Governor