AMENDED IN ASSEMBLY MAY 25, 2012

AMENDED IN ASSEMBLY MAY 1, 2012

AMENDED IN ASSEMBLY MARCH 20, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1800

Introduced by Assembly Member Ma

February 21, 2012

An act to amend ~~Sections 1342.7 and~~ *Section* 1367 of, and to add Section 1367.005 to, the Health and Safety Code, and to add Section 10123.197.5 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1800, as amended, Ma. Health care coverage.

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. Existing law provides that the willful violation of provisions regulating health care service plans is a crime. Existing law provides for the licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires health care service plans and health insurers to provide certain benefits, but generally does not require plans and insurers to cover prescription drugs.

Existing law imposes various requirements on plans and insurers if they offer coverage for prescription drugs. Existing law, with respect to health care service plans, authorizes a plan to file information with the department to seek the approval of, among other things, a copayment, deductible, or exclusion to a plan's prescription drug benefit and specifies that an approved exclusion shall not be subject to review

through the independent medical review process on the grounds of medical necessity.

Existing federal law, the Patient Protection and Affordable Care Act, commencing January 1, 2014, imposes an annual limitation on cost sharing incurred under a health plan that shall not exceed a specified amount.

This bill would, commencing January 1, 2014, require a health care service plan contract and a health insurance policy, except for a specialized plan or policy, to provide for a limit on annual out-of-pocket expenses for all covered benefits, except as specified, and would provide that this limit shall not exceed that federal limit. The bill would also provide, commencing January 1, 2014, that these provisions shall not be construed to affect the reduction in cost sharing for eligible insureds described in federal law~~, and that any deductible for covered benefits shall also apply to covered prescription drugs~~.

~~This bill would, commencing January 1, 2013, with respect to health care service plans, prohibit the Department of Managed Health Care from approving an exclusion for a medically necessary prescription drug for which there is no therapeutic equivalent and would also require the department to review specified factors in determining whether to allow an exclusion to a plan's prescription drug benefits.~~

Existing law provides that the obligation of a plan to comply with specified standards is not waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

This bill would apply those provisions regarding waiver to the obligation of a plan to comply with the Knox-Keene Health Care Service Plan Act of 1975, rather than to the obligation of the plan to comply with specified standards.

Because this bill would impose new requirements on health care service plans, the willful violation of which would be a crime, it would thereby 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 1342.7 of the Health and Safety Code is amended to read:~~

~~1342.7. (a) The Legislature finds that in enacting Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72, it did not intend to limit the department's authority to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent that the plan provides coverage for those benefits.~~

~~(b) (1) (A) Nothing in this chapter shall preclude a plan from filing relevant information with the department pursuant to Section 1352 to seek the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits.~~

~~(B) No exclusion shall be approved for a medically necessary prescription drug for which there is no therapeutic equivalent. If the department approves an exclusion to a plan's prescription drug benefits, the exclusion shall not be subject to review through the independent medical review process pursuant to Section 1374.30 on the grounds of medical necessity. In determining whether to allow an exclusion to a plan's prescription drug benefits, the department shall review whether the prescription drug is medically necessary, whether there is a therapeutic equivalent, and whether peer-reviewed scientific literature indicates that the prescription drug is likely to provide a benefit to the consumer. The department shall retain its role in assessing whether issues are related to coverage or medical necessity pursuant to paragraph (2) of subdivision (d) of Section 1374.30.~~

~~(2) A plan seeking approval of a copayment or deductible may file an amendment pursuant to Section 1352.1. A plan seeking approval of a limitation or exclusion shall file a material modification pursuant to subdivision (b) of Section 1352.~~

~~(c) Nothing in this chapter shall prohibit a plan from charging a subscriber or enrollee a copayment or deductible for a prescription drug benefit or from setting forth by contract, a limitation or an exclusion from, coverage of prescription drug benefits, if the copayment, deductible, limitation, or exclusion is reported to, and found unobjectionable by, the director and disclosed to the subscriber or enrollee pursuant to the provisions of Section 1363.~~

~~(d) The department in developing standards for the approval of a copayment, deductible, limitation, or exclusion to a plan's prescription drug benefits, shall consider alternative benefit designs, including, but not limited to, the following:~~

~~(1) Different out-of-pocket costs for consumers, including copayments and deductibles.~~

~~(2) Different limitations, including caps on benefits.~~

~~(3) Use of exclusions from coverage of prescription drugs to treat various conditions, including the effect of the exclusions on the plan's ability to provide basic health care services, the amount of subscriber or enrollee premiums, and the amount of out-of-pocket costs for an enrollee.~~

~~(4) Different packages negotiated between purchasers and plans.~~

~~(5) Different tiered pharmacy benefits, including the use of generic prescription drugs.~~

~~(6) Current and past practices.~~

~~(e) The department shall develop a regulation outlining the standards to be used in reviewing a plan's request for approval of its proposed copayment, deductible, limitation, or exclusion on its prescription drug benefits.~~

~~(f) Nothing in subdivision (b) or (c) shall permit a plan to limit prescription drug benefits provided in a manner that is inconsistent with Sections 1367.215, 1367.25, 1367.45, 1367.51, and 1374.72.~~

~~(g) Nothing in this section shall be construed to require or authorize a plan that contracts with the State Department of Health Care Services to provide services to Medi-Cal beneficiaries or with the Managed Risk Medical Insurance Board to provide services to enrollees of the Healthy Families Program to provide coverage for prescription drugs that are not required pursuant to those programs or contracts, or to limit or exclude any prescription drugs that are required by those programs or contracts.~~

~~(h) Nothing in this section shall be construed as prohibiting or otherwise affecting a plan contract that does not cover outpatient prescription drugs except for coverage for limited classes of prescription drugs because they are integral to treatments covered as basic health care services, including, but not limited to, immunosuppressives, in order to allow for transplants of bodily organs.~~

~~(i) (1) The department shall periodically review its regulations developed pursuant to this section.~~

~~(2) On or before July 1, 2004, and annually thereafter, the department shall report to the Legislature on the ongoing implementation of this section.~~

~~SEC. 2.~~

SECTION 1. Section 1367 of the Health and Safety Code is amended to read:

1367. A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Public Health , where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) (1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service consistent with Section 1367.005, provided that the copayments or deductibles are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) A health care service plan shall not require registration under the federal Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this chapter shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

~~SEC. 3.~~

SEC. 2. Section 1367.005 is added to the Health and Safety Code, to read:

1367.005. (a) ~~(1)~~ A health care service plan contract, except a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2014, shall provide for a limit on annual out-of-pocket expenses for all covered benefits.

~~(2)~~

(b) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for any covered benefits, including prescription drugs, if covered.

~~(3)~~

(c) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section.

~~(4)~~

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

~~(b) Notwithstanding any other provision of law, on and after January 1, 2014, a health care service plan contract that is issued, amended, or renewed shall provide that any deductible for covered benefits shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and any other covered benefits.~~

~~SEC. 4.~~

SEC. 3. Section 10123.197.5 is added to the Insurance Code, to read:

10123.197.5. (a) ~~(1)~~ A health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2014, shall provide for a limit on annual out-of-pocket expenses for all covered benefits and include the insured's out-of-pocket costs of covered prescription drugs in that limit.

~~(2)~~

(b) This limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for any covered benefits, including prescription drugs, if covered.

~~(3)~~

(c) This limit shall not exceed the limit described in Section 1302(c) of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18022) and any subsequent rules, regulations, or guidance issued under that section .

~~(4)~~

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of the federal Patient Protection and Affordable Care Act, as amended by the federal Health Care and Education Reconciliation Act of 2010 (42 U.S.C. Sec. 18071) and any subsequent rules, regulations, or guidance issued under that section.

~~(b) Notwithstanding any other provision of law, a health insurance policy that is issued, amended, or renewed on and after January 1, 2014, shall provide that any deductible for covered benefits shall also apply to covered prescription drugs. There shall not be separate deductibles for covered prescription drugs and any other covered benefits.~~

~~SEC. 5.~~

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.

O