AMENDED IN ASSEMBLY JUNE 2, 2009

AMENDED IN ASSEMBLY APRIL 22, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 786

Introduced by Assembly Member Jones

February 26, 2009

An act to add Sections 1399.819 and 127664.5 to the Health and Safety Code, and to add Section 10903 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 786, as amended, Jones. Individual health care coverage: coverage choice categories.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), 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 health care service plans and health insurers that offer contracts or policies to individuals to comply with specified requirements.

This bill would require, by September 1, 2010, the Department of Managed Health Care and the Department of Insurance to jointly, by regulation, develop a system to categorize all health care service plan contracts and health insurance policies offered and sold to individuals into ~~5~~ *6* coverage choice categories that meet specified requirements. The bill would require 4 of those categories to consist of contracts and policies that meet the requirements imposed under the Knox-Keene

Act, and would require the fifth ~~category~~ *and sixth categories* to consist solely of health insurance policies that do *not* meet the Knox-Keene Act requirements, *as specified*. The bill would require a health insurer offering a policy in that fifth *or sixth* category to include a specified notice in materials used to market the policy and in the offer of coverage under the policy. The bill would require individual health care service plan contracts and individual health insurance policies offered or sold on or after January 1, 2011, to contain a maximum dollar limit on out-of-pocket costs for covered ~~benefits~~ *services by in-network providers*, as specified. The bill would authorize health care service plans and health insurers to offer products in any coverage choice category subject to specified restrictions. The bill would also require health care service plans and health insurers to establish prices for the products offered to individuals that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. The bill would require the Department of Managed Health Care and the Department of Insurance to develop a notice providing information on the coverage choice categories and would require this notice to be provided with the marketing, purchase, and renewal of individual contracts and policies, as specified. The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner to annually report on the contracts and policies offered in each coverage choice category and on the enrollment in those contracts and policies. The bill would also require, commencing January 1, 2013, and every 3 years thereafter, the director and the commissioner to jointly determine whether the coverage choice categories should be revised to meet the needs of consumers. The bill would enact other related provisions.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

Existing law requests the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate or repeal a benefit or service, as defined, and to prepare a written analysis in accordance with specified criteria.

This bill would request the University of California, as part of that program, to prepare a written analysis with relevant data on, among other things, the health insurance and health care service plan products sold in the individual market. The bill would request the University of

California to provide this report 3 months prior to the implementation of the bill's other provisions and would authorize the Director of the Department of Managed Health Care, in consultation with the Insurance Commissioner, to request that analysis prior to specified annual reports and triennial reviews. The bill would also require those departments to require data from health care service plans and health insurers in order to assist the University of California in fulfilling these responsibilities.

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

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

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

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

SECTION 1. Section 1399.819 is added to the Health and Safety Code, to read:

1399.819. (a) On or before September 1, 2010, the department and the Department of Insurance shall jointly, by regulation, *and in consultation with stakeholders,* develop a system to categorize all health care service plan contracts and health insurance policies offered and sold to individuals pursuant to this chapter and Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code into ~~five~~ *the following six* coverage ~~choice categories. In developing these categories, the departments shall develop four categories applicable to both individual health care service plan contracts and individual health insurance policies. These four categories shall consist of contracts and policies that meet the requirements of this chapter and that, at a minimum, include basic health care services as defined in Section 1345. The departments shall also develop a fifth category~~ *choice categories:*

(1) Four categories applicable to both individual health care service plan contracts and individual health insurance policies that meet the requirement of this chapter, including, but not limited to, providing coverage for basic health care services as defined in Section 1345.

(2) A fifth and sixth category applicable only to individual health insurance policies subject to the jurisdiction of the Department of

Insurance. ~~This fifth category shall~~ *These fifth and sixth categories shall either* be established based on the highest cost sharing and the lowest benefit levels among the ~~five~~ *six* categories and shall apply to individual health insurance policies where the benefit levels and cost sharing requirements do not otherwise meet the requirements ~~of this chapter. These coverage choice categories shall do all of~~ *of this chapter, or shall be established based on benefit limits that are not permissible under this chapter regardless of cost sharing or comprehensiveness of coverage.*

(b) The coverage choice categories established pursuant to this section shall do all of the following:

(1) Reflect a reasonable continuum between the coverage choice category with the lowest level of health care benefits and the coverage choice category with the highest level of health care benefits based on the actuarial value of each product.

(2) Permit reasonable benefit variation within each coverage choice category.

(3) For the four categories applicable to both health care service plan contracts and health insurance policies, the director shall coordinate with the Insurance Commissioner to ensure consistent interpretation across products and markets and ease of comparison for consumers.

(4) Within each coverage choice category, include one standard health maintenance organization (HMO) product and one standard preferred provider organization (PPO) product, as defined by regulation, except for ~~the fifth category with the highest cost sharing and the lowest benefit levels~~ *the fifth and sixth categories* applicable only to health insurance policies, which shall include a standard preferred provider organization health insurance product and no standard health care service plan product.

(5) Within each coverage choice category, have a maximum dollar limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered ~~benefits~~ *services by in-network providers. Maximum permissible out-of-pocket cost limits shall be indexed to and automatically increase annually with the medical consumer price index.*

(6) Use standard definitions and terminology for covered benefits and cost sharing between health care service plans and health insurers in the same marketplace regardless of licensure.

(7) Be developed by taking into account any written analysis provided by the University of California pursuant to Section 127664.5.

~~(b)~~

(c) (1) In establishing the ~~five~~ *six* coverage choice categories, the department and the Department of Insurance shall establish the third category as the midpoint of the individual market for contracts and policies that cover medical, surgical, and hospital expenses and that meet the coverage requirements of existing applicable law.

(2) The first category shall provide the most comprehensive benefits and the lowest cost sharing, shall be comparable to coverage provided by large employers to their employees, and shall be described as such.

(3) The second category shall provide benefits and cost sharing that fall between the first and the third categories.

(4) The fourth category, which shall apply to both health care service plan contracts and health insurance policies, shall have the highest cost sharing permitted for health care service plan contracts under this chapter.

(5) The fifth ~~category~~ *and sixth categories*, which shall apply only to health insurance policies, shall *either* have the highest cost sharing and least comprehensive benefits among the ~~five categories~~ *six categories or have benefit limits that are not permitted under this chapter*, shall include coverage for medical, surgical, and hospital expenses, and shall meet the minimum benefit standards applicable to health insurance policies under the Insurance Code.

~~(c)~~

(d) The regulations developed by the department and the Department of Insurance pursuant to this section shall identify and require the submission of any information needed to categorize each health care service plan contract and health insurance policy subject to this section.

~~(d)~~

(e) All health care service plan contracts offered or sold to individuals on or after January 1, 2011, shall contain a maximum dollar limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered ~~benefits~~ *services by in-network providers. Maximum permissible*

out-of-pocket cost limits shall be indexed to and automatically increase annually with the medical consumer price index.

~~(e)~~

(f) All health care service plans shall submit filings no later than April 1, 2011, for all individual health care service plan contracts to be offered or sold on or after that date, and thereafter any additional individual health care plan contracts shall be filed with the department. *At the time of submission of a contract pursuant to this subdivision, a health care service plan may suggest to the director the category for which the plan designed the contract.* The director shall categorize each individual health care service plan contract offered by a plan into the appropriate coverage choice category within 90 days of the date the contract is filed pursuant to this section. A health care service plan shall not offer or sell an individual health care service plan contract until the director has categorized the contract pursuant to this subdivision.

~~(f)~~

(g) To facilitate accurate information about consumer choices, a health care service plan may offer products in any coverage choice category. However, if a plan offers a product in ~~the fifth~~ *either the fifth or sixth* category, it shall also offer the standard product in ~~the fifth~~ *either the fifth or sixth* category, the standard product in either the first or second category, and the standard product in the third category. Every plan shall offer at least the standard product in the third category, except that a plan that offers the standard product in either the first or second category shall not be required to offer products in the third, fourth, ~~or fifth~~ *fifth, or sixth* category. For purposes of this subdivision, "standard product" means the product developed pursuant to paragraph (4) of subdivision (a). A plan may meet its obligations under this subdivision with products filed with and approved by the department as well as products filed with and approved by the Department of Insurance *for a subsidiary or an affiliate of the plan*.

~~(g)~~

(h) To facilitate consumer comparison shopping, the department and the Department of Insurance shall develop a notice that provides information about the coverage choice categories developed pursuant to this section, including the range of cost sharing and the benefits and services provided in each category,

including any variation in those benefits and services. For each product, the notice shall include the percentage of expense paid by the coverage, the estimated annual out-of-pocket cost and the estimated total annual cost, including both premium and out-of-pocket costs for persons with average health care costs and persons with high health care needs. A health care service plan, solicitor, or solicitor firm shall provide this notice when marketing any individual health care service plan contract. The notice shall also accompany the purchase and renewal of an individual health care service plan contract. With the agreement of the consumer, the notice may be provided electronically.

~~(h)~~

(i) (1) A health care service plan shall establish prices for its products that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. ~~A~~

(2) A health care service plan shall not establish a standard risk rate for a product in a coverage choice category at a lower rate than a product offered in a lower coverage choice category for a consumer of the same age and the same risk rate living in the same geographic region. For purposes of this ~~subdivision~~ *paragraph*, "geographic region" shall mean the geographic regions established pursuant to paragraph (3) of subdivision (k) of Section 1357. *This paragraph shall not apply to a conversion contract offered pursuant to Section 1373.6 or to a contract offered to a federally eligible defined individual.*

~~(i)~~

(j) The director shall annually report on the health care service plan contracts offered by plans in each coverage choice category pursuant to this section and on the enrollment in those contracts within each coverage choice category. Commencing January 1, 2013, and every three years thereafter, the director and the Insurance Commissioner shall jointly determine whether the coverage choice categories should be revised to meet the needs of consumers.

~~(j)~~

(k) The department shall require data from health care service plans in order to assist the University of California in fulfilling the

responsibilities of Section 127664.5 and shall promptly provide that data to the University of California.

~~(k)~~

(l) This section shall not apply to Medicare supplement plans or to coverage offered by specialized health care service plans or government-sponsored programs.

(m) This section shall not apply to an individual health care service plan contract renewal issued prior to April 1, 2011.

SEC. 2. Section 127664.5 is added to the Health and Safety Code, to read:

127664.5. (a) In order to assist the Department of Managed Health Care and the Department of Insurance with the implementation of Section 1399.819 of this code and Section 10903 of the Insurance Code, the Legislature requests the University of California, as part of the California Health Benefit Review Program established pursuant to Section 127660, to prepare a written analysis with relevant data on all of the following:

(1) The health care service plan and health insurance products that are sold in the individual market.

(2) The benefits and services covered by the products described in paragraph (1), including any limitations or exclusions.

(3) The cost sharing applicable to the products described in paragraph (1), including deductibles, copayments, coinsurance, maximum out-of-pocket limits, and other limits or exclusions that require individual consumers to pay for basic health care services in whole or in part.

(4) The distribution of health care service plan and health insurance products purchased by individuals in terms of the benefits and services included and the cost sharing involved.

(5) The share of the individual health care coverage market that is short-term coverage, conversion coverage, renewal of existing coverage, or coverage sold to a person not previously covered by individual health care coverage.

(b) In providing the data described in subdivision (a), the University of California is requested to distinguish between products provided by entities regulated by the Department of Managed Health Care and those provided by entities regulated by the Department of Insurance.

(c) The Legislature requests that the written analysis described in subdivision (a) be provided three months prior to the

implementation of Section 1399.819 of this code and Section 10903 of the Insurance Code.

(d) The Director of the Department of Managed Health Care, in consultation with the Insurance Commissioner, shall request the University of California to provide the written analysis described in subdivision (a) prior to the annual reports and triennial reviews required by Section 1399.819 of this code and Section 10903 of the Insurance Code.

(e) The Department of Managed Health Care and the Department of Insurance shall assist the University of California by requiring and collecting data from health care service plans and health insurers in order to fulfill the responsibilities of this section and of Section 1399.819 of this code and Section 10903 of the Insurance Code.

(f) The work of the University of California in providing the written analyses specified in this section shall be supported by moneys in the fund established pursuant to Section 127662.

SEC. 3. Section 10903 is added to the Insurance Code, to read:

10903. (a) On or before September 1, 2010, the department and the Department of Managed Health Care shall jointly, by regulation, *and in consultation with stakeholders,* develop a system to categorize all health insurance policies and health care service plan contracts offered and sold to individuals pursuant to this part and Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code ~~into five coverage choice categories. In developing these categories, the departments shall develop four categories applicable to both individual health care service plan contracts and individual health insurance policies. These four categories shall consist of contracts and policies that meet the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and that, at a minimum, include basic health care services as defined in Section 1345 of the Health and Safety Code. The departments shall also develop a fifth category~~ *into the following six coverage choice categories:*

(1) Four categories applicable to both individual health care service plan contracts and individual health insurance policies that meet the requirement of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), including, but not

limited to, providing coverage for basic health care services as defined in Section 1345 of the Health and Safety Code.

(2) A fifth and sixth category applicable only to individual health insurance policies subject to the jurisdiction of the ~~Department of Insurance. This fifth category shall~~ *department. These fifth and sixth categories shall either* be established based on the highest cost sharing and the lowest benefit levels among the ~~five~~ *six* categories and shall apply to individual health insurance policies where the benefit levels and cost sharing requirements would not otherwise meet the requirements of the Knox-Keene Health Care Service Plan Act of ~~1975. These coverage choice categories shall do all of the~~ *1975, or shall be established based on benefit limits that are not permissible under the Knox-Keene Health Care Service Plan Act of 1975 regardless of cost sharing or comprehensiveness of coverage.*

(b) The coverage choice categories established pursuant to this section shall do all of the following:

(1) Reflect a reasonable continuum between the coverage choice category with the lowest level of health care benefits and the coverage choice category with the highest level of health care benefits based upon the actuarial value of each product.

(2) Permit reasonable benefit variation within each coverage choice category.

(3) For the four categories applicable to both health care service plan contracts and health insurance policies, the commissioner shall coordinate with the Director of *the Department of* Managed Health Care to ensure consistent interpretation across products and markets and ease of comparison for consumers.

(4) Within each coverage choice category, include one standard health maintenance organization (HMO) product, and one standard preferred provider organization (PPO) product, as defined by ~~regulation, except for the fifth category with the highest cost sharing and the lowest benefit levels applicable only to health insurance policies, which~~ *regulation, except for the fifth and sixth categories applicable only to health insurance policies, which shall* include a standard preferred provider organization health insurance product and no standard health care service *plan* product.

(5) Within each coverage choice category, have a maximum dollar limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered ~~benefits~~

services by in-network providers. Maximum permissible out-of-pocket cost limits shall be indexed to and automatically increase annually with the medical consumer price index.

(6) Use standard definitions and terminology for covered benefits and cost sharing between health insurers and health care service plans in the same marketplace regardless of licensure.

(7) Be developed by taking into account any written analysis provided by the University of California pursuant to Section 127664.5 of the Health and Safety Code.

~~(b)~~

(c) (1) In establishing the ~~five~~ *six* coverage choice categories, the department and the Department of Managed Health Care shall establish the third category as the midpoint of the individual market for contracts and policies that cover medical, surgical, and hospital expenses and that meet the coverage requirements of existing applicable law.

(2) The first category shall provide the most comprehensive benefits and the lowest cost sharing, shall be comparable to coverage provided by large employers to their employees, and shall be described as such.

(3) The second category shall provide benefits and cost sharing that fall between the first and the third categories.

(4) The fourth category, which shall apply to both health care service plan contracts and health insurance policies, shall have the highest cost sharing permitted for health care service plan contracts under the Knox-Keene Health Care Service Plan Act of 1975 (~~chapter~~ *(Chapter* 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(5) The fifth ~~category~~ *and sixth categories*, which shall apply only to health insurance policies, shall *either* have the highest cost sharing and least comprehensive benefits among the ~~five categories~~ *six categories or have benefit limits that are not permitted under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code)*, shall include coverage for medical, surgical, and hospital expenses, and shall meet the minimum benefit standards applicable to health insurance policies under this code.

~~(c)~~

(d) The regulations developed by the department and the Department of Managed Health Care pursuant to this section shall

identify and require the submission of any information needed to categorize each health insurance policy and health care service plan contract subject to this section.

~~(d)~~

(e) All health insurance policies offered or sold to individuals on or after January 1, 2011, shall contain a maximum dollar limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered ~~benefits~~ *services by in-network providers* and, shall, at a minimum, cover hospital, medical, and surgical expenses, and meet existing coverage requirements applicable to health insurance policies under this code. Effective January 1, 2011, for the ~~fifth coverage~~ *sixth coverage choice* category that applies only to health insurance policies, the maximum out-of-pocket expenditure, including copayments, coinsurance, and deductibles, *may be up to but* shall not exceed ten thousand dollars ~~($10,000) per year. The commissioner shall adjust this amount annually according to changes in the California Consumer Price Index.~~ *($10,000) per year for covered services by in-network providers. Maximum permissible out-of-pocket cost limits shall be indexed to and automatically increase with the medical consumer price index.*

~~(e)~~

(f) All health insurers shall submit the filings no later than April 1, 2011, for all individual health insurance policies to be offered or sold on or after that date, and thereafter any additional individual health insurance policies shall be filed with the commissioner. *At the time of submission of a policy pursuant to this subdivision, a health insurer may suggest to the commissioner the category for which the insurer designed the policy.* The commissioner shall categorize each individual health insurance policy offered by a health insurer into the appropriate coverage choice category within 90 days of the date the policy is filed pursuant to this section. A health insurer shall not offer or sell an individual health insurance policy until the commissioner has categorized the policy pursuant to this subdivision.

~~(f)~~

(g) To facilitate accurate information about consumer choices, a health insurer may offer health insurance products in any coverage choice category. However, if a health insurer offers a health insurance product in ~~the fifth~~ *either the fifth or sixth*

category, it shall also offer the standard product in ~~the fifth~~ *either the fifth or sixth* category, the standard product in either the first or second category, and the standard product in the third category. Every insurer shall offer at least the standard product in the third category, except that an insurer that offers the standard product in either the first or second category shall not be required to offer products in the third, fourth, ~~or fifth~~ *fifth, or sixth* category. For purposes of this subdivision, "standard product" means the product developed pursuant to paragraph (4) of subdivision (a). An insurer may meet its obligations under this subdivision with products filed with and approved by the department as well as products filed with and approved by the Department of Managed Health Care *for a subsidiary or an affiliate of the insurer*.

~~(g)~~

(h) To facilitate consumer comparison shopping, the department and the Department of Managed Health Care shall develop a notice that provides information about the coverage choice categories developed pursuant to this section, including the range of cost sharing and the benefits and services provided in each category, including any variation in those benefits and services. For each product, the notice shall include the percentage of expense paid by the coverage, the estimated annual out-of-pocket cost and the estimated total annual cost, including both premium and out-of-pocket costs for persons with average health care costs and persons with high health care needs. A health insurer, broker, or agent shall provide this notice when marketing any individual health insurance policy. The notice shall also accompany the purchase and renewal of an individual health insurance policy. With the agreement of the consumer, the notice may be provided electronically.

~~(h)~~

(i) An insurer selling a policy under the fifth *or sixth* category shall include the following disclosure in 14-point type in all materials used to market the policy and in the offer of coverage under the policy:

"Insurance products in this category include significant limits on benefits and the health care services that are covered. If you have a serious injury, a serious illness such as a heart attack or cancer, or ongoing health care costs associated with a chronic condition such as diabetes or heart disease, coverage under this

policy may not pay for a substantial share of the costs of doctors, hospitals, or other treatments. You may face additional out-of-pocket costs for doctors, hospitals, and other services even if you have met your deductible or out-of-pocket maximum. This product does not provide maternity coverage. Please examine this policy carefully before purchasing."

~~(i)~~

(j) (1) A health insurer shall establish prices for its products that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. ~~A~~

(2) A health insurer shall not establish a standard risk rate for a product in a coverage choice category at a lower rate than a product offered in a lower coverage choice category for a consumer of the same age and the same risk rate living in the same geographic region. For purposes of this ~~subdivision~~ *paragraph*, "geographic region" shall mean the geographic regions established pursuant to paragraph (3) of subdivision (v) of Section 10700. *This paragraph shall not apply to a conversion policy offered pursuant to Section 12682.1 or to a policy offered to a federally eligible defined individual.*

~~(j)~~

(k) The commissioner shall annually report on the health insurance policies offered by health insurers in each coverage choice category pursuant to this section and on the enrollment in those policies within each coverage choice category. Commencing January 1, 2013, and every three years thereafter, the commissioner and the Director of the Department of Managed Health Care shall jointly determine whether the coverage choice categories should be revised to meet the needs of consumers.

~~(k)~~

(l) The department shall require data from health insurers in order to assist the University of California in fulfilling the responsibilities of Section 127664.5 of the Health and Safety Code and shall promptly provide that data to the University of California.

~~(l)~~

(m) Nothing in this section shall be construed to limit disability insurance, including, but not limited to, hospital indemnity, accident only, and specified disease insurance that pays benefits

on a fixed benefit, cash payment only basis, from being sold as supplemental insurance.

~~(m)~~

(n) This section shall not apply to Medicare supplement, Tricare supplement, or CHAMPUS supplement insurance, to specialized health insurance policies, as defined in subdivision (c) of Section 106, or to coverage offered by government-sponsored programs.

(o) This section shall not apply to an individual health insurance policy renewal issued prior to April 1, 2011.

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

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