

AMENDED IN SENATE SEPTEMBER 4, 2015

AMENDED IN SENATE JUNE 25, 2015

AMENDED IN ASSEMBLY MAY 5, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1305**

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**Introduced by Assembly Member Bonta**

February 27, 2015

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An act to amend Sections 1367.006 and 1367.007 of the Health and Safety Code, and to amend Sections 10112.28 and 10112.29 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1305, as amended, Bonta. Limitations on cost sharing: family 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 specified forms of cost sharing, including deductibles, on all essential health benefits for nongrandfathered individual and group health insurance coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires, for nongrandfathered products in the individual or small group markets, a health care service plan contract or health insurance policy, except a specialized health care service plan or health insurance policy, that is

issued, amended, or renewed on or after January 1, 2015, to provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, and requires the plan contract or policy, for nongrandfathered products in the large group market, to provide that limit for covered benefits to the extent that the limit does not conflict with federal law or guidance, as specified. Existing law prohibits this limit from exceeding the limit described in a specified provision of federal law.

This bill would require, for family coverage, ~~the above-described limit on annual out-of-pocket expenses to include a maximum out-of-pocket limit for each individual covered by the plan contract or policy that is less than or equal to the maximum out-of-pocket limit that an individual within a family shall not have a maximum out-of-pocket limit that is greater than the maximum out-of-pocket limit for individual coverage under the plan contract or policy. for that product.~~ The bill would require a plan contract or policy and, commencing ~~July 1, 2016,~~ *January 1, 2017*, a large group market plan contract or policy, for family coverage that includes a deductible, except a high deductible health plan, ~~to include a deductible for each individual covered under the plan contract or policy that is less than or equal to the deductible that an individual within a family shall not have a deductible that is greater than the deductible limit for individual coverage under the plan contract or policy. for that product.~~ The bill would require a plan contract or policy and, commencing ~~July 1, 2016,~~ *January 1, 2017*, a large group market health plan contract or policy, for family coverage that includes a deductible and is a high deductible health plan, as defined in federal law, to include a deductible for each individual covered by the plan contract or policy that is equal to either the amount set forth in a specified provision of federal law or the deductible for individual coverage under the plan contract or policy, whichever is greater. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

*Existing law prohibits the deductible under a small employer health care service plan contract or small employer health insurance policy that is offered, sold, or renewed on or after January 1, 2014, from exceeding specified dollar amounts. Existing law requires those dollar amounts to be indexed consistent with specified provisions of the PPACA and any federal rules or guidance pursuant to those provisions.*

*This bill would instead require those dollar amounts to be indexed consistent with provisions of the PPACA that specify a formula for calculating health plan premium adjustment percentages. Because a willful violation of this requirement by a health care service plan would be a crime, this bill would impose a state-mandated local program.*

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

1 SECTION 1. Section 1367.006 of the Health and Safety Code  
2 is amended to read:

3 1367.006. (a) This section shall apply to nongrandfathered  
4 individual and group health care service plan contracts that provide  
5 coverage for essential health benefits, as defined in Section  
6 1367.005, and that are issued, amended, or renewed on or after  
7 January 1, 2015.

8 (b) (1) For nongrandfathered health care service plan contracts  
9 in the individual or small group markets, a health care service plan  
10 contract, except a specialized health care service plan contract,  
11 that is issued, amended, or renewed on or after January 1, 2015,  
12 shall provide for a limit on annual out-of-pocket expenses for all  
13 covered benefits that meet the definition of essential health benefits  
14 in Section 1367.005, including out-of-network emergency care  
15 consistent with Section 1371.4.

16 (2) For nongrandfathered health care service plan contracts in  
17 the large group market, a health care service plan contract, except  
18 a specialized health care service plan contract, that is issued,  
19 amended, or renewed on or after January 1, 2015, shall provide  
20 for a limit on annual out-of-pocket expenses for covered benefits,  
21 including out-of-network emergency care consistent with Section  
22 1371.4. This limit shall only apply to essential health benefits, as  
23 defined in Section 1367.005, that are covered under the plan to  
24 the extent that this provision does not conflict with federal law or

1 guidance on out-of-pocket maximums for nongrandfathered health  
2 care service plan contracts in the large group market.

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

6 (2) The limit described in subdivision (b) shall result in a total  
7 maximum out-of-pocket limit for all covered essential health  
8 benefits equal to the dollar amounts in effect under Section  
9 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the  
10 dollar amounts adjusted as specified in Section 1302(c)(1)(B) of  
11 PPACA.

12 (3) For family coverage, ~~the limit described in subdivision (b)~~  
13 ~~shall include a maximum out-of-pocket limit for each individual~~  
14 ~~covered by the plan that is less than or equal to the maximum~~  
15 ~~out-of-pocket limit~~ *an individual within a family shall not have a*  
16 *maximum out-of-pocket limit that is greater than the maximum*  
17 *out-of-pocket limit for individual coverage under the plan contract.*  
18 *for that product.*

19 (d) Nothing in this section shall be construed to affect the  
20 reduction in cost sharing for eligible enrollees described in Section  
21 1402 of PPACA, and any subsequent rules, regulations, or guidance  
22 issued under that section.

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

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

33 (g) (1) (A) Except as provided in paragraph (2), if a health care  
34 service plan contract for family coverage includes a deductible,  
35 ~~the plan contract shall include a deductible for each individual~~  
36 ~~covered by the plan that is less than or equal to the deductible~~ *an*  
37 *individual within a family shall not have a deductible that is greater*  
38 *than the deductible limit for individual coverage under the plan*  
39 *contract. for that product.*

1 (B) Except as provided in paragraph (2), if a large group market  
2 health care service plan contract for family coverage that is issued,  
3 amended, or renewed on or after ~~July 1, 2016~~, *January 1, 2017*,  
4 includes a deductible, ~~the plan contract shall include a deductible~~  
5 ~~for each individual covered by the plan that is less than or equal~~  
6 ~~to the deductible~~ *an individual within a family shall not have a*  
7 *deductible that is more than the deductible limit* for individual  
8 coverage ~~under the plan contract.~~ *for that product.*

9 (2) (A) If a health care service plan contract for family coverage  
10 includes a deductible and is a high deductible health plan under  
11 the definition set forth in Section 223(c)(2) of Title 26 of the United  
12 States Code, the plan contract shall include a deductible for each  
13 individual covered by the plan that is equal to either the amount  
14 set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United  
15 States Code or the deductible for individual coverage under the  
16 plan contract, whichever is greater.

17 (B) If a large group market health care service plan contract for  
18 family coverage that is issued, amended, or renewed on or after  
19 ~~July 1, 2016~~, *January 1, 2017*, includes a deductible and is a high  
20 deductible health plan under the definition set forth in Section  
21 223(c)(2) of Title 26 of the United States Code, the plan contract  
22 shall include a deductible for each individual covered by the plan  
23 that is equal to either the amount set forth in Section  
24 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the  
25 deductible for individual coverage under the plan contract,  
26 whichever is greater.

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

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

37 SEC. 2. Section 1367.007 of the Health and Safety Code is  
38 amended to read:

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

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

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

8 (2) The dollar amounts in this section shall be indexed consistent  
9 with ~~Section 1302(e)(1)~~ *1302(c)(4)* of PPACA and any federal  
10 rules or guidance pursuant to that section.

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

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

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

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

29 SEC. 3. Section 10112.28 of the Insurance Code is amended  
30 to read:

31 10112.28. (a) This section shall apply to nongrandfathered  
32 individual and group health insurance policies that provide  
33 coverage for essential health benefits, as defined in Section  
34 10112.27, and that are issued, amended, or renewed on or after  
35 January 1, 2015.

36 (b) (1) For nongrandfathered health insurance policies in the  
37 individual or small group markets, a health insurance policy, except  
38 a specialized health insurance policy, that is issued, amended, or  
39 renewed on or after January 1, 2015, shall provide for a limit on  
40 annual out-of-pocket expenses for all covered benefits that meet

1 the definition of essential health benefits in Section 10112.27,  
2 including out-of-network emergency care.

3 (2) For nongrandfathered health insurance policies in the large  
4 group market, a health insurance policy, except a specialized health  
5 insurance policy, that is issued, amended, or renewed on or after  
6 January 1, 2015, shall provide for a limit on annual out-of-pocket  
7 expenses for covered benefits, including out-of-network emergency  
8 care. This limit shall apply only to essential health benefits, as  
9 defined in Section 10112.27, that are covered under the policy to  
10 the extent that this provision does not conflict with federal law or  
11 guidance on out-of-pocket maximums for nongrandfathered health  
12 insurance policies in the large group market.

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

16 (2) The limit described in subdivision (b) shall result in a total  
17 maximum out-of-pocket limit for all covered essential health  
18 benefits that shall equal the dollar amounts in effect under Section  
19 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the  
20 dollar amounts adjusted as specified in Section 1302(c)(1)(B) of  
21 PPACA.

22 (3) For family coverage, ~~the limit described in subdivision (b)~~  
23 ~~shall include a maximum out-of-pocket limit for each individual~~  
24 ~~covered by the policy that is less than or equal to the maximum~~  
25 ~~out-of-pocket limit~~ *an individual within a family shall not have a*  
26 *maximum out-of-pocket limit that is greater than the maximum*  
27 *out-of-pocket limit for individual coverage under the policy. for*  
28 *that product.*

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

33 (e) If an essential health benefit is offered or provided by a  
34 specialized health insurance policy, the total annual out-of-pocket  
35 maximum for all covered essential benefits shall not exceed the  
36 limit in subdivision (b). This section shall not apply to a specialized  
37 health insurance policy that does not offer an essential health  
38 benefit as defined in Section 10112.27.

39 (f) The maximum out-of-pocket limit shall apply to any  
40 copayment, coinsurance, deductible, and any other form of cost

1 sharing for all covered benefits that meet the definition of essential  
 2 health benefits, as defined in Section 10112.27.

3 (g) (1) (A) Except as provided in paragraph (2), if a health  
 4 insurance policy for family coverage includes a deductible, ~~the~~  
 5 ~~policy shall include a deductible for each individual covered under~~  
 6 ~~the policy that is less than or equal to the deductible~~ *an individual*  
 7 *within a family shall not have a deductible that is greater than the*  
 8 *deductible limit for individual coverage under the policy. for that*  
 9 *product.*

10 (B) Except as provided in paragraph (2), ~~if~~ *for* a large group  
 11 market health insurance policy for family coverage that is issued,  
 12 amended, or renewed on or after ~~July 1, 2016,~~ *January 1, 2017,*  
 13 includes a deductible, ~~the policy shall include a deductible for each~~  
 14 ~~individual covered under the policy that is less than or equal to the~~  
 15 ~~deductible~~ *an individual within a family shall not have a deductible*  
 16 *that is greater than the deductible limit for individual coverage*  
 17 *under the policy. for that product.*

18 (2) (A) If a health insurance policy for family coverage includes  
 19 a deductible and is a high deductible health plan under the  
 20 definition set forth in Section 223(c)(2) of Title 26 of the United  
 21 States Code, the policy shall include a deductible for each  
 22 individual covered by the policy that is equal to either the amount  
 23 set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United  
 24 States Code or the deductible for individual coverage under the  
 25 policy, whichever is greater.

26 (B) If a large group market health insurance policy for family  
 27 coverage that is issued, amended, or renewed on or after ~~July 1,~~  
 28 ~~2016,~~ *January 1, 2017,* includes a deductible and is a high  
 29 deductible health plan under the definition set forth in Section  
 30 223(c)(2) of Title 26 of the United States Code, the policy shall  
 31 include a deductible for each individual covered by the policy that  
 32 is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II)  
 33 of Title 26 of the United States Code or the deductible for  
 34 individual coverage under the policy, whichever is greater.

35 (h) For nongrandfathered health insurance policies in the group  
 36 market, “policy year” has the meaning set forth in Section 144.103  
 37 of Title 45 of the Code of Federal Regulations. For  
 38 nongrandfathered health insurance policies sold in the individual  
 39 market, “policy year” means the calendar year.

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

6 SEC. 4. Section 10112.29 of the Insurance Code is amended  
7 to read:

8 10112.29. (a) (1) For a small employer health insurance policy  
9 offered, sold, or renewed on or after January 1, 2014, the deductible  
10 under the policy shall not exceed:

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

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

15 (2) The dollar amounts in this section shall be indexed consistent  
16 with ~~Section 1302(e)(1)~~ 1302(c)(4) of PPACA and any federal  
17 rules or guidance pursuant to that section.

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

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

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

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

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

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

3 SEC. 5. No reimbursement is required by this act pursuant to  
4 Section 6 of Article XIII B of the California Constitution because  
5 the only costs that may be incurred by a local agency or school  
6 district will be incurred because this act creates a new crime or  
7 infraction, eliminates a crime or infraction, or changes the penalty  
8 for a crime or infraction, within the meaning of Section 17556 of  
9 the Government Code, or changes the definition of a crime within  
10 the meaning of Section 6 of Article XIII B of the California  
11 Constitution.

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