AMENDED IN SENATE JUNE 30, 2009

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~~, *1399.820, and 1399.821* to the Health and Safety Code, and to add ~~Section 10903~~ *Sections 10903, 10904, and 10905* 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 establishes the Office of Patient Advocate within the department to represent the interests of plan enrollees.* 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 individual health care service plan contracts and individual health insurance policies issued, amended, or renewed on or after January 1, 2011, to contain a maximum limit on out-of-pocket costs for covered benefits provided by contracted or in-network*

providers, as specified. The bill would require, by ~~September 1, 2010,~~ *December 31, 2011,* the Department of Managed Health Care and the Department of Insurance to jointly, by regulation, develop *standard definitions and terminology for benefits and cost-sharing provisions applicable to individual contracts and policies to be offered and sold on and after September 1, 2012, and to develop* a system to categorize ~~all health care service plan contracts and health insurance policies offered and sold to individuals~~ *those contracts and policies* into ~~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 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 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.~~ *The bill would require plans and insurers to submit*

certain information to the departments by February 1, 2012, and would require the Director of the Department of Managed Health Care and the Insurance Commissioner to categorize the contracts and policies into the appropriate coverage choice category on or before June 30, 2012. The bill would require the Office of Patient Advocate to develop and maintain on its Internet Web site a uniform benefits matrix of those contracts and policies arranged by coverage choice category along with other specified information. The bill would require health care service plans, health insurers, solicitors, solicitor firms, brokers, and agents to make prospective enrollees or insureds aware of the availability and contents of the benefits matrix when marketing or selling a contract or policy in the individual market.

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 December 31, 2011, the department and the Department of Insurance shall jointly, by regulation, develop standard definitions and terminology for covered benefits and cost-sharing provisions, including, but not limited to, copayments, coinsurance, deductibles, limitations, and exclusions, applicable to all health care service plan contracts and health insurance policies to be offered and sold to individuals on or after September 1, 2012.

(b) The regulations developed by the department and the Department of Insurance pursuant to this section may identify and require the submission of any information needed to develop the standard definitions and terminology required by this section.

(c) All individual health care service plan contracts issued, amended, or renewed on or after January 1, 2011, shall contain a maximum limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits provided by contracted providers. With respect to individual health care service plan contracts issued, amended, or renewed on or after April 1, 2011, this limit shall not exceed ten thousand dollars ($10,000) per person per year.

SEC. 2. Section 1399.820 is added to the Health and Safety Code, to read:

1399.820. (a) (1) On or before December 31, 2011, the department and the Department of Insurance shall jointly, by regulation, and in consultation with health care service plans, health insurers, and consumer representatives, develop a system to categorize all health care service plan contracts and health insurance policies to be offered and sold to individuals on and after September 1, 2012, into coverage choice categories in order to facilitate transparency and consumer comparison shopping. These coverage choice categories shall 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) The coverage choice categories shall be based on the benefits covered and the out-of-pocket costs. The categories shall be developed to ensure ease of consumer comparison and understanding of the benefit design choices in the individual market. The coverage choice categories shall be developed to be user-friendly for consumers, with the lowest number of choice categories necessary to include the full range of individual products into meaningful categories, but, in any event, there shall be no more than a total of 10 coverage choice categories across all products offered and sold to individuals, including health care service plan contracts and health insurance policies. There shall be no fewer than two categories in common between products in the two departments.

(3) The first coverage choice category shall provide the most comprehensive benefits and the lowest cost sharing and shall be comparable to the coverage provided by large employers to their employees.

(b) 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, including, but not limited to, the copayments, coinsurance, deductibles, limitations, exclusions, and premium rates applicable to, and the actuarial value of, each contract or policy.

(c) A health care service plan shall submit the information required by the department to implement this section no later than February 1, 2012, for all new individual contracts to be offered or sold on or after September 1, 2012.

(d) The director shall categorize each individual health care service plan contract to be offered by a plan into the appropriate coverage choice category on or before June 30, 2012.

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

SEC. 3. Section 1399.821 is added to the Health and Safety Code, to read:

1399.821. (a) The Office of Patient Advocate shall develop and maintain on its Internet Web site a uniform benefits matrix of all available individual health plan contracts and individual health

insurance policies arranged by coverage choice category, as developed pursuant to Section 1399.820 of this code and Section 10904 of the Insurance Code. This uniform benefit matrix shall include, but not be limited to, all of the following information:

(1) Benefit information submitted by health care service plans pursuant to Section 1399.820 and by health insurers pursuant to Section 10904 of the Insurance Code, including, but not limited to, the following category descriptions:

(A) Standard rates by age, family size, and geographic region.

(B) Deductibles.

(C) Copayments or coinsurance, as applicable.

(D) Annual out-of-pocket maximums.

(E) Professional services.

(F) Outpatient services.

(G) Preventive services.

(H) Hospitalization services.

(I) Emergency health services.

(J) Ambulance services.

(K) Prescription drug coverage.

(L) Durable medical equipment.

(M) Mental health and substance abuse services.

(N) Home health services.

(O) Other.

(2) The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Insurance, as appropriate, for additional assistance.

(3) For each health care service plan contract or health insurance policy included in the matrix, a link to provider network information on the Internet Web site of the corresponding health care service plan or health insurer.

(b) The Office of Patient Advocate may also utilize the information provided by health care service plans and health insurers pursuant to Section 1399.819 of this code and Section 10903 of the Insurance Code to develop additional information and tools to facilitate consumer comparison shopping of individual health care service plan contracts and individual health insurance policies.

(c) When marketing or selling a health care service plan contract in the individual market, a health care service plan, a solicitor, or a solicitor firm shall make the prospective enrollee

aware of the availability and contents of the benefit matrix described in this section. This subdivision shall not apply until the Office of Patient Advocate has developed the benefit matrix required by this section.

SEC. 4. Section 10903 is added to the Insurance Code, to read:

10903. (a) On or before December 31, 2011, the department and the Department of Managed Health Care shall jointly, by regulation, develop standard definitions and terminology for covered benefits and cost-sharing provisions, including, but not limited to, copayments, coinsurance, deductibles, limitations, and exclusions, applicable to all health care service plan contracts and health insurance policies to be offered and sold to individuals on or after September 1, 2012.

(b) The regulations developed by the department and the Department of Managed Health Care pursuant to this section may identify and require the submission of any information needed to develop the standard definitions and terminology required by this section.

(c) All individual health insurance policies issued, amended, or renewed on or after January 1, 2011, shall contain a maximum limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits provided by in-network providers. With respect to individual health insurance policies issued, amended, or renewed on or after April 1, 2011, this limit shall not exceed ten thousand dollars ($10,000) per person per year.

SEC. 5. Section 10904 is added to the Insurance Code, to read:

10904. (a) (1) On or before December 31, 2011, the department and the Department of Managed Health Care shall jointly, by regulation, and in consultation with health care service plans, health insurers, and consumer representatives, develop a system to categorize all health care service plan contracts and health insurance policies to be offered and sold to individuals on and after September 1, 2012, into coverage choice categories in order to facilitate transparency and consumer comparison shopping. These coverage choice categories shall 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) The coverage choice categories shall be based on the benefits covered and the out-of-pocket costs. The categories shall be developed to ensure ease of consumer comparison and understanding of the benefit design choices in the individual market. The coverage choice categories shall be developed to be user-friendly for consumers, with the lowest number of choice categories necessary to include the full range of individual products into meaningful categories, but, in any event, there shall be no more than a total of 10 coverage choice categories across all products offered and sold to individuals, including health care service plan contracts and health insurance policies. There shall be no fewer than two categories in common between products in the two departments.

(3) The first coverage choice category shall provide the most comprehensive benefits and the lowest cost sharing and shall be comparable to the coverage provided by large employers to their employees.

(4) The commissioner shall require health insurers, agents, and brokers selling products in the coverage choice category with the lowest benefits to provide a standard written notice to potential purchasers as follows:

"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 product 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 product carefully before purchasing."

(b) 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 care service plan contract and health insurance policy subject to this section, including, but not limited to, the copayments, coinsurance, deductibles, limitations,

exclusions, and premium rates applicable to, and the actuarial value of, each contract or policy.

(c) A health insurer shall submit the information required by the department to implement this section no later than February 1, 2012, for all new individual policies to be offered or sold on or after September 1, 2012.

(d) The commissioner shall categorize each individual health insurance policy to be offered by an insurer into the appropriate coverage choice category on or before June 30, 2012.

(e) 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.

SEC. 6. Section 10905 is added to the Insurance Code, to read:

10905. When marketing or selling a health insurance policy in the individual market, a health insurer, a broker, or an agent shall make the prospective insured aware of the availability and contents of the benefit matrix described in Section 1399.821 of the Health and Safety Code. This section shall not apply until the Office of Patient Advocate has developed the benefit matrix required by Section 1399.821 of the Health and Safety Code.

SEC. 7. 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.

All matter omitted in this version of the bill appears in the bill as amended in the Assembly, June 2, 2009 (JR11)

O