

AMENDED IN ASSEMBLY AUGUST 6, 2013

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE APRIL 9, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL

No. 639

Introduced by Senator Hernandez

February 22, 2013

An act to amend Section 1367 of, and to add Sections 1367.006, 1367.007, 1367.008, and 1367.009 to, the Health and Safety Code, and to add Sections 10112.28, 10112.29, 10112.295, 10112.297, and 10112.7 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 639, as amended, Hernandez. Health care coverage.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA establishes annual limits on deductibles for employer-sponsored plans and defines bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets.

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.

This bill would prohibit the deductible under a small employer health care service plan contract or health insurance policy offered, sold, or renewed on or after January 1, 2014, from exceeding \$2,000 in the case

of a plan contract or policy covering a single individual, or \$4,000 in all other cases.

The bill would require, for nongrandfathered products in the individual or small group markets, a health care service plan contract or health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2014, to provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits, as defined, and would require the contract or policy, for nongrandfathered products in the large group market, to provide that limit for covered benefits, including out-of-network emergency ~~care~~: *care, to the extent that the limit does not conflict with federal law or guidance, as specified. The bill would, effective January 1, 2015, apply the above-described provisions to a specialized plan or specialized health insurance policy that offers an essential health benefit, as specified.*

The bill would define bronze, silver, gold, and platinum levels of coverage for the nongrandfathered individual and small group markets consistent with the definitions in PPACA. The bill would prohibit a carrier that is not participating in the Exchange from offering a catastrophic plan, as defined, in the individual market.

PPACA requires a health insurance issuer offering group or individual coverage that provides or covers benefits with respect to services in the emergency department of a hospital to cover emergency services without the need for prior authorization, regardless of whether the provider is a participating provider, and subject to the same cost sharing required if the services were provided by a participating provider, as specified.

This bill would impose that requirement with respect to health insurance policies issued, amended, or renewed on or after January 1, 2014, as specified.

Because a willful violation of these 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:

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

3 1367. A health care service plan and, if applicable, a specialized
4 health care service plan shall meet the following requirements:

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

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

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

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

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

25 (2) To the extent that telehealth services are appropriately
26 provided through telehealth, as defined in subdivision (a) of Section
27 2290.5 of the Business and Professions Code, these services shall
28 be considered in determining compliance with Section 1300.67.2
29 of Title 28 of the California Code of Regulations.

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

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

35 (g) The plan shall have the organizational and administrative
36 capacity to provide services to subscribers and enrollees. The plan
37 shall be able to demonstrate to the department that medical

1 decisions are rendered by qualified medical providers, unhindered
2 by fiscal and administrative management.

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

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

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

23 (i) A health care service plan contract shall provide to
24 subscribers and enrollees all of the basic health care services
25 included in subdivision (b) of Section 1345, except that the director
26 may, for good cause, by rule or order exempt a plan contract or
27 any class of plan contracts from that requirement. The director
28 shall by rule define the scope of each basic health care service that
29 health care service plans are required to provide as a minimum for
30 licensure under this chapter. Nothing in this chapter shall prohibit
31 a health care service plan from charging subscribers or enrollees
32 a copayment or a deductible for a basic health care service
33 consistent with Section 1367.006 or 1367.007, provided that the
34 copayments, deductibles, or other cost sharing are reported to the
35 director and set forth to the subscriber or enrollee pursuant to the
36 disclosure provisions of Section 1363. Nothing in this chapter shall
37 prohibit a health care service plan from setting forth, by contract,
38 limitations on maximum coverage of basic health care services,
39 provided that the limitations are reported to, and held

1 unobjectionable by, the director and set forth to the subscriber or
2 enrollee pursuant to the disclosure provisions of Section 1363.

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

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

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

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

18 SEC. 2. Section 1367.006 is added to the Health and Safety
19 Code, to read:

20 1367.006. (a) (1) For nongrandfathered products in the
21 individual or small group markets, a health care service plan
22 contract, except a specialized health care service plan contract,
23 that is issued, amended, or renewed on or after January 1, 2014,
24 shall provide for a limit on annual out-of-pocket expenses for all
25 covered benefits that meet the definition of essential health benefits
26 in paragraph (1) of subdivision (a) of Section 1367.005.

27 (2) For nongrandfathered products in the large group market, a
28 health care service plan contract, except a specialized health care
29 service plan contract, that is issued, amended, or renewed on or
30 after January 1, 2014, shall provide for a limit on annual
31 out-of-pocket expenses for covered benefits, including
32 out-of-network emergency care consistent with Section 1371.4.
33 *This limit shall apply to essential health benefits covered under*
34 *the plan to the extent that this provision does not conflict with*
35 *federal law or guidance on out-of-pocket maximums for*
36 *nongrandfathered products in the large group market.* For large
37 group products for the first plan year commencing on or after
38 January 1, 2014, the requirement that a product provide for a limit
39 on annual out-of-pocket expenses shall be satisfied if both of the
40 following apply:

1 (A) The product complies with the requirements of this
 2 paragraph with respect to basic health care services.

3 (B) To the extent the product includes an out-of-pocket
 4 maximum on coverage other than basic health care services, that
 5 out-of-pocket maximum also does not exceed the limit established
 6 pursuant to this paragraph.

7 (b) The limit described in subdivision (a) shall apply to any
 8 copayment, coinsurance, deductible, incentive payment, and any
 9 other form of cost sharing for all covered benefits, including
 10 prescription drugs covered pursuant to Section 1367.24.

11 (c) The limit described in subdivision (a) shall not exceed the
 12 limit described in Section 1302(c) of PPACA, and any subsequent
 13 rules, regulations, or guidance issued under that section.

14 (d) Nothing in this section shall be construed to affect the
 15 reduction in cost sharing for eligible enrollees described in Section
 16 1402 of PPACA, and any subsequent rules, regulations, or guidance
 17 issued under that section.

18 (e) *Effective January 1, 2015, if an essential health benefit is*
 19 *offered by a specialized plan, this section shall apply so that the*
 20 *total annual out-of-pocket maximum for all essential benefits does*
 21 *not exceed the limit in this section. This section shall not apply to*
 22 *a specialized plan that does not offer an essential health benefit*
 23 *as defined in Section 1367.005.*

24 (e)

25 (f) “PPACA” means the federal Patient Protection and
 26 Affordable Care Act (Public Law 111-148), as amended by the
 27 federal Health Care and Education Reconciliation Act of 2010
 28 (Public Law 111-152), and any rules, regulations, or guidance
 29 issued thereunder.

30 SEC. 3. Section 1367.007 is added to the Health and Safety
 31 Code, to read:

32 1367.007. (a) (1) For a small employer health care service
 33 plan contract offered, sold, or renewed on or after January 1, 2014,
 34 the deductible under the plan shall not exceed:

35 (A) Two thousand dollars (\$2,000) in the case of a plan contract
 36 covering a single individual.

37 (B) Four thousand dollars (\$4,000) in the case of any other plan
 38 contract.

1 (2) The dollar amounts in this section shall be indexed consistent
2 with Section 1302(c)(2) of PPACA and any federal rules or
3 guidance pursuant to that section.

4 (3) The limitation in this subdivision shall be applied in a
5 manner that does not affect the actuarial value of any small
6 employer health care service plan contract.

7 (4) For small group products at the bronze level of coverage,
8 as defined in Section 1367.008, the department may permit plans
9 to offer a higher deductible in order to meet the actuarial value
10 requirement of the bronze level. In making this determination, the
11 department shall consider affordability of cost sharing for enrollees
12 and shall also consider whether enrollees may be deterred from
13 seeking appropriate care because of higher cost sharing.

14 (b) Nothing in this section shall be construed to allow a plan
15 contract to have a deductible that applies to preventive services as
16 defined in Section 1367.002.

17 (c) “PPACA” means the federal Patient Protection and
18 Affordable Care Act (Public Law 111-148), as amended by the
19 federal Health Care and Education Reconciliation Act of 2010
20 (Public Law 111-152), and any rules, regulations, or guidance
21 issued thereunder.

22 SEC. 4. Section 1367.008 is added to the Health and Safety
23 Code, to read:

24 1367.008. (a) Levels of coverage for the nongrandfathered
25 individual market are defined as follows:

26 (1) Bronze level: A health care service plan contract in the
27 bronze level shall provide a level of coverage that is actuarially
28 equivalent to 60 percent of the full actuarial value of the benefits
29 provided under the plan contract. ~~No product shall be offered at
30 this level of coverage unless it is a standardized product consistent
31 with Section 1366.6.~~

32 (2) Silver level: A health care service plan contract in the silver
33 level shall provide a level of coverage that is actuarially equivalent
34 to 70 percent of the full actuarial value of the benefits provided
35 under the plan contract. ~~No product shall be offered at this level
36 of coverage unless it is a standardized product consistent with
37 Section 1366.6.~~

38 (3) Gold level: A health care service plan contract in the gold
39 level shall provide a level of coverage that is actuarially equivalent
40 to 80 percent of the full actuarial value of the benefits provided

1 under the plan contract. ~~No product shall be offered at this level~~
2 ~~of coverage unless it is a standardized product consistent with~~
3 ~~Section 1366.6.~~

4 (4) Platinum level: A health care service plan contract in the
5 platinum level shall provide a level of coverage that is actuarially
6 equivalent to 90 percent of the full actuarial value of the benefits
7 provided under the plan contract. ~~No product shall be offered at~~
8 ~~this level of coverage unless it is a standardized product consistent~~
9 ~~with Section 1366.6.~~

10 (b) Actuarial value for nongrandfathered individual health care
11 service plan contracts shall be determined in accordance with the
12 following:

13 (1) Actuarial value shall not vary by more than plus or minus
14 2 percent.

15 (2) Actuarial value shall be determined on the basis of essential
16 health benefits as defined in Section 1367.005 and as provided to
17 a standard, nonelderly population. For this purpose, a standard
18 population shall not include those receiving coverage through the
19 Medi-Cal or Medicare programs.

20 (3) The department may use the actuarial value methodology
21 developed consistent with Section 1302(d) of PPACA.

22 (4) *The actuarial value for pediatric dental benefits, whether*
23 *offered by a full service plan or a specialized plan, shall be*
24 *consistent with federal law and guidance.*

25 ~~(4)~~

26 (5) The department, in consultation with the Department of
27 Insurance and the Exchange, shall consider whether to exercise
28 state-level flexibility with respect to the actuarial value calculator
29 in order to take into account the unique characteristics of the
30 California health care coverage market, including the prevalence
31 of health care service plans, total cost of care paid for by the plan,
32 price of care, patterns of service utilization, and relevant
33 demographic factors.

34 (c) For all products in the nongrandfathered individual market
35 commencing January 1, 2015, any deductible shall apply to the
36 same services for any product in the same level of coverage
37 whether regulated by the department or the Department of
38 Insurance.

39 (d) (1) A catastrophic plan is a health care service plan contract
40 that provides no benefits for any plan year until the enrollee has

1 incurred cost-sharing expenses in an amount equal to the annual
2 limit on out-of-pocket costs as specified in Section 1367.006 except
3 that it shall provide coverage for at least three primary care visits.
4 A carrier that is not participating in the Exchange shall not offer,
5 market, or sell a catastrophic plan in the individual market. ~~No~~
6 ~~product shall be offered at this level of coverage unless it is a~~
7 ~~standardized product consistent with Section 1366.6.~~

8 (2) A catastrophic plan may be offered only in the individual
9 market and only if consistent with subdivision (c) and this
10 paragraph. Catastrophic plans may be offered only if either of the
11 following apply:

12 (A) The individual purchasing the plan has not yet attained 30
13 years of age.

14 (B) The individual has a certificate of exemption from Section
15 5000(A) of the Internal Revenue Code because the individual is
16 not offered affordable coverage or because the individual faces
17 hardship.

18 *(e) (1) Nongrandfathered products in the individual market*
19 *that are not standardized products as provided under Section*
20 *1366.1 shall be subject to review by the department consistent with*
21 *this subdivision prior to product approval. This section shall also*
22 *apply to carriers offering specialized plans that provide coverage*
23 *of an essential health benefit as defined in Section 1367.005.*

24 *(2) The department shall publicly post information on*
25 *nonstandardized products no less than 60 days prior to the date*
26 *on which the product is approved by the department. For purposes*
27 *of products offered by the Exchange, the department shall post*
28 *nonstandardized products for review 60 days prior to the*
29 *finalization of any contract between the Exchange and the health*
30 *care service plan.*

31 *(3) For each proposed product, the plan shall provide to the*
32 *department all of the following:*

33 *(A) Information as to whether the product was proposed to the*
34 *Exchange and any written information from the Exchange as to*
35 *whether the product was approved, denied, or modified.*

36 *(B) The estimated actuarial value of the proposed product and*
37 *the actuarial value tier of the proposed product.*

38 *(C) The anticipated impact on risk mix of plan enrollees*
39 *purchasing the proposed product, including information on the*

1 risk mix of enrollees purchasing the same or similar products in
2 prior years.

3 (D) Any benefit to consumers, including the anticipated impacts
4 on premiums.

5 (4) The department shall review and take public comment on
6 the nonstandardized products with regard to all of the following:

7 (A) Whether the proposed product is likely to affect the risk
8 adjustment scores or reinsurance amounts for the product or health
9 care service plan.

10 (B) Whether the consumer will be provided additional or more
11 comprehensive benefits.

12 (C) Whether the proposed product has a disproportional impact
13 on individuals with high health care needs.

14 (D) The anticipated impact on premiums.

15 (E) Whether the proposed product is otherwise consistent with
16 this chapter.

17 (5) If this product is approved or modified, the approved product
18 shall be posted.

19 (e)

20 (f) Nothing in this section shall prohibit a plan from offering
21 supplemental benefits for services that are not included in essential
22 health benefits as defined in Section 1367.005, including adult
23 dental, adult vision, acupuncture, or chiropractic, if the plan
24 demonstrates to the satisfaction of the director that those benefits
25 will not affect the risk adjustment scores or the reinsurance amounts
26 for the product or the plan. For a plan to continue to offer a
27 supplemental benefit, the plan shall annually provide to the
28 department information necessary to determine whether the benefit
29 has affected the risk mix in the prior plan year.

30 (f)

31 (g) "PPACA" means the federal Patient Protection and
32 Affordable Care Act (Public Law 111-148), as amended by the
33 federal Health Care and Education Reconciliation Act of 2010
34 (Public Law 111-152), and any rules, regulations, or guidance
35 issued thereunder.

36 SEC. 5. Section 1367.009 is added to the Health and Safety
37 Code, to read:

38 1367.009. (a) Levels of coverage for the nongrandfathered
39 small group market are defined as follows:

1 (1) Bronze level: A health care service plan contract in the
2 bronze level shall provide a level of coverage that is actuarially
3 equivalent to 60 percent of the full actuarial value of the benefits
4 provided under the plan contract.

5 (2) Silver level: A health care service plan contract in the silver
6 level shall provide a level of coverage that is actuarially equivalent
7 to 70 percent of the full actuarial value of the benefits provided
8 under the plan contract.

9 (3) Gold level: A health care service plan contract in the gold
10 level shall provide a level of coverage that is actuarially equivalent
11 to 80 percent of the full actuarial value of the benefits provided
12 under the plan contract.

13 (4) Platinum level: A health care service plan contract in the
14 platinum level shall provide a level of coverage that is actuarially
15 equivalent to 90 percent of the full actuarial value of the benefits
16 provided under the plan contract.

17 (b) Actuarial value for nongrandfathered small employer health
18 care service plan contracts shall be determined in accordance with
19 the following:

20 (1) Actuarial value shall not vary by more than plus or minus
21 2 percent.

22 (2) Actuarial value shall be determined on the basis of essential
23 health benefits as defined in Section 1367.005 and as provided to
24 a standard, nonelderly population. For this purpose, a standard
25 population shall not include those receiving coverage through the
26 Medi-Cal or Medicare programs.

27 (3) The department may use the actuarial value methodology
28 developed consistent with Section 1302(d) of PPACA.

29 (4) *The actuarial value for pediatric dental benefits, whether*
30 *offered by a full service plan or a specialized plan, shall be*
31 *consistent with federal law and guidance.*

32 ~~(4)~~

33 (5) The department, in consultation with the Department of
34 Insurance and the Exchange, shall consider whether to exercise
35 state-level flexibility with respect to the actuarial value calculator
36 in order to take into account the unique characteristics of the
37 California health care coverage market, including the prevalence
38 of health care service plans, total cost of care paid for by the plan,
39 price of care, patterns of service utilization, and relevant
40 demographic factors.

1 ~~(5)~~
 2 (6) Employer contributions toward health reimbursement
 3 accounts and health savings accounts shall count toward the
 4 actuarial value of the product in the manner specified in federal
 5 rules and guidance.

6 (c) For all products in the nongrandfathered small group market
 7 commencing January 1, 2015, any deductible shall apply to the
 8 same services for any product in the same level of coverage
 9 whether regulated by the department or the Department of
 10 Insurance.

11 (d) “PPACA” means the federal Patient Protection and
 12 Affordable Care Act (Public Law 111-148), as amended by the
 13 federal Health Care and Education Reconciliation Act of 2010
 14 (Public Law 111-152), and any rules, regulations, or guidance
 15 issued thereunder.

16 SEC. 6. Section 10112.28 is added to the Insurance Code, to
 17 read:

18 10112.28. (a) (1) For nongrandfathered products in the
 19 individual or small group markets, a health insurance policy, except
 20 a specialized health insurance policy, that is issued, amended, or
 21 renewed on or after January 1, 2014, shall provide for a limit on
 22 annual out-of-pocket expenses for all covered benefits that meet
 23 the definition of essential health benefits in paragraph (1) of
 24 subdivision (a) of Section 10112.27.

25 (2) For nongrandfathered products in the large group market, a
 26 health insurance policy, except a specialized health insurance
 27 policy, that is issued, amended, or renewed on or after January 1,
 28 2014, shall provide for a limit on annual out-of-pocket expenses
 29 for covered benefits, including out-of-network emergency care.
 30 *This limit shall apply to essential health benefits covered under*
 31 *the policy to the extent that this provision does not conflict with*
 32 *federal law or guidance on out-of-pocket maximums for*
 33 *nongrandfathered products in the large group market.* For large
 34 group products for the first plan year commencing on or after
 35 January 1, 2014, the requirement that a product provide for a limit
 36 on annual out-of-pocket expenses shall be satisfied if both of the
 37 following apply:

38 (A) The product complies with the requirements of this
 39 paragraph with respect to basic health care services.

1 (B) To the extent the product includes an out-of-pocket
2 maximum on coverage other than basic health care services, that
3 out-of-pocket maximum also does not exceed the limit established
4 pursuant to this paragraph.

5 (b) The limit described in subdivision (a) shall apply to any
6 copayment, coinsurance, deductible, incentive payment and any
7 other form of cost sharing for all covered benefits, including
8 nonformulary prescription drugs that are authorized as medically
9 necessary.

10 (c) The limit described in subdivision (a) shall not exceed the
11 limit described in Section 1302(c) of PPACA and any subsequent
12 rules, regulations, or guidance issued under that section.

13 (d) Nothing in this section shall be construed to affect the
14 reduction in cost sharing for eligible enrollees described in Section
15 1402 of PPACA and any subsequent rules, regulations, or guidance
16 issued under that section.

17 (e) *Effective January 1, 2015, if an essential health benefit is*
18 *offered by a specialized health insurance policy, this section shall*
19 *apply so that the total annual out-of-pocket maximum for all*
20 *essential benefits does not exceed the limit in this section. This*
21 *section shall not apply to a specialized policy that does not offer*
22 *an essential health benefit as defined in Section 1367.005.*

23 (e)

24 (f) “PPACA” means the federal Patient Protection and
25 Affordable Care Act (Public Law 111-148), as amended by the
26 federal Health Care and Education Reconciliation Act of 2010
27 (Public Law 111-152), and any rules, regulations, or guidance
28 issued thereunder.

29 SEC. 7. Section 10112.29 is added to the Insurance Code, to
30 read:

31 10112.29. (a) (1) For a small employer health insurance policy
32 offered, sold, or renewed on or after January 1, 2014, the deductible
33 under the policy shall not exceed:

34 (A) Two thousand dollars (\$2,000) in the case of a policy
35 covering a single individual.

36 (B) Four thousand dollars (\$4,000) in the case of any other
37 policy.

38 (2) The dollar amounts in this section shall be indexed consistent
39 with Section 1302(c)(2) of PPACA and any federal rules or
40 guidance pursuant to that section.

1 (3) The limitation in this subdivision shall be applied in a
2 manner that does not affect the actuarial value of any small
3 employer health insurance policy.

4 (4) For small group products at the bronze level of coverage,
5 as defined in Section 10112.295, the department may permit
6 insurers to offer a higher deductible in order to meet the actuarial
7 value requirement of the bronze level. In making this
8 determination, the department shall consider affordability of cost
9 sharing for insureds and shall also consider whether insureds may
10 be deterred from seeking appropriate care because of higher cost
11 sharing.

12 (b) Nothing in this section shall be construed to allow a policy
13 to have a deductible that applies to preventive services as defined
14 in PPACA.

15 (c) “PPACA” means the federal Patient Protection and
16 Affordable Care Act (Public Law 111-148), as amended by the
17 federal Health Care and Education Reconciliation Act of 2010
18 (Public Law 111-152), and any rules, regulations, or guidance
19 issued thereunder.

20 SEC. 8. Section 10112.295 is added to the Insurance Code, to
21 read:

22 10112.295. (a) Levels of coverage for the nongrandfathered
23 individual market are defined as follows:

24 (1) Bronze level: A health insurance policy in the bronze level
25 shall provide a level of coverage that is actuarially equivalent to
26 60 percent of the full actuarial value of the benefits provided under
27 the policy. ~~No product shall be offered at this level of coverage
28 unless it is a standardized product consistent with Section 10112.3.~~

29 (2) Silver level: A health insurance policy in the silver level
30 shall provide a level of coverage that is actuarially equivalent to
31 70 percent of the full actuarial value of the benefits provided under
32 the policy. ~~No product shall be offered at this level of coverage
33 unless it is a standardized product consistent with Section 10112.3.~~

34 (3) Gold level: A health insurance policy in the gold level shall
35 provide a level of coverage that is actuarially equivalent to 80
36 percent of the full actuarial value of the benefits provided under
37 the policy. ~~No product shall be offered at this level of coverage
38 unless it is a standardized product consistent with Section 10112.3.~~

39 (4) Platinum level: A health insurance policy in the platinum
40 level shall provide a level of coverage that is actuarially equivalent

1 to 90 percent of the full actuarial value of the benefits provided
2 under the policy. ~~No product shall be offered at this level of~~
3 ~~coverage unless it is a standardized product consistent with Section~~
4 ~~10112.3.~~

5 (b) Actuarial value for nongrandfathered individual health
6 insurance policies shall be determined in accordance with the
7 following:

8 (1) Actuarial value shall not vary by more than plus or minus
9 2 percent.

10 (2) Actuarial value shall be determined on the basis of essential
11 health benefits as defined in Section 10112.27 and as provided to
12 a standard, nonelderly population. For this purpose, a standard
13 population shall not include those receiving coverage through the
14 Medi-Cal or Medicare programs.

15 (3) The department may use the actuarial value methodology
16 developed consistent with Section 1302(d) of PPACA.

17 (4) *The actuarial value for pediatric dental benefits, whether*
18 *offered by a major medical policy or a specialized health insurance*
19 *policy, shall be consistent with federal law and guidance.*

20 ~~(4)~~

21 (5) The department, in consultation with the Department of
22 Managed Health Care and the Exchange, shall consider whether
23 to exercise state-level flexibility with respect to the actuarial value
24 calculator in order to take into account the unique characteristics
25 of the California health care coverage market, including the
26 prevalence of health insurance policies, total cost of care paid for
27 by the health insurer, price of care, patterns of service utilization,
28 and relevant demographic factors.

29 (c) For all products in the nongrandfathered individual market
30 commencing January 1, 2015, any deductible shall apply to the
31 same services for any product in the same level of coverage
32 whether regulated by the department or the Department of Managed
33 Health Care.

34 (d) (1) A catastrophic policy is a health insurance policy that
35 provides no benefits for any plan year until the insured has incurred
36 cost-sharing expenses in an amount equal to the annual limit on
37 out-of-pocket costs as specified in Section 10112.28 except that
38 it shall provide coverage for at least three primary care visits. ~~No~~
39 ~~product shall be offered at this level of coverage unless it is a~~
40 ~~standardized product consistent with Section 10112.3.~~ A carrier

1 that is not participating in the Exchange shall not offer, market, or
2 sell a catastrophic plan in the individual market.

3 (2) A catastrophic policy may be offered only in the individual
4 market and only if consistent with subdivision (c) and this
5 paragraph. Catastrophic policies may be offered only if either of
6 the following apply:

7 (A) The individual purchasing the policy has not yet attained
8 30 years of age.

9 (B) The individual has a certificate of exemption from Section
10 5000(A) of the Internal Revenue Code because the individual is
11 not offered affordable coverage or because the individual faces
12 hardship.

13 *(e) (1) Nongrandfathered products in the individual market*
14 *that are not standardized products as provided under Section*
15 *10112.3 shall be subject to review by the department consistent*
16 *with this subdivision prior to product approval. This section shall*
17 *also apply to carriers offering specialized health insurance policies*
18 *that provide coverage of an essential health benefit as defined in*
19 *Section 10112.27.*

20 *(2) The department shall publicly post information on*
21 *nonstandardized products no less than 60 days prior to the date*
22 *on which the product is approved by the department. For purposes*
23 *of products offered by the Exchange, the department shall post*
24 *nonstandardized products for review 60 days prior to the*
25 *finalization of any contract between the Exchange and the health*
26 *insurer or carrier offering a specialized health insurance policy.*

27 *(3) For each proposed product, the insurer shall provide to the*
28 *department all of the following:*

29 *(A) Information as to whether the product was proposed to the*
30 *Exchange and any written information from the Exchange as to*
31 *whether the product was approved, denied, or modified.*

32 *(B) The estimated actuarial value of the proposed product and*
33 *the actuarial value tier of the proposed product.*

34 *(C) The anticipated impact on risk mix of insureds purchasing*
35 *the proposed product, including information on the risk mix of*
36 *insureds purchasing the same or similar products in prior years.*

37 *(D) Any benefit to consumers, including the anticipated impacts*
38 *on premiums.*

39 *(4) The department shall review and take public comment on*
40 *the nonstandardized products with regard to all of the following:*

1 (A) Whether the proposed product is likely to affect the risk
2 adjustment scores or reinsurance amounts for the product or the
3 health insurance policy.

4 (B) Whether the consumer will be provided additional or more
5 comprehensive benefits.

6 (C) Whether the proposed product has a disproportional impact
7 on individuals with high health care needs.

8 (D) The anticipated impact on premiums.

9 (E) Whether the proposed product is otherwise consistent with
10 this chapter.

11 (5) If this product is approved or modified, the approved product
12 shall be posted.

13 (e)

14 (f) Nothing in this section shall prohibit an insurer *under a health*
15 *insurance policy* from offering supplemental benefits for services
16 that are not included in essential health benefits as defined in
17 paragraph (1) of subdivision (a) of Section 10112.27, including
18 adult dental, adult vision, acupuncture, or chiropractic, if the insurer
19 demonstrates to the satisfaction of the commissioner that those
20 benefits will not affect the risk adjustment scores or the reinsurance
21 amounts for the product or the policy. For an insurer to continue
22 to offer a supplemental benefit, the insurer shall annually provide
23 to the department information necessary to determine whether the
24 benefit has affected the risk mix in the prior policy year.

25 (f)

26 (g) “PPACA” means the federal Patient Protection and
27 Affordable Care Act (Public Law 111-148), as amended by the
28 federal Health Care and Education Reconciliation Act of 2010
29 (Public Law 111-152), and any rules, regulations, or guidance
30 issued thereunder.

31 SEC. 9. Section 10112.297 is added to the Insurance Code, to
32 read:

33 10112.297. (a) Levels of coverage for the nongrandfathered
34 small group market are defined as follows:

35 (1) Bronze level: A health insurance policy in the bronze level
36 shall provide a level of coverage that is actuarially equivalent to
37 60 percent of the full actuarial value of the benefits provided under
38 the policy.

39 (2) Silver level: A health insurance policy in the silver level
40 shall provide a level of coverage that is actuarially equivalent to

1 70 percent of the full actuarial value of the benefits provided under
2 the policy.

3 (3) Gold level: A health insurance policy in the gold level shall
4 provide a level of coverage that is actuarially equivalent to 80
5 percent of the full actuarial value of the benefits provided under
6 the policy.

7 (4) Platinum level: A health insurance policy in the platinum
8 level shall provide a level of coverage that is actuarially equivalent
9 to 90 percent of the full actuarial value of the benefits provided
10 under the policy.

11 (b) Actuarial value for nongrandfathered small employer health
12 insurance policies shall be determined in accordance with the
13 following:

14 (1) Actuarial value shall not vary by more than plus or minus
15 2 percent.

16 (2) Actuarial value shall be determined on the basis of essential
17 health benefits as defined in paragraph (1) of subdivision (a) of
18 Section 10112.27 and as provided to a standard, nonelderly
19 population. For this purpose, a standard population shall not include
20 those receiving coverage through the Medi-Cal or Medicare
21 programs.

22 (3) The department may use the actuarial value methodology
23 developed consistent with Section 1302(d) of PPACA.

24 (4) *The actuarial value for pediatric dental benefits, whether*
25 *offered by a major medical policy or a specialized health insurance*
26 *policy, shall be consistent with federal law and guidance.*

27 ~~(4)~~

28 (5) The department, in consultation with the Department of
29 Managed Health Care and the Exchange, shall consider whether
30 to exercise state-level flexibility with respect to the actuarial value
31 calculator in order to take into account the unique characteristics
32 of the California health care coverage market, including the
33 prevalence of health insurance policies, total cost of care paid for
34 by the health insurer, price of care, patterns of service utilization,
35 and relevant demographic factors.

36 ~~(5)~~

37 (6) Employer contributions toward health reimbursement
38 accounts and health savings accounts shall count toward the
39 actuarial value of the product in the manner specified in federal
40 rules and guidance.

1 (c) For all products in the nongrandfathered small group market
2 commencing January 1, 2015, any deductible shall apply to the
3 same services for any product in the same level of coverage
4 whether regulated by the department or the Department of Managed
5 Health Care.

6 (d) “PPACA” means the federal Patient Protection and
7 Affordable Care Act (Public Law 111-148), as amended by the
8 federal Health Care and Education Reconciliation Act of 2010
9 (Public Law 111-152), and any rules, regulations, or guidance
10 issued thereunder.

11 SEC. 10. Section 10112.7 is added to the Insurance Code, to
12 read:

13 10112.7. (a) A group or individual health insurance policy
14 issued, amended, or renewed on or after January 1, 2014, that
15 provides or covers any benefits with respect to services in an
16 emergency department of a hospital shall cover emergency services
17 as follows:

18 (1) Without the need for any prior authorization determination.

19 (2) Whether the health care provider furnishing the services is
20 a participating provider with respect to those services.

21 (3) In a manner so that, if the services are provided to an insured:

22 (A) By a nonparticipating health care provider with or without
23 prior authorization; or

24 (B) (i) The services will be provided without imposing any
25 requirement under the policy for prior authorization of services or
26 any limitation on coverage where the provider of services does
27 not have a contractual relationship with the insurer for the
28 providing of services that is more restrictive than the requirements
29 or limitations that apply to emergency department services received
30 from providers who do have such a contractual relationship with
31 the insurer; and

32 (ii) If the services are provided to an insured out-of-network,
33 the cost-sharing requirement, expressed as a copayment amount
34 or coinsurance rate, is the same requirement that would apply if
35 the services were provided in-network.

36 (b) For the purposes of this section, the term “emergency
37 services” means, with respect to an emergency medical condition:

38 (1) A medical screening examination that is within the capability
39 of the emergency department of a hospital, including ancillary

1 services routinely available to the emergency department to
2 evaluate that emergency medical condition.

3 (2) Within the capabilities of the staff and facilities available at
4 the hospital, further medical examination and treatment as are
5 required under Section 1867(e)(3) of the federal Social Security
6 Act (42 U.S.C. 1395dd(e)(3)) to stabilize the patient.

7 SEC. 11. No reimbursement is required by this act pursuant
8 to Section 6 of Article XIII B of the California Constitution because
9 the only costs that may be incurred by a local agency or school
10 district will be incurred because this act creates a new crime or
11 infraction, eliminates a crime or infraction, or changes the penalty
12 for a crime or infraction, within the meaning of Section 17556 of
13 the Government Code, or changes the definition of a crime within
14 the meaning of Section 6 of Article XIII B of the California
15 Constitution.

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