Assembly Bill No. 2042

Passed the Assembly August 25, 2010

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Chief Clerk of the Assembly

Passed the Senate August 23, 2010

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2010, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Section 1374.255 to the Health and Safety Code, and to add Section 10199.49 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2042, Feuer. Health care coverage: rate changes.

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. Under existing law, no change in premium rates or coverage in a health care service plan contract or a health insurance policy may become effective without prior written notification of the change to the contractholder or policyholder. Existing law prohibits a plan or insurer during the term of a group plan contract or policy from changing the rate of the premium, copayment, coinsurance, or deductible during specified time periods.

This bill would prohibit a health care service plan or health insurer from altering the rates, as defined, that apply to individual health care service plan contracts or individual health insurance policies, or altering any benefits included in individual contracts or policies, more than once each calendar year, except as specified. Among those exceptions, the bill would provide that, if a brand name drug becomes available as a generic drug, the application of a lower cost-sharing rate for the generic drug would not constitute an alteration of benefits. The bill's provisions would apply to a new individual plan contract or policy issued to an enrollee or insured who transfers from another plan or policy, as specified, and would prohibit the issuance of new plan contracts or policies more often than annually.

Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the

state. Statutory provisions establish procedures for making that reimbursement.

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

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

SECTION 1. Section 1374.255 is added to the Health and Safety Code, to read:

1374.255. (a) (1) For purposes of this section, "rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, out-of-pocket costs, and any other charges for covered benefits.

(2) For purposes of this section, "cost sharing" includes, but is not limited to, copayments, coinsurance obligations, deductibles, out-of-pocket costs, and charges for covered benefits other than the premium.

(b) Notwithstanding any other provision of law, except as required by changes in state or federal law or as provided in subdivision (c), a health care service plan shall not do either of the following more than once each calendar year:

(1) Alter in any manner the rates that apply to individual plan contracts.

(2) Alter in any manner any benefits included in individual plan contracts.

(c) (1) If an enrollee changes geographic region or family composition, the plan may alter the rates to reflect that change but shall ensure that the change in the rates offered reflects only the change in geographic region or family composition.

(2) If coinsurance obligations are based on a percentage of the cost of services, nothing in this section shall prevent a change in provider rates during the term of the contract between the enrollee and the health care service plan even if that change increases the charge for covered benefits to the enrollee.

(3) If a generic version of a brand name prescription drug becomes available, the application of a lower cost-sharing rate for the generic drug than that of the brand name version shall not constitute an alteration in benefits. If a generic equivalent of a brand name prescription drug becomes available, the placement of the brand drug into another formulary tier or increasing the

copayment for that brand shall not constitute an alteration of benefits or rate increase. Nothing in this paragraph shall otherwise permit a plan to change the structure, tiers, or cost sharing for generic and brand name drugs during the course of the year.

(4) Notwithstanding paragraph (1) of subdivision (b), a plan may lower the premium if it does not otherwise alter cost sharing or any benefits and if the reduction in premium is consistent with other provisions of state and federal law.

(d) Upon issuance of a new individual plan contract consistent with Section 1389.5, the provisions of this section shall apply to that contract. In no instance shall a new individual plan contract be issued more often than annually.

(e) This section shall not apply to health care service plan contracts issued through a publicly funded state health care coverage program, including, but not limited to, the Medi-Cal program and the Healthy Families Program, or to Medicare supplement contracts.

(f) Nothing in this section shall prevent a plan from providing coverage for newly approved treatments, therapies, and prescription drugs related to an existing benefit or service provided under the contract. Nothing in this section shall be construed to provide any limitation on medically necessary services.

(g) This section shall apply only to health care service plan contracts issued, amended, or renewed on or after January 1, 2011.

(h) This section shall be implemented to the extent that it does not conflict with federal laws and regulations.

SEC. 2. Section 10199.49 is added to the Insurance Code, to read:

10199.49. (a) (1) For purposes of this section, "rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, out-of-pocket costs, and any other charges for covered benefits.

(2) For purposes of this section, "cost sharing" includes, but is not limited to, copayments, coinsurance obligations, deductibles, out-of-pocket costs, and charges for covered benefits other than the premium.

(b) Notwithstanding any other provision of law, except as required by changes in state or federal law or as provided in subdivision (c), a health insurer shall not do either of the following more than once each calendar year:

(1) Alter in any manner the rates that apply to individual health insurance policies.

(2) Alter in any manner any benefits included in individual health insurance policies.

(c) (1) If an insured changes geographic region or family composition, the health insurance policy may alter the rates to reflect that change but shall ensure that the change in the rates offered reflects only the change in geographic region or family composition.

(2) If coinsurance obligations are based on a percentage of the cost of services, nothing in this section shall prevent a change in provider rates during the term of the policy between the insured and the health insurer even if that change increases the charge for covered benefits to the insured.

(3) If a generic version of a brand name prescription drug becomes available, the application of a lower cost-sharing rate for the generic drug than that of the brand name version shall not constitute an alteration in benefits. If a generic equivalent of a brand name prescription drug becomes available, the placement of the brand drug into another formulary tier or increasing the copayment for that brand shall not constitute an alteration of benefits or rate increase. Nothing in this paragraph shall otherwise permit an insurer to change the structure, tiers, or cost sharing for generic and brand name drugs during the course of the year.

(4) Notwithstanding paragraph (1) of subdivision (b), a plan may lower the premium if it does not otherwise alter cost sharing or any benefits and if the reduction in premium is consistent with other provisions of state and federal law.

(d) Upon issuance of a new individual health benefit plan consistent with Section 10119.1, the provisions of this section shall apply to that plan. In no instance shall a new individual health benefit plan be issued more often than annually.

(e) This section shall not apply to health insurance policies issued through a publicly funded state health care coverage program, including, but not limited to, the Medi-Cal program and the Healthy Families Program, or to Medicare supplement policies.

(f) Nothing in this section shall prevent an insurer from providing coverage for newly approved treatments, therapies, and prescription drugs related to an existing benefit or service provided

under the policy. Nothing in this section shall be construed to provide any limitation on medically necessary services.

(g) This section shall apply only to health insurance policies and health benefit plans issued, amended, or renewed on or after January 1, 2011.

(h) This section shall be implemented to the extent that it does not conflict with federal laws or regulations.

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.

Approved _____, 2010

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Governor