AMENDED IN SENATE SEPTEMBER 4, 2009

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CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 786

Introduced by Assembly Member Jones
(Principal coauthor: Senator Steinberg)

February 26, 2009

An act to add ~~Sections 1399.819, 1399.820, and 1399.821 to~~ *Article 12 (commencing with Section 1399.819) to Chapter 2.2 of Division 2 of* the Health and Safety Code, and to add ~~Sections 10903, 10904, and 10905 to~~ *Chapter 9.7 (commencing with Section 10903) to Part 2 of Division 2 of* 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, 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~~, not to exceed $15,000 per person per year,~~ on out-of-pocket costs for covered benefits provided by in-network providers *and for covered emergency services*, as specified. The bill would require, by ~~December 31, 2011,~~ *July 1, 2012,* 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, as specified, and to develop a system to categorize those contracts and policies into coverage choice categories that meet specified requirements. The bill would require plans and insurers to submit certain information to the departments by ~~February 1, 2012,~~ *a specified date* 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~~ *by a specified date*. 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.

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.~~

SECTION 1. Article 12 (commencing with Section 1399.819) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 12. Individual Coverage: Coverage Choice Categories

1399.819. (a) (1) On or before ~~December 31, 2011~~ *July 1, 2012*, 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 individual health care service plan contracts and individual health insurance policies as described in paragraphs (2) and (3). Standard definitions for covered benefits shall not include standardized benefit limits or standardized benefit levels.

(2) Health care service plans shall comply with the standard definitions and terminology developed pursuant to paragraph (1) for all new individual plan contracts issued ~~one year after~~ *on or after one year following the date* the departments develop those definitions and terminology.

(3) Individual health care service plan contracts in existence as of the date the departments develop the standard definitions and terminology pursuant to paragraph (1) shall have ~~three~~ *two* years from that date to comply with those definitions and terminology. In lieu of compliance with respect to a specific health care service plan contract, a plan may offer individuals enrolled in that contract the opportunity to transfer, without medical underwriting, to an alternative contract that offers comparable benefits and cost sharing and that complies with the standard definitions and terminology. This paragraph shall not apply to a health care service plan that no longer markets or sells individual health care service plan contracts *or to a closed block of business pursuant to Section 1367.15*.

(4) In developing standard definitions and terminology pursuant to this section, the department and the Department of Insurance shall, to the greatest extent possible, take into account and incorporate definitions and terminology in common usage in individual health care service plan contracts and individual health insurance policies.

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

(c) (1) All individual health care service plan contracts issued, amended, or renewed on or after January 1, 2011, shall contain a maximum limit, not to exceed ~~fifteen thousand dollars ($15,000)~~ *five thousand dollars ($5,000)* per person per year, on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits provided by in-network contracted providers *and for covered emergency services. The out-of-pocket maximum for a family shall not exceed twice the amount of the out-of-pocket maximum for an individual*. For purposes of this subdivision, out-of-pocket costs do not include premium payments or prepaid periodic charges paid by the subscriber or enrollee.

(2) Notwithstanding paragraph (1), a health care service plan contract issued, amended, or renewed on or after January 1, 2011, may include a separate out-of-pocket limit for cost sharing related to ~~prescription drugs~~ *covered prescription drugs consistent with Section 1342.7*. The contract shall clearly disclose this separate out-of-pocket limit.

(3) The maximum permissible out-of-pocket cost limit described in paragraph (1) shall be indexed to, and shall ~~increase~~ *be adjusted* annually with, the medical cost component of the consumer price index. The director shall annually update and publish, by September 1, the maximum out-of-pocket limit to be used for the next calendar year based on changes in the medical cost component of the consumer price index.

(d) Any product that meets the requirements of this chapter, including subdivision (c) of this section, and that is submitted for review pursuant to Section 1399.820 shall be eligible for categorization under Section 1399.820 and shall have definitions and terminology consistent with this section.

(e) The regulations developed pursuant to this section shall take into account any applicable federal requirements.

~~(d)~~

(f) This section shall not apply to Medicare supplement contracts or to coverage offered by specialized health care service plans, other than specialized ~~mental~~ *behavioral* health plans, or to *coverage offered by* government-sponsored programs.

~~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~~ *July 1, 2012*, 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 *into coverage choice categories* 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~~ *one year following the date that the regulations are adopted*, 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. The coverage choice categories shall be based on the actuarial value of each product ~~and shall be identified based on the benefits covered and the consumer cost sharing elements.~~ *or another reasonable alternative, as jointly determined by the department and the Department of Insurance, in consultation with stakeholders, and shall be identified based on the benefits covered, the consumer cost sharing elements, and other information consistent with Section 1399.821.*

(2) The coverage choice categories shall be developed to ensure ease of consumer comparison and understanding of the benefit design choices in the individual market. The categories shall be developed to be user-friendly for consumers, with the lowest number of 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 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 department and the Department of Insurance shall develop consumer-oriented descriptions for each coverage choice category in order to provide for ease of consumer use and product choice.

(4) The regulations developed pursuant to this section shall take into account any applicable federal requirements.

(b) The regulations developed by the department and the Department of Insurance pursuant to this section shall identify and require the submission of information reasonably 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. The regulations shall require health insurers and health care service plans to use a standard method of calculation, as established by those regulations, for the purpose of submitting the actuarial values of their products to the departments.

~~(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.~~

(c) With respect to each health care service plan contract subject to categorization under subdivision (a), a health care service plan shall submit the information required by the department to implement this section no later than seven months prior to offering that contract.

(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~~ *four months prior to the offer of new individual contracts after the adoption of the regulations required in subdivision (a).*

(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 description of each coverage

choice category developed by the department and the Department of Insurance pursuant to Section 1399.820 of this code and Section 10904 of the Insurance Code and a uniform benefits matrix of all available individual health care service plan contracts and individual health insurance policies arranged by coverage choice category. 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.~~

SEC. 2. Chapter 9.7 (commencing with Section 10903) is added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 9.7. Individual Coverage: Coverage Choice Categories

10903. (a) (1) On or before ~~December 31, 2011~~ *July 1, 2012*, 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 individual health care service plan contracts and individual health insurance policies as described in paragraphs (2) and (3). Standard definitions for covered benefits shall not include standardized benefit limits or standardized benefit levels.

(2) Health insurers shall comply with the standard definitions and terminology developed pursuant to paragraph (1) for all new individual health insurance policies issued ~~one year after~~ *on or after one year following the date* the departments develop those standard definitions and terminology.

(3) Individual health insurance policies in existence as of the date the departments develop the standard definitions and terminology pursuant to paragraph (1) shall have ~~three~~ *two* years from that date to comply with those definitions and terminology. In lieu of compliance with respect to a specific health insurance policy, an insurer may offer individuals enrolled in that policy the opportunity to transfer, without medical underwriting, to an alternative policy that offers comparable benefits and cost sharing and that complies with the standard definitions and terminology. This paragraph shall not apply to a health insurer that no longer

markets or sells individual health insurance policies *or to a closed block of business pursuant to Section 10176.10*.

(4) In developing standard definitions and terminology pursuant to this section, the department and the Department of Managed Health Care shall, to the greatest extent possible, take into account and incorporate definitions and terminology in common usage in individual health care service plan contracts and individual health insurance policies.

(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 information reasonably needed to develop the standard definitions and terminology required by this section.

(c) (1) All individual health insurance policies issued, amended, or renewed on or after January 1, 2011, shall contain a maximum limit, not to exceed ~~fifteen thousand dollars ($15,000)~~ *five thousand dollars ($5,000)* per person per year, on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits provided by in-network providers *and for covered emergency services. The out-of-pocket maximum for a family shall not exceed twice the amount of the out-of-pocket maximum for an individual*. For purposes of this subdivision, out-of-pocket costs do not include premium payments paid by the policyholder or insured.

(2) Notwithstanding paragraph (1), a health insurance policy issued, amended, or renewed on or after January 1, 2011, may include a separate out-of-pocket limit for cost sharing related to prescription drugs. The policy shall clearly disclose this separate out-of-pocket limit.

(3) The maximum permissible out-of-pocket cost limit described in paragraph (1) shall be indexed to, and shall ~~increase~~ *be adjusted* annually with, the medical cost component of the consumer price index. The commissioner shall annually update and publish, by September 1, the maximum out-of-pocket limit to be used for the next calendar year based on changes in the medical cost component of the consumer price index.

(d) Any product that meets the requirements of this code, including subdivision (c) of this section, and that is submitted for review pursuant to Section 10904 shall be eligible for

categorization under Section 10904 and shall have definitions and terminology consistent with this section.

(e) The regulations developed pursuant to this section shall take into account any applicable federal requirements.

~~(d)~~

(f) This section shall not apply to Medicare supplement policies or to specialized health insurance policies, other than specialized ~~mental~~ *behavioral* health policies*, or to coverage offered by government-sponsored programs*.

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

10904. (a) (1) On or before ~~December 31, 2011~~ *July 1, 2012*, 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 *into coverage choice categories* 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~~ *and after one year following the date that the regulations are adopted, 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. The coverage choice categories shall be based on the actuarial value of each product ~~and shall be identified based on the benefits covered and the consumer cost sharing elements.~~ *or other reasonable alternative, as jointly determined by the department and the Department of Managed Health Care, in consultation with stakeholders, and shall be identified based on the benefits covered, the consumer cost sharing elements, and other information consistent with Section 1399.821 of the Health and Safety Code.*

(2) The coverage choice categories shall be developed to ensure ease of consumer comparison and understanding of the benefit design choices in the individual market. The categories shall be developed to be user-friendly for consumers, with the lowest number of 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 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 department and the Department of Managed Health Care shall develop consumer-oriented descriptions for each coverage choice category in order to provide for ease of consumer use and product choice.

(4) The regulations developed pursuant to this section shall take into account any applicable federal requirements.

(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 information reasonably 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. The regulations shall require health insurers and health care service plans to use a standard method of calculation, as established by those regulations, for the purpose of submitting the actuarial values of their products to the departments.

~~(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.~~

(c) With respect to each health insurance policy subject to categorization under subdivision (a), a health insurer shall submit the information required by the department to implement this section no later than seven months prior to offering that policy.

(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~~ *four months prior to the offer of new individual policies after the adoption of the regulations required in subdivision (a).*

(e) This section shall not apply to specialized health insurance, Medicare supplement insurance, short-term limited duration health insurance, CHAMPUS supplement insurance, TRI-CARE supplement insurance, *coverage offered by* government-sponsored programs, or to hospital indemnity, accident-only, or specified disease 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.~~

SEC. 3. 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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