AMENDED IN ASSEMBLY MAY 5, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1334

Introduced by Assembly Member Feuer

February 18, 2011

An act to add Section 1366.5 to the Health and Safety Code, and to add Section 10112.58 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1334, as amended, Feuer. Health care coverage.

Existing law, the federal Patient Protection and Affordable Care Act, on and after January 1, 2014, requires a health insurance issuer offering health insurance coverage in the individual or group market to accept every employer and individual in the state that applies for that coverage, as specified, and requires issuers in the individual and small group markets to ensure that the coverage includes a specified essential benefits package. The act requires an essential health benefits package to provide coverage in one of 5 levels based on actuarial value, as specified.

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 provides for the regulation of health insurers by the Department of Insurance.

Existing law imposes various requirements with respect to individual contracts and policies issued by health care service plans and health insurers.

This bill would require plans and insurers to~~, commencing July 1, 2012,~~ categorize all products offered in the individual market into 5

tiers according to actuarial value, as specified, and would require plans and insurers to disclose this value and other information in certain disclosure forms. *These requirements would become operative 30 days after the issuance of federal guidance on minimum essential benefits.*

Because a willful violation of the bill's requirements with respect 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 1366.5 is added to the Health and Safety Code, to read:

~~1366.5. (a) Effective July 1, 2012, a health care service plan shall categorize all products offered or renewed in the individual market in accordance with this section.~~

~~(b)~~

1366.5. (a) From July 1, 2012, to December 31, 2013, inclusive, *for* each product offered or renewed in the individual market, *a health care service plan* shall disclose whether or not it offers minimum essential benefits, as defined in the federal Patient Protection and ~~Afordable~~ *Affordable* Care Act (Public Law 111-148) and whether or not it offers an actuarial value of at least 70 percent.

~~(c)~~

(b) On and after January 1, 2014, *a health care service plan shall categorize* each product offered or renewed in the individual market ~~shall be categorized~~ on the basis of actuarial value into one of the following tiers:

(1) Bronze level for products with an actuarial value equal to 60 percent.

(2) Silver level for products with an actuarial value equal to 70 percent.

(3) Gold level for products with an actuarial value equal to 80 percent.

(4) Platinum level for products with an actuarial value equal to 90 percent.

(5) Catastrophic coverage for products with an actuarial value less than 60 percent.

~~(d)~~

(c) In categorizing the actuarial value of products for purposes of subdivision (c), a health care service plan may have a de minimis variation from the actuarial values set forth in that subdivision.

~~(e)~~

(d) On and after January 1, 2014, an actuarial value shall be calculated using the method contained in subdivision (d) of Section 1302 of the federal Patient Protection and Affordable Care Act and the regulations adopted thereunder.

~~(f)~~

(e) A plan shall use a qualified actuary to certify the accuracy of its calculations under this section.

~~(g)~~

(f) (1) The department may review the categorization of any product under this section for accuracy, including, but not limited to, the methodology used by the plan to establish an actuarial value.

(2) The department may require the submission of any information needed to categorize products pursuant to this section.

~~(h)~~

(g) As part of the disclosure form required by Section 1363 for an individual plan contract, a health care service plan shall include the actuarial value of the particular product reflected in the contract, as determined under this section, along with an explanation of the actuarial value in easily understood language expressed as a percentage of expenses paid by the plan versus out of pocket. In addition, the disclosure shall include an estimate of the annual out-of-pocket expenses of an individual in average health who is enrolled in the product, and the total annual cost (the sum of the premium plus out-of-pocket costs) of an individual of average health who is enrolled in the product. The disclosure shall also state that an individual's share of cost may be more or less depending on his or her age, illness, or health condition. The disclosure shall also include the following statement:

"Please examine the other features of this product carefully, including prescription drug coverage, exclusion of specific conditions, and other costs such as copayments and deductibles."

~~(i)~~

(h) This section shall not apply to Medicare supplement contracts or to specialized health care service plan contracts.

~~(j)~~

(i) For purposes of this section, "qualified actuary" means an actuary who is a member of the American Academy of Actuaries, who is qualified to perform such work, and who meets the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States as promulgated by the American Academy of Actuaries.

(j) This section shall become operative 30 days after initial federal guidance on minimum essential benefits is issued.

SEC. 2. Section 10112.58 is added to the Insurance Code, to read:

~~10112.58. (a) Effective July 1, 2012, a health insurer shall categorize all products offered or renewed in the individual market in accordance with this section.~~

~~(b)~~

10112.58. (a) From July 1, 2012, to December 31, 2013, inclusive, *for* each product offered or renewed in the individual market, *a health insurer* shall disclose whether or not it offers minimum essential benefits, as defined in the federal Patient Protection and ~~Afordable~~ *Affordable* Care Act (Public Law 111-148) and whether or not it offers an actuarial value of at least 70 percent.

~~(c)~~

(b) On and after January 1, 2014, *a health insurer shall categorize* each product offered or renewed in the individual market ~~shall be categorized~~ on the basis of actuarial value into one of the following tiers:

(1) Bronze level for products with an actuarial value equal to 60 percent.

(2) Silver level for products with an actuarial value equal to 70 percent.

(3) Gold level for products with an actuarial value equal to 80 percent.

(4) Platinum level for products with an actuarial value equal to 90 percent.

(5) Catastrophic coverage for products with an actuarial value less than 60 percent.

~~(d)~~

(c) In categorizing the actuarial value of products for purposes of subdivision (c), a health insurer may have a de minimis variation from the actuarial values set forth in that subdivision.

~~(e)~~

(d) On and after January 1, 2014, an actuarial value shall be calculated using the method contained in subdivision (d) of Section 1302 of the federal Patient Protection and Affordable Care Act and the regulations adopted thereunder.

~~(f)~~

(e) An insurer shall use a qualified actuary to certify the accuracy of its calculations under this section.

~~(g)~~

(f) (1) The department may review the categorization of any product under this section for accuracy, including, but not limited to, the methodology used by the insurer to establish an actuarial value.

(2) The department may require the submission of any information needed to categorize products pursuant to this section.

~~(h)~~

(g) As part of the disclosure form required by Section 10603 for an individual health insurance policy, a health insurer shall include the actuarial value of the particular product reflected in the policy, as determined under this section, along with an explanation of the actuarial value in easily understood language expressed as a percentage of expenses paid by insurance versus out of pocket. In addition, the disclosure shall include an estimate of the annual out-of-pocket expenses of an individual in average health who is enrolled in the product, and the total annual cost (the sum of the premium plus out-of-pocket costs) of an individual of average health who is enrolled in the product. The disclosure shall also state that an individual’s share of cost may be more or less depending on his or her age, illness, or health condition. The disclosure shall also include the following statement:

"Please examine the other features of this product carefully, including prescription drug coverage, exclusion of specific conditions, and other costs such as copayments and deductibles."

~~(i)~~

(h) This section shall not apply to Medicare supplement, CHAMPUS-supplement, specified disease, TRICARE supplement, or accident-only insurance policies, to specialized health insurance policies, or to insurance policies excluded from the definition of "health insurance" under subdivision (b) of Section 106.

~~(j)~~

(i) For purposes of this section, "qualified actuary" means an actuary who is a member of the American Academy of Actuaries, who is qualified to perform such work, and who meets the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States as promulgated by the American Academy of Actuaries.

(j) This section shall become operative 30 days after initial federal guidance on minimum essential benefits is issued.

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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