ASSEMBLY BILL No. 2281

Introduced by Assembly Member Chan

February 22, 2006

An act to add Sections 1346.2, 1374.19, 1374.195, and 1380.4 to the Health and Safety Code, and to add Chapter 2.7 (commencing with Section 10238) to Part 2 of Division 2, of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2281, as introduced, Chan. High deductible 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 and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, health care service plans and health insurers are required to comply with specified standards with regard to the benefits provided under their plan contracts and policies.

This bill would establish benefits standards and disclosure requirements for a high deductible health plan contract, as defined, offered by a health care service plan and for a high deductible health insurance policy, as defined, offered by a health insurer. The bill would require a plan and insurer to also offer a plan contract or a policy with a lower deductible and cost-sharing amount than allowed for high deductible products. The bill would also require the Director of Managed Health Care and the Insurance Commissioner to develop specified data elements before July 1, 2007, that a plan and an insurer would be required to report, respectively, to the director and

commissioner on or before January 1, 2008, and to develop a guide to high deductible products on or before July 1, 2007.

Because the bill would specify additional requirements for the operation of health care service plans, the willful violation of which would be a crime, it 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 1346.2 is added to the Health and Safety Code, to read:

1346.2. On or before July 1, 2007, the director shall develop, in conjunction with the Insurance Commissioner, a consumer guide on high deductible health plan contracts to assist consumers in evaluating competing products in the market and understanding their rights and responsibilities, including their rights under the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104-191), the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. Law 99-272), the California Continuation Benefits Replacement Act (Article 4.5 (commencing with Section 1366.20), and other applicable state and federal laws.

SEC. 2. Section 1374.19 is added to the Health and Safety Code, to read:

1374.19. (a) "High deductible health plan contract" means an individual or group plan contract, except for a specialized health care service plan contract, with an annual deductible of one thousand dollars ($1,000) or more for an individual or two thousand dollars ($2,000) or more for a family.

(b) Every high deductible health plan contract offered, delivered, amended, or renewed on or after July 1, 2007 shall contain the following provisions:

(1) A limitation on annual out-of-pocket expenses to not more than five thousand dollars ($5,000) for an individual or ten thousand dollars ($10,000) for a family. Out-of-pocket expenses include deductibles, copayments, coinsurance, and other amounts an enrollee or subscriber is required to pay, except for premium payments.

(2) Coverage for preventive care benefits without a deductible. For purposes of this section, preventive care includes, but is not limited to, the following:

(A) Periodic health evaluations, such as annual physicals and routine monitoring and management of chronic diseases, such as asthma, diabetes, hypertension, heart disease, and depression, and tests and diagnostic procedures ordered in connection with those evaluations.

(B) Routine prenatal and well-child care.

(C) Child and adult immunizations.

(D) Tobacco cessation programs.

(E) Obesity weight-loss programs.

(F) Screening services, including screening services for the following:

(i) Cancer.

(ii) Heart and vascular diseases.

(iii) Infectious diseases.

(iv) Mental health conditions.

(v) Substance abuse.

(vi) Metabolic, nutritional, and endocrine conditions.

(vii) Musculoskeletal disorders.

(viii) Obstetric and gynecological conditions.

(ix) Pediatric conditions.

(x) Vision and hearing disorders.

(3) If the health care service plan has negotiated and entered into a contract with providers to provide services at alternative rates of payment of the type described in Section 10133 of the Insurance Code, a requirement that the amount of any payment, copayment, or coinsurance paid by the enrollee or subscriber shall be calculated exclusively based on the negotiated rate for the service provided, even if the enrollee or subscriber is required to pay the negotiated rate for the service and this payment is counted toward satisfying the contract’s deductible amount.

(4) A limitation on the amount paid by an enrollee or subscriber for copayments and coinsurance to not more than 30 percent of the negotiated rate for the service furnished to the enrollee or subscriber. If the service is furnished by a provider who does not contract with the plan or by a participating provider who is not subject to a negotiated contract rate, the amount paid by an enrollee or subscriber for copayments and coinsurance shall be limited to not more than 30 percent of the plan's allowable rate for the service furnished to the enrollee or subscriber.

(c) A health care service plan shall make the following disclosures to enrollees and subscribers, and prospective enrollees and subscribers, regarding its high deductible health plan contract in addition to any other legally required notices or disclosures:

(1) The specific expenses and charges incurred by the enrollee or subscriber that count towards satisfying the deductible amount and a clear notice that the plan will not pay any amounts under the high deductible health plan contract until the enrollee or subscriber has incurred annual covered health care expenses in excess of the minimum annual deductible amount, except for amounts for preventive care benefits as described in subdivision (b).

(2) The method and process for tracking and calculating health care expenses that count toward satisfying the deductible amount, including any utilization review criteria, provider network requirements, allowable charges, or other limitations that will be used in determining whether expenses incurred by the enrollee or subscriber count toward satisfying the deductible amount.

(d) A health care service plan offering or selling a high deductible health plan contract shall make available to enrollees and subscribers, and prospective enrollees and subscribers, the following information:

(1) For comparison purposes, the rates and potential charges enrollees and subscribers can expect to pay participating and nonparticipating providers for services or procedures covered under the plan contract and that count toward satisfying the deductible amount, the quality ratings for the providers who are available to the enrollee and subscriber, and other information

that will assist them in selecting high quality, cost-effective providers.

(2) The ratio of the amount of prepaid or periodic charge revenue received by the plan to the amount it paid for health care services during its preceding fiscal year under the same high deductible health plan contract for both individual and group contracts. This information shall be included in all marketing materials for the high deductible health plan contract, including those transmitted in an electronic format, such as the health care service plan's Internet Web site or the Internet Web sites of solicitors or agents marketing the high deductible health plan contract.

(e) On at least a quarterly basis, and upon request by the subscriber or enrollee, the health care service plan shall provide information on the health care expenses incurred by the enrollee or subscriber that count toward satisfying the deductible amount under the high deductible health plan contract and the specific dollar amount remaining before the deductible amount is satisfied. Upon request by the enrollee or subscriber, the plan shall inform him or her of the total out-of-pocket costs incurred under the high deductible health plan contract to date in the current contract year.

(f) No health care service plan or provider entering into a contract to provide services to an enrollee or subscriber under a high deductible health plan contract shall charge or collect payments, copayments, or coinsurance amounts greater than those allowed under this section.

SEC. 3. Section 1374.195 is added to the Health and Safety Code, to read:

1374.195. At the time a health care service plan markets or sells a high deductible health plan contract, as defined in Section 1374.19, to an individual or group, the plan shall also offer to the individual or group a plan contract that provides comprehensive health care benefits with a deductible amount and an out-of-pocket cost-sharing amount that are less than the maximum deductible amount and maximum out-of-pocket cost-sharing amount allowed in Section 1374.19 for a high deductible health plan contract.

SEC. 4. Section 1380.4 is added to the Health and Safety Code, to read:

1380.4. On or before July 1, 2007, the director, in consultation with the Insurance Commissioner, health care service plans, providers, and consumer representatives, shall develop data elements on health care utilization by enrollees and the amount paid by enrollees for health care. On or before January 1, 2008, a health care service plan that markets and sells a high deductible plan contract shall annually report the data elements to the director for its high deductible health plan contracts and for its other plan contracts to facilitate analysis of the impact of high deductible health plan contracts on enrollees' access to health care, utilization of health care services, and health outcomes, such as preventable hospitalizations.

SEC. 5. Chapter 2.7 (commencing with Section 10238) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 2.7. HIGH DEDUCTIBLE HEALTH INSURANCE POLICIES

10238. This chapter applies to all health benefit plans, as defined in Section 10198.6, that provide hospital, medical, or surgical benefits to residents of this state regardless of the situs of the contract or group master policyholder.

10238.1. "High deductible health insurance policy" means an individual or group policy with an annual deductible of one thousand dollars ($1,000) or more for an individual or two thousand dollars ($2,000) or more for a family.

10238.2. Every high deductible health insurance policy offered, delivered, amended or renewed after July 1, 2007, shall contain the following provisions:

(a) A limitation on annual out-of-pocket expenses to not more than five thousand dollars ($5,000) for an individual or ten thousand dollars ($10,000) for a family. Out-of-pocket expenses include deductibles, copayments, coinsurance, and other amounts the insured is required to pay, except for premium payments.

(b) Coverage for preventive care benefits without a deductible. For purposes of this chapter, preventive care includes, but is not limited to, the following:

(1) Periodic health evaluations, such as annual physicals and routine monitoring and management of chronic diseases, such as asthma, diabetes, hypertension, heart disease, and depression and

tests and diagnostic procedures ordered in connection with those evaluations.

(2) Routine prenatal and well-child care.

(3) Child and adult immunizations.

(4) Tobacco cessation programs.

(5) Obesity weight-loss programs.

(6) Screening services, including screening services for the following:

(A) Cancer.

(B) Heart and vascular diseases.

(C) Infectious diseases.

(D) Mental health conditions.

(E) Substance abuse.

(F) Metabolic, nutritional, and endocrine conditions.

(G) Musculoskeletal disorders.

(H) Obstetric and gynecological conditions.

(I) Pediatric conditions.

(J) Vision and hearing disorders.

(c) If the insurer has negotiated and entered into a contract with providers to provide services at alternative rates of payment of the type described in Section 10133, a requirement that the amount of any payment, copayment, or coinsurance paid by the insured shall be calculated exclusively based on the negotiated rate for the service provided, even if full payment is the responsibility of the insured as expenses counted toward the policy's deductible amount.

(d) A limitation on the amount paid by the insured for copayments and coinsurance to not more than 30 percent of the negotiated rate for the service furnished to the insured. For a noncontracting provider, the amount of copayments and coinsurance paid by the insured shall be limited to not more than 30 percent of the insurer's allowable rate for the service furnished to the insured.

10238.3. A health insurer shall make the following disclosures to insureds and policyholders and prospective insureds and policyholders, regarding its high deductible health insurance policy in addition to any other legally required notices or disclosures:

(a) The specific expenses and charges incurred by the insured that count toward satisfying the deductible amount and a clear

notice that the insurer will not pay any amounts under the high deductible health insurance policy until the insured has incurred annual covered health care expenses in excess of the minimum annual deductible amount, except for amounts for preventive care benefits as described in Section 10238.2.

(b) The method and process for tracking and calculating health care expenses that count toward satisfying the deductible amount, including any utilization review criteria, provider network requirements, allowable charges, or other limitations that will be used in determining whether expenses incurred by the insured count toward satisfying the deductible amount.

10238.4. An insurer offering or selling high deductible health insurance policy shall make available to insureds and policyholders, and prospective insureds and policyholders, the following information:

(a) For comparison purposes, the rates and potential charges insureds can expect to pay contracting and noncontracting providers for services or procedures covered under the policy and that count toward satisfying the deductible amount, the quality ratings for the providers who are available to the insured and policyholder, and other information that will assist them in selecting high quality, cost-effective providers.

(b) The ratio of the amount of premium revenue received by the insurer to the amount it paid for health care services during its preceding fiscal year under the same high deductible health insurance policy for individual and group policies. This information shall be included in all marketing materials for the high deductible health insurance policy, including those transmitted in an electronic format, such as the insurer's Internet Web site or the Internet Web sites of solicitors or agents marketing and offering for sale the high deductible health insurance policy.

10238.5. On at least a quarterly basis, and upon request by the insured or policyholder, the health insurer shall provide information on the health care expenses incurred by the insured or policyholder that count toward satisfying the deductible amount under the high deductible health insurance policy and the specific dollar amount remaining before the deductible amount is satisfied. Upon request by the insured or policyholder, the health insurer shall inform him or her of the total out-of-pocket costs

incurred under the high deductible health insurance policy to date in the current policy year.

10238.6. No health insurer or provider entering into a contract to provide services to an insured under a high deductible health insurance policy shall charge or collect payments, copayments, or coinsurance amounts greater than those allowed under this chapter.

10239. At the time an insurer markets or sells a high deductible health insurance policy, as defined in Section 10238.1, to an individual or group, the insurer shall also offer to the individual or group a policy that provides comprehensive health care benefits with a deductible amount and an out-of-pocket cost-sharing amount that are less than the maximum deductible amount and the maximum out-of-pocket cost-sharing amount allowed in Sections 10238.1 and 10238.2 for a high deductible health insurance policy.

10239.1. On or before July 1, 2007, the commissioner, in consultation with the Director of Managed Health Care, health insurers, providers, and consumer representatives, shall develop data elements on health care utilization by insureds and the amount paid by insureds for health care. On or before January 1, 2008, a health insurer that markets and sells a high deductible health insurance policy shall annually report the data elements to the commissioner for its high deductible health insurance policies and for its other policies to facilitate analysis of the impact of high deductible health insurance policies on insureds' access to health care, utilization of health care services, and health outcomes, such as preventable hospitalizations.

10239.2. On or before July 1, 2007, the commissioner shall develop, in conjunction with the Director of Managed Health Care, a consumer guide on high deductible health insurance policies to assist consumers in evaluating competing products in the market and understanding their consumer rights and responsibilities, including their rights under the Health Insurance Portability and Accountability Act of 1996 (Pub. Law 104–191), the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. Law 99–272), the California Continuation Benefits Replacement Act (Article 1.7 (commencing with Section 10128.50) of Chapter 1), and other applicable state and federal laws.

SEC. 6. 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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