AMENDED IN SENATE MAY 31, 2016

AMENDED IN ASSEMBLY MAY 14, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1216

Introduced by Assembly Member Bonta

February 27, 2015

~~An act to amend Section 14100.3 of the Welfare and Institutions Code, relating to Medi-Cal.~~ *An act to amend Section 1367.006 of the Health and Safety Code, and to amend Section 10112.28 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1216, as amended, Bonta. ~~Medi-Cal: plan amendments and waiver applications.~~ *Limitations on cost sharing: family coverage.*

Existing federal law, the 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 specified forms of cost sharing, including deductibles, on all essential health benefits for nongrandfathered individual and group health insurance 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 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. Existing law requires a plan contract or policy and, commencing January 1, 2017, for a large group market health plan contract or policy, for family coverage that includes a deductible and is a high deductible health plan, as defined

in federal law, to include a deductible for each individual covered by the plan contract or policy that is equal to either the amount set forth in a specified provision of federal law or the deductible for individual coverage under the plan contract or policy, whichever is greater.

This bill would instead prohibit a large group market health plan contract or policy for family coverage that is a high deductible health plan, as defined in federal law, and that includes a deductible for individual coverage from subjecting an individual covered by the plan contract or policy to a deductible that is greater than the deductible for individual coverage under the plan contract or policy if the deductible for individual coverage is greater than or equal to the amount set forth in the provision of federal law described above. Because a willful violation of this prohibition by a health care service plan would be a crime, this 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.

~~Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law grants the department the rights and duties necessary to conform to requirements for securing approval of an agreement, or state plan, between the state and the federal government under Title XIX of the federal Social Security Act that describes the nature and scope of the Medi-Cal program. Existing law requires the department to seek approval from the federal Centers for Medicare and Medicaid Services (CMS) of any amendments to the state plan or a waiver from the requirements of the act for the purposes of continued federal financial participation under the act. Existing law requires the department to post on its Internet Web site all submitted state plan amendments and all federal waiver applications and requests for new waivers, waiver amendments, and waiver renewals and extensions, within 10 business days from the date of submission of those documents to CMS. Existing law requires the department to post on its Internet Web site all pending submitted state plan amendments~~

~~and federal waiver applications and requests that the department submitted to CMS in 2009 and every year thereafter.~~

~~This bill would instead require the department to post on its Internet Web Site all submitted state plan amendments and all federal waiver applications and requests for new waivers, waiver amendments, and waiver renewals and extensions within 7 business days from the date of submission, and would also require the department to post all pending submitted state plan amendments and federal waiver applications and requests. The bill would require the department to accept public comment on all state plan amendments and waivers, as specified, and would authorize use of information from the comments to make amendments to those documents.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Section 1367.006 of the Health and Safety Code is amended to read:

1367.006. (a) This section shall apply to nongrandfathered individual and group health care service plan contracts that provide coverage for essential health benefits, as defined in Section 1367.005, and that are issued, amended, or renewed on or after January 1, 2015.

(b) (1) For nongrandfathered health care service plan contracts in the individual or small group markets, 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, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 1367.005, including out-of-network emergency care consistent with Section 1371.4.

(2) For nongrandfathered health care service plan contracts in the large group market, 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, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care consistent with Section 1371.4. This limit shall only apply to essential health benefits, as defined in Section 1367.005, that are covered under the plan to

the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health care service plan contracts in the large group market.

(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA, and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(3) For family coverage, an individual within a family shall not have a maximum out-of-pocket limit that is greater than the maximum out-of-pocket limit for individual coverage for that product.

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

(e) If an essential health benefit is offered or provided by a specialized health care service plan, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health care service plan that does not offer an essential health benefit as defined in Section 1367.005.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits in Section 1367.005.

(g) (1) (A) Except as provided in paragraph (2), if a health care service plan contract for family coverage includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible limit for individual coverage for that product.

(B) Except as provided in paragraph (2), if a large group market health care service plan contract for family coverage that is issued, amended, or renewed on or after January 1, 2017, includes a deductible, an individual within a family shall not have a deductible

that is more than the deductible limit for individual coverage for that product.

(2) (A) ~~If~~ *For coverage in the individual and small group markets, if* a health care service plan contract for family coverage includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the plan contract shall include a deductible for each individual covered by the plan that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract, whichever is greater.

(B) If a large group market health care service plan contract for family coverage that is issued, amended, or renewed on or after January 1, 2017, ~~includes a deductible and~~ is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States ~~Code, the plan contract shall include a deductible for each individual covered by the plan that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the plan contract, whichever is greater.~~ *Code and includes a deductible for individual coverage that is equal to or greater than the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code and federal regulations thereunder, then no individual covered by the plan may be subject to a deductible greater than the deductible for individual coverage under the plan contract.*

(h) For nongrandfathered health plan contracts in the group market, "plan year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health plan contracts sold in the individual market, "plan year" means the calendar year.

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

SEC. 2. Section 10112.28 of the Insurance Code is amended to read:

10112.28. (a) This section shall apply to nongrandfathered individual and group health insurance policies that provide

coverage for essential health benefits, as defined in Section 10112.27, and that are issued, amended, or renewed on or after January 1, 2015.

(b) (1) For nongrandfathered health insurance policies in the individual or small group markets, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 10112.27, including out-of-network emergency care.

(2) For nongrandfathered health insurance policies in the large group market, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care. This limit shall apply only to essential health benefits, as defined in Section 10112.27, that are covered under the policy to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health insurance policies in the large group market.

(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits that shall equal the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(3) For family coverage, an individual within a family shall not have a maximum out-of-pocket limit that is greater than the maximum out-of-pocket limit for individual coverage for that product.

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

(e) If an essential health benefit is offered or provided by a specialized health insurance policy, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the

limit in subdivision (b). This section shall not apply to a specialized health insurance policy that does not offer an essential health benefit as defined in Section 10112.27.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.27.

(g) (1) (A) Except as provided in paragraph (2), if a health insurance policy for family coverage includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible limit for individual coverage for that product.

(B) Except as provided in paragraph (2), for a large group market health insurance policy for family coverage that is issued, amended, or renewed on or after January 1, 2017, includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible limit for individual coverage for that product.

(2) ~~(A) If~~ *For coverage in the individual and small group markets, if* a health insurance policy for family coverage includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the policy shall include a deductible for each individual covered by the policy that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the policy, whichever is greater.

~~(B) If~~

If a large group market health insurance policy for family coverage that is issued, amended, or renewed on or after January 1, 2017, ~~includes a deductible and~~ is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States ~~Code, the policy shall include a deductible for each individual covered by the policy that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the policy, whichever is greater.~~ *Code and includes a deductible for individual coverage that is equal to or greater than the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code and federal regulations thereunder, then no individual covered by the plan may be subject to a deductible greater than the deductible for individual coverage under the policy.*

(h) For nongrandfathered health insurance policies in the group market, "policy year" has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health insurance policies sold in the individual market, "policy year" means the calendar year.

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

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.

~~SECTION 1. Section 14100.3 of the Welfare and Institutions Code is amended to read:~~

~~14100.3. (a) (1) The State Department of Health Care Services shall post on its Internet Web site all submitted state plan amendments and all federal waiver applications and requests for new waivers, waiver amendments, and waiver renewals and extensions, within seven business days from the date the department submits these documents for approval to the federal Centers for Medicare and Medicaid Services (CMS).~~

~~(2) The department shall accept public comment on all submitted state plan amendments and all federal waiver applications and requests for new waivers, waiver amendments, and waiver renewals and extensions, for a period of 30 days from the date the department submits these documents for approval to CMS, and post the comments on the department's Internet Web site. The department shall not be required to respond to any comment submitted. However, the department may use any information provided in the comments to make amendments to any submitted state plan amendment or waiver, as the department deems necessary.~~

~~(b) The department shall post on its Internet Web site final approval or denial letters and accompanying documents for all submitted state plan amendments and federal waiver applications and requests within 10 business days from the date the department receives notification of final approval or denial from CMS.~~

~~(c) If the department notifies CMS of the withdrawal of a submitted state plan amendment or federal waiver application or request, as described in subdivisions (a) and (b), the department shall post on its Internet Web site the withdrawal notification within 10 business days from the date the department notifies CMS of the withdrawal.~~

~~(d) Unless already posted on the Internet Web site pursuant to subdivisions (a) to (c), inclusive, the department shall post on its Internet Web site all pending submitted state plan amendments and federal waiver applications and requests.~~

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