AMENDED IN SENATE APRIL 2, 2008

SENATE BILL No. 1522

Introduced by Senator Steinberg

February 22, 2008

An act to add Section 1399.819 to the Health and Safety Code, and to add Section 10903 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1522, as amended, Steinberg. Health care coverage: coverage choice categories.

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 health care service plans and health insurers that offer contracts or policies to individuals to comply with specified requirements.

This bill would require, by a specified date, the Department of Managed Health Care and the Department of Insurance to jointly, by regulation, develop a system to categorize all health care service plan contracts and health insurance policies offered and sold to individuals into ~~five~~ *5* coverage choice categories that meet specified requirements. *The bill would require individual health care service plan contracts and individual health insurance policies to contain a maximum limit on out-of-pocket costs for covered benefits.* The bill would require health care service plans and health insurers that offer coverage on an individual basis to offer at least one contract or policy in each coverage choice category. The bill would also require health care service plans

and health insurers to establish prices for the products offered to individuals that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. *The bill would require the director and the commissioner to annually report on the contracts and policies offered in each coverage choice category and on the enrollment in those contracts and policies. The bill would also require, commencing January 1, 2012, and every 3 years thereafter, the director and the commissioner to jointly determine whether the coverage choice categories should be revised to meet the needs of consumers.* The bill would enact other related provisions.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

SECTION 1. Section 1399.819 is added to the Health and Safety Code, to read:

1399.819. (a) On or before April 1, 2009, the department and the Department of Insurance shall jointly, by regulation, develop a system to categorize all health care service plan contracts and health insurance policies offered and sold to individuals pursuant to this article and Chapter 9.5 (commencing with Section 10900) of Part 2 of Division 2 of the Insurance Code into five coverage choice categories. These coverage choice categories shall do all of the following:

(1) Reflect a reasonable continuum between the coverage choice category with the lowest level of health care benefits and the coverage choice category with the highest level of health care benefits.

(2) Permit reasonable benefit variation ~~that will allow for a diverse market~~ within each coverage choice category.

(3) Be enforced consistently between health care service plans and health insurers in the same marketplace regardless of licensure.

(4) Within each coverage choice category, include one standard health maintenance organization (HMO) and one standard preferred provider organization (PPO), each of which is the health care service plan contract or health insurance policy with the lowest benefit level in that category and for that type of contract or policy.

(b) All health care service plan contracts offered or sold to individuals on or after January 1, 2009, shall contain a maximum limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits.

~~(b)~~

(c) All health care service plans shall submit filings ~~required pursuant to Section ___~~ no later than October 1, 2009, for all individual health care service plan contracts to be offered or sold on or after ~~___, to comply with ___~~ *that date*, and thereafter any additional individual health care plan contracts shall be filed ~~pursuant to Section ___~~ *with the department*. The director shall categorize each individual health care service plan contract offered by a plan into the appropriate coverage choice category ~~on or before ___~~ *within 90 days of the date the contract is filed pursuant to this section. A health care service plan shall not offer or sell an individual health care service plan contract until the director has categorized the contract pursuant to this subdivision*.

~~(c)~~

(d) To facilitate consumer comparison shopping, all health care service plans that offer coverage on an individual basis shall offer at least one health care service plan contract in each coverage choice category, including offering at least one of the standard contracts developed pursuant to paragraph (4) of subdivision (a), but a plan may offer multiple products in each category.

~~(d)~~

(e) If a health care service plan offers a specific type of health care service plan contract in one coverage choice category, it must offer that specific type of health care service plan contract in each coverage choice category. A "type of health care service plan contract" includes a preferred provider organization, an exclusive

provider organization model plan, a point of service model plan, and a health maintenance organization model plan.

~~(e)~~

(f) Health care service plans shall have flexibility in establishing provider networks, provided that access to care standards pursuant to this chapter are met, and provided that the provider network offered for one health care service plan contract in one coverage choice category is offered for at least one health care service plan contract in each coverage choice category.

~~(f)~~

(g) A health care service plan shall establish prices for its products that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. A health care service plan shall not establish a standard risk rate for a product in a coverage choice category at a lower rate than a product offered in a lower coverage choice category.

(h) The director shall annually report on the health care service plan contracts offered by plans in each coverage choice category pursuant to this section and on the enrollment in those contracts within each coverage choice category. Commencing January 1, 2012, and every three years thereafter, the director and the Insurance Commissioner shall jointly determine whether the coverage choice categories should be revised to meet the needs of consumers.

SEC. 2. Section 10903 is added to the Insurance Code, to read:

10903. (a) On or before April 1, 2009, the department and the Department of Managed Health Care shall jointly, by regulation, develop a system to categorize all health insurance policies and health care service plan contracts offered and sold to individuals pursuant to this chapter and Article 11.5 (commencing with Section 1399.801) of Chapter 2.2 of Division 2 of the Health and Safety Code into five coverage choice categories. These coverage choice categories shall do all of the following:

(1) Reflect a reasonable continuum between the coverage choice category with the lowest level of health care benefits and the coverage choice category with the highest level of health care benefits.

(2) Permit reasonable benefit variation ~~that will allow for a diverse market~~ within each coverage choice category.

(3) Be enforced consistently between carriers and health care service plans in the same marketplace regardless of licensure.

(4) Within each coverage choice category, include one standard preferred provider organization (PPO), which is the health insurance policy or health care service plan contract with the lowest benefit level in that category and for that type of policy or contract.

(b) All health insurance policies offered or sold to individuals on or after January 1, 2009, shall contain a maximum limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits.

~~(b)~~

(c) All carriers shall submit the filings ~~required pursuant to Section ___~~ no later than October 1, 2009, for all individual health insurance policies to be sold on or after ~~___, to comply with ___~~ *that date,* and thereafter any additional individual health insurance policies shall be filed ~~pursuant to Section ___~~ *with the commissioner*. The commissioner shall categorize each individual health insurance policy offered by a carrier into the appropriate coverage choice category ~~on or before ___~~ *within 90 days of the date the policy is filed pursuant to this section. A carrier shall not offer or sell an individual health insurance policy until the commissioner has categorized the policy pursuant to this subdivision*.

~~(c)~~

(d) To facilitate consumer comparison shopping, all carriers that offer coverage on an individual basis shall offer at least one individual health insurance policy in each coverage choice category, including offering at least one of the standard policies developed pursuant to paragraph (4) of subdivision (a), but a carrier may offer multiple products in each category.

~~(d)~~

(e) If a carrier offers a specific type of health insurance policy in one coverage choice category, it must offer that specific type of health insurance policy in each coverage choice category. A "type of health insurance policy" includes a health maintenance organization model, a preferred provider organization model, an exclusive provider organization model, a traditional indemnity model, and a point of service model.

~~(e)~~

(f) Carriers shall have flexibility in establishing provider networks, provided that access to care standards pursuant to Section 10133.5 are met, and provided that the provider network offered for one health benefit plan in one coverage choice category is offered for at least one health benefit plan in each coverage choice category.

~~(f)~~

(g) A carrier shall establish prices for its products that reflect a reasonable continuum between the products offered in the coverage choice category with the lowest level of benefits and the products offered in the coverage choice category with the highest level of benefits. A carrier shall not establish a standard risk rate for a product in a coverage choice category at a lower rate than a product offered in a lower coverage choice category.

(h) The commissioner shall annually report on the health insurance policies offered by carriers in each coverage choice category pursuant to this section and on the enrollment in those policies within each coverage choice category. Commencing January 1, 2012, and every three years thereafter, the commissioner and the Director of Managed Health Care shall jointly determine whether the coverage choice categories should be revised to meet the needs of consumers.

(i) All health insurance policies offered and sold to individuals on or after January 1, 2009, shall cover physicians, hospitals, and preventive services, and shall, at a minimum, meet existing coverage requirements.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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