AB 1453 (Monning) – Essential Health Benefits

Introduced January 5, 2012, Amended April 17, 2012

This bill sets minimum standards for "essential health benefits" (EHB)s in California in response to guidance from the federal Health and Human Services Agency guidance issued pursuant to the federal Patient Protection and Affordable Care Act (ACA). The author indicates that with this guidance in mind, the choice of the benchmark plan is based on the following principles:

a) Recognition of the importance of existing state mandated benefits and incorporation of as many state mandates as possible.

b) Protection of California's commitment to reproductive services.

c) Embracing the consumer oriented regulatory framework in place at the DMHC.

d) Maintaining affordability for consumers.

Through a process of comparison to these principles, other available plan choices were eliminated and the Kaiser Small Group HMO was chosen.

The author believes, based on the information available, the Kaiser Small Group HMO represents the best benchmark plan choice for Californians. The Kaiser Small Group HMO covers all of California's mandates and includes vision exams. The contract covers reproductive services, is licensed at DMHC as a Knox-Keene plan with corresponding consumer protections, and while the cost differentials among all of the options are not significant, this plan falls in the middle.

AMENDED IN ASSEMBLY APRIL 17, 2012

AMENDED IN ASSEMBLY MARCH 29, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1453

Introduced by Assembly Member Monning

January 5, 2012

An act to add Section 1367.005 to the Health and Safety Code, and to add Section 10112.27 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1453, as amended, Monning. Essential health benefits.

Commencing January 1, 2014, existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides the essential health benefits package. Existing state law creates the California Health Benefit Exchange (the Exchange) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.

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 plan contracts and health insurance policies to cover various benefits.

This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the benefits and services covered by particular plans. The bill would specify that this provision applies regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that it does not apply to grandfathered plans or plans that offer excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, issuing, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill.

Because a willful violation of the bill's provisions 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:

SECTION 1. The Legislature hereby finds and declares the following:

(a) Commencing January 1, 2014, the federal Patient Protection and Affordable Care Act (PPACA) requires a health insurance issuer that offers coverage to small employers or individuals, both inside and outside of an American Health Benefit Exchange, with the exception of grandfathered plans, to provide minimum coverage that includes essential health benefits, as defined.

(b) It is the intent of the Legislature to comply with federal law and consistently implement the essential health benefits provisions

of PPACA and related federal guidance and regulations, by adopting the uniform minimum essential benefits requirement in state-regulated health care coverage regardless of whether the policy or contract is regulated by the Department of Managed Health Care or the Department of Insurance and regardless of whether the policy or contract is offered to individuals or small employers inside or outside of the California Health Benefit Exchange.

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

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) (A) The benefits and services covered by the Kaiser Small Group HMO plan contract (product number 40513CA035) as ~~of December 31, 2011,~~ *this contract was offered during the first quarter of 2012,* including, but not limited to, all of the following:

(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric vision care.

~~(ii) The items and services covered by the plan contract within the following categories: acupuncture services, chiropractic services, skilled nursing facility services, hospice care, bariatric surgery, nonsevere mental illness services, substance abuse services, smoking cessation counseling, alcoholism treatment, applied behavior analysis therapy for autism, smoking cessation drugs, pain medication for terminally ill patients, rehabilitative services, habilitative, physical, and occupational therapy, speech therapy, orthotics and prosthetics, prosthetic devices for laryngectomy, special footwear for persons suffering from foot disfigurement, surgically implanted hearing devices, home health~~

~~services, HIV/AIDS services, osteoporosis services, and diabetes education.~~

(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.

(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the plan contract identified in subparagraph (A).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the plan contract covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(3) With respect to pediatric oral care *and pediatric vision care*, the same services and benefits for pediatric oral care *and pediatric vision care* covered under the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012*. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the FEHB as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012.*

(4) Any other benefits required to be covered under this chapter.

(b) When offering, issuing, selling, or marketing a health care service plan contract, a health care service plan shall not indicate or imply that the plan contract covers essential health benefits unless the plan contract covers essential health benefits as defined in this section.

(c) This section shall apply regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(d) A plan contract subject to this section shall also comply with Section 1367.001.

(e) This section shall not be construed to prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(f) Subdivision (a) shall not apply to any of the following:

(1) A plan contract that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).

(2) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA.

(g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.

(h) For purposes of this section, the following definitions shall apply:

(1) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living.

(2) "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.

(3) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.

SEC. 3. Section 10112.27 is added to the Insurance Code, to read:

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) (A) The benefits and services covered by the Kaiser Small Group HMO plan contract (product number 40513CA035) as ~~of December 31, 2011~~, *this contract was offered during the first quarter of 2012,* including, but not limited to, all of the following:

(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric vision care.

~~(ii) The items and services covered by the plan contract within the following categories: acupuncture services, chiropractic services, skilled nursing facility services, hospice care, bariatric surgery, nonsevere mental illness services, substance abuse services, smoking cessation counseling, alcoholism treatment, applied behavior analysis therapy for autism, smoking cessation drugs, pain medication for terminally ill patients, rehabilitative services, habilitative, physical, and occupational therapy, speech therapy, orthotics and prosthetics, prosthetic devices for laryngectomy, special footwear for persons suffering from foot disfigurement, surgically implanted hearing devices, home health services, HIV/AIDS services, osteoporosis services, and diabetes education.~~

(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.

(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the health care service plan contract identified in subparagraph (A).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the policy covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(3) With respect to pediatric oral care *and pediatric vision care*, the same services and benefits for pediatric oral care *and pediatric vision care* covered under the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of~~

~~December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012.* Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the FEHB as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012.*

(4) Any other benefits required to be covered under this part.

(b) When offering, issuing, selling, or marketing a health insurance policy, a health insurer shall not indicate or imply that the policy covers essential health benefits unless the policy covers essential health benefits as defined in this section.

(c) This section shall apply regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(d) A health insurance policy subject to this section shall also comply with Section 10112.1.

(e) This section shall not be construed to prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(f) Subdivision (a) shall not apply to any of the following:

(1) A policy that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).

(2) A health insurance policy that qualifies as a grandfathered health plan under Section 1251 of PPACA.

(g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.

(h) For purposes of this section, the following definitions shall apply:

(1) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living.

(2) "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.

(3) "Small group health insurance policy" means a group health insurance policy issued to a small employer, as defined in Section 10700.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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SB 951 (Hernandez) – Health Care Coverage: Essential Health Benefits

Introduced January 5, 2012, Amended April 16, 2012

Effective January 1, 2014, federal law requires Medicaid benchmark and benchmark-equivalent plans, plans sold through the American Health Benefit Exchange and the Basic Health Program (if enacted), and health plans and health insurers providing coverage to individuals and small employers to ensure coverage of essential health benefits (EHBs), as defined by the Secretary of the Department of Health and Human Services (HHS). HHS is required to ensure that the scope of EHBs is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.

Existing federal law:

1) Requires, under the federal Patient Protection and Affordable Care Act (ACA), health plans and health insurers that offer coverage in the small group or individual market to ensure that coverage includes the (EHB) package.

2) Requires each state, by January 1, 2014, to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers.

Existing state law:

1) Establishes the Department of Managed Health Care (DMHC) to license and regulate health care service plans (health plans) and establishes the Department of Insurance to provide for the regulation of health insurers.

2) Requires health plan contracts and health insurance policies to cover various benefits.

3) Establishes the California Health Benefit Exchange to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.

This bill:

1) Requires individual and small group health plans and health insurance policy contracts, both inside and outside of the American Health Benefit Exchange, to cover EHBs, as defined.

2) Defines EHBs as the benefits and services covered by Kaiser Small Group HMO, including the categories identified in the ACA.

3) Requires the services and benefits to be covered to the extent they are medically necessary, and prohibits the scope and duration limits from exceeding the scope and duration limits imposed on those services by the plan contract.

4) Requires habilitative services to be provided for the same services as the plan contract provides for rehabilitative services and under the same terms and conditions of the plan contract for rehabilitative services.

5) Requires the same services and benefits for pediatric oral care as provided by a specified federal plan to be provided as an EHB.

6) Prohibits plans from indicating or implying a contract or policy meets the EHB standard unless it covers EHBs, as defined.

7) Exempts self-insured group health plans, large group market health plans, or grandfathered health plans.

AMENDED IN SENATE APRIL 16, 2012

AMENDED IN SENATE MARCH 26, 2012

SENATE BILL No. 951

Introduced by Senator Hernandez

January 5, 2012

An act to add Section 1367.005 to the Health and Safety Code, and to add Section 10112.27 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 951, as amended, Hernandez. Health care coverage: essential health benefits.

Commencing January 1, 2014, existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health insurance issuer that offers coverage in the small group or individual market to ensure that such coverage includes the essential health benefits package, as defined. PPACA requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers. PPACA defines a qualified health plan as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange (the Exchange) to facilitate the purchase of qualified health plans by qualified individuals and qualified small employers by January 1, 2014.

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 plan contracts and health insurance policies to cover various benefits.

This bill would require an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, to cover essential health benefits, which would be defined to include the benefits and services covered by particular plans. The bill would specify that this provision applies regardless of whether the contract or policy is offered inside or outside the Exchange but would provide that it does not apply to grandfathered plans or plans that offer excepted benefits, as specified. The bill would prohibit a health care service plan or health insurer, when offering, issuing, selling, or marketing a plan contract or policy, from indicating or implying that the contract or policy covers essential health benefits unless the contract or policy covers essential health benefits as provided in the bill.

Because a willful violation of the bill's provisions 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:

SECTION 1. The Legislature hereby finds and declares the following:

(a) Commencing January 1, 2014, the federal Patient Protection and Affordable Care Act (PPACA) requires a health insurance issuer that offers coverage to small employers or individuals, both inside and outside of the California Health Benefit Exchange, with the exception of grandfathered plans, to provide minimum coverage that includes essential health benefits, as defined.

(b) It is the intent of the Legislature to comply with federal law and consistently implement the essential health benefits provisions of PPACA and related federal guidance and regulations, by adopting the uniform minimum essential benefits requirement in

state-regulated health care coverage regardless of whether the policy or contract is regulated by the Department of Managed Health Care or the Department of Insurance and regardless of whether the policy or contract is offered to individuals or small employers inside or outside of the California Health Benefit Exchange.

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

1367.005. (a) An individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) (A) The benefits and services covered by the Kaiser ~~Small~~ *Foundation Health Plan* Group HMO *thirty-dollar ($30) deductible* plan contract ~~(product~~ *(federal health product identification* number 40513CA035) as ~~of December 31, 2011,~~ *this contract was offered during the first quarter of 2012,* including, but not limited to, all of the following:

(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric *services, including oral and* vision care.

~~(ii) The items and services covered by the plan contract within the following categories: acupuncture services, chiropractic services, skilled nursing facility services, hospice care, bariatric surgery, nonsevere mental illness services, substance abuse services, smoking cessation counseling, alcoholism treatment, applied behavior analysis therapy for autism, smoking cessation drugs, pain medication for terminally ill patients, rehabilitative services, habilitative, physical, and occupational therapy, speech therapy, orthotics and prosthetics, prosthetic devices for laryngectomy, special footwear for persons suffering from foot disfigurement, surgically implanted hearing devices, home health~~

~~services, HIV/AIDS services, osteoporosis services, and diabetes education.~~

(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.

(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the plan contract identified in subparagraph (A).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the plan contract covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

(3) With respect to pediatric oral care *and pediatric vision care*, the same services and benefits for pediatric oral care *and pediatric vision care* covered under the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012.* Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the FEHB as of December 31, 2011.~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric oral and vision care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental, orthodontic, or vision services covered under the plan contract identified in paragraph (1).*

(4) Any other benefits required to be covered under this chapter.

~~(d)~~

(b) When offering, issuing, selling, or marketing a health care service plan contract, a health care service plan shall not indicate or imply that the plan contract covers essential health benefits

unless the plan contract covers essential health benefits as defined in this section.

~~(e)~~

(c) This section shall apply regardless of whether the plan contract is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

~~(f)~~

(d) A plan contract subject to this section shall also comply with Section 1367.001.

~~(g)~~

(e) This section shall not be construed to prohibit a plan contract from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

~~(h)~~

(f) Subdivision (a) shall not apply to any of the following:

(1) A plan contract that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).

(2) A plan contract that qualifies as a grandfathered health plan under Section 1251 of PPACA.

~~(i)~~

(g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.

~~(j)~~

(h) For purposes of this section, the following definitions shall apply:

(1) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living.

(2) "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.

(3) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.

SEC. 3. Section 10112.27 is added to the Insurance Code, to read:

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2014, shall, at a minimum, include coverage for essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) (A) The benefits and services covered by the Kaiser ~~Small~~ *Foundation Health Plan* Group HMO *thirty-dollar ($30) deductible* plan contract ~~(product~~ *(federal health product identification* number 40513CA035) as ~~of December 31, 2011~~ *this contract was offered during the first quarter of 2012*, including, but not limited to, all of the following:

(i) The items and services covered by the plan contract within the categories identified in subsection (b) of Section 1302 of PPACA, including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric *services, including oral and* vision care.

~~(ii) The items and services covered by the plan contract within the following categories: acupuncture services, chiropractic services, skilled nursing facility services, hospice care, bariatric surgery, nonsevere mental illness services, substance abuse services, smoking cessation counseling, alcoholism treatment, applied behavior analysis therapy for autism, smoking cessation drugs, pain medication for terminally ill patients, rehabilitative services, habilitative, physical, and occupational therapy, speech therapy, orthotics and prosthetics, prosthetic devices for laryngectomy, special footwear for persons suffering from foot disfigurement, surgically implanted hearing devices, home health services, HIV/AIDS services, osteoporosis services, and diabetes education.~~

(ii) Mandated benefits pursuant to statutes enacted before December 31, 2011.

(B) The services and benefits described in this paragraph shall be covered to the extent they are medically necessary. Scope and duration limits imposed on the services and benefits described in

this paragraph shall be no greater than the scope and duration limits imposed on those services and benefits by the health care service plan contract identified in subparagraph (A).

(2) With respect to habilitative services, in addition to any habilitative services identified in paragraph (1), the same services as the policy covers for rehabilitative services. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(3) With respect to pediatric oral care *and pediatric vision care*, the same services and benefits for pediatric oral care *and pediatric vision care* covered under the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the Federal Employees Health Benefit Plan (FEHB) as of December 31, 2011~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012.* Scope and duration limits imposed on the services and benefits described in this paragraph shall be no greater than the scope and duration limitations imposed on those benefits by the ~~federal Blue Cross and Blue Shield Standard Option Service Benefit Plan available to enrollees through the FEHB as of December 31, 2011.~~ *Federal Employees Dental and Vision Insurance Program dental plan and vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric oral and vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental, orthodontic, or vision services covered under the plan contract identified in paragraph (1).*

(4) Any other benefits required to be covered under this chapter.

~~(d)~~

(b) When offering, issuing, selling, or marketing a health insurance policy, a health insurer shall not indicate or imply that the policy covers essential health benefits unless the policy covers essential health benefits as defined in this section.

~~(e)~~

(c) This section shall apply regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

~~(f)~~

(d) A health insurance policy subject to this section shall also comply with Section 10112.1.

~~(g)~~

(e) This section shall not be construed to prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

~~(h)~~

(f) Subdivision (a) shall not apply to any of the following:

(1) A policy that provides excepted benefits as described in Section 2722 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA.

~~(i)~~

(g) This section shall be implemented only to the extent that federal law or policy does not require the state to defray the costs of benefits included within the definition of essential health benefits under this section.

~~(j)~~

(h) For purposes of this section, the following definitions shall apply:

(1) "Habilitative services" means health care services that help a person keep, learn, or improve skills and functioning for daily living.

(2) "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.

(3) "Small group health insurance policy" means a group health care service insurance policy issued to a small employer, as defined in Section 10700.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

O

SB 961 (Hernandez) – Individual Health Care Coverage

Introduced January 10, 2012, Amended April 9, 2012

This bill reforms California's individual market in accordance with federal health care reform and applies its provisions to health plans and disability insurers in the individual market; requires guaranteed issue of individual market health plans and health insurance policies; prohibits the use of preexisting conditions provisions; establishes open and special enrollment periods consistent with the California Health Benefit Exchange (Exchange); prohibits conditioning the issuance or offering based on specified discriminatory factors; prohibits specified marketing and solicitation practices consistent with small group requirements; requires guaranteed renewability of plans and permits rating factors based on age, geographic region and family size only.

AMENDED IN SENATE APRIL 9, 2012

SENATE BILL **No. 961**

Introduced by Senator Hernandez
(Principal coauthor: Assembly Member Monning)

January 10, 2012

An act to ~~add Section 1374.59 to the Health and Safety Code, relating to health care service plans~~ *amend Sections 1357.51 and 1399.829 of, to amend the heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of, to add Section 1399.836 to, to add Article 11.8 (commencing with Section 1399.845) to Chapter 2.2 of Division 2 of, and to repeal Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 10198.7 and 10954 of, to amend the heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, to add Section 10961 to, to add Chapter 9.8 (commencing with Section 10965) to Part 2 of Division 2 of, and to repeal Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of, the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

SB 961, as amended, Hernandez. ~~Health care service plans.~~ *Individual health care coverage.*

Existing 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 requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for that coverage and to renew that coverage at the option of the plan sponsor or the individual. PPACA

prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage. PPACA allows the premium rate charge by a health insurance issuer offering small group or individual coverage to vary only by family composition, rating area, age, and tobacco use, as specified, and prohibits discrimination against individuals based on health status.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the ~~licensing~~ *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 ~~licensing and~~ regulation of health insurers by the Insurance Commissioner. ~~The California Health Benefit Exchange is governed by a board and the board is required to facilitate enrollment of qualified individuals in qualified health plans.~~ *Existing law requires plans and insurers offering coverage in the individual market to offer coverage for a child subject to specified requirements.*

This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2014, from imposing any preexisting condition provision upon any individual, except as specified. The bill would require a plan or insurer, on and after January 1, 2014, to offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals in each service area in which the plan provides or arranges for the provision of health care services, but would require plans and insurers to limit enrollment to specified open enrollment and special enrollment periods. Commencing January 1, 2014, the bill would prohibit a plan or insurer from conditioning the issuance or offering of individual health benefit plans on any health status-related factor, as specified, and would authorize plans and insurers to use only age, geographic region, and family size for purposes of establishing rates for individual health benefit plans. The bill would enact other related provisions and make related conforming changes.

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

~~Existing federal law, the federal Patient Protection and Affordable Care Act, commencing on and after January 1, 2014, requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and~~

~~individual in the state that applies for that coverage and requires the issuer to renew that coverage. Existing federal law, commencing on and after January 1, 2014, prohibits discriminatory premium rates charged by a health insurance issuer for health insurance coverage offered in the individual or small group market, as specified, and also prohibits discrimination against individuals based on health status. Existing federal law, commencing on and after January 1, 2014, except as otherwise specified, prohibits a group health plan and a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition exclusion with respect to that plan or coverage.~~

~~This bill would, to the extent required by federal law, require a health care service plan contract to comply with these federal requirements. The bill would require the department to consult and coordinate with the commissioner and the Exchange in carrying out these provisions.~~

~~Because a willful violation of these provisions would constitute 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 1357.51 of the Health and Safety Code is amended to read:

1357.51. (a) No plan contract that covers three or more enrollees shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No plan contract that covers one or two individuals shall exclude coverage on the basis of a preexisting condition provision

for a period greater than 12 months following the individual's effective date of coverage, nor shall the plan limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in plan contracts may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a plan contract for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age. *A plan contract for group coverage issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.*

(2) Notwithstanding subdivision (b), a plan contract for individual coverage that is not a grandfathered health plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (P.L. 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age. *A plan contract for individual coverage that is issued, amended, or renewed on or after January 1, 2014, and that is not a grandfathered health plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any individual.*

(d) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the plan is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) A plan that does not utilize a preexisting condition provision in plan contracts that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No plan may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in plan contracts may relate only to conditions for which

medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any enrollee, a plan shall credit the time the enrollee was covered under creditable coverage, provided that the enrollee becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting or affiliation period.

However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.

(g) No plan shall exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No plan shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(h) A health care service plan issuing group coverage may not impose a preexisting condition exclusion upon a condition relating to benefits for pregnancy or maternity care.

(i) An individual's period of creditable coverage shall be certified pursuant to subsection (e) of Section 2701 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec. 300gg(e)).

SEC. 2. The heading of Article 11.7 (commencing with Section 1399.825) of Chapter 2.2 of Division 2 of the Health and Safety Code is amended to read:

Article 11.7. ~~Individual~~ *Child* Access to Health Care Coverage

SEC. 3. Section 1399.829 of the Health and Safety Code is amended to read:

1399.829. (a) A health care service plan may use the following characteristics of an eligible child for purposes of establishing the rate of the plan contract for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health care service plan contract selected by the child or the responsible party for the child.

(b) From the effective date of this article to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with any health care service plan or health insurer for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a health care service plan may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health care service plan contract issued, sold, or renewed prior to December 31, 2013, the health plan shall provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the

premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial open enrollment period shall be deemed to have maintained coverage during that period.

~~(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.~~

~~(f)~~

(e) Health care service plans may require documentation from applicants relating to their coverage history.

SEC. 4. Section 1399.836 is added to the Health and Safety Code, to read:

1399.836. This article shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 5. Article 11.8 (commencing with Section 1399.845) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 11.8. Individual Access to Health Care Coverage

1399.845. For purposes of this article, the following definitions shall apply:

(a) "Dependent" means the spouse or child of an individual, subject to applicable terms of the health benefit plan.

(b) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(c) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(d) "Health benefit plan" means any individual or group health insurance policy or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile

medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(e) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any subsequent rules or regulations issued pursuant to that law.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of PPACA.

(h) "Rating period" means the period for which premium rates established by a plan are in effect.

1399.847. Every health care service plan offering individual health benefit plans shall, in addition to complying with the provisions of this chapter and rules adopted thereunder, comply with the provisions of this article.

1399.849. (a) (1) On and after January 1, 2014, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health benefit plans that are sold in the individual market to all individuals in each service area in which the plan provides or arranges for the provision of health care services. A plan shall limit enrollment to open enrollment periods and special enrollment periods as provided in subdivisions (c) and (d).

(2) A plan that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraph (1) with respect to an individual health benefit plan offered through the Exchange in those geographic regions in which the plan offers health benefit plans through the Exchange.

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.

(c) A plan shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual

enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.

(d) Subject to subdivision (e), a plan shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(1) He or she loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

(A) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(B) "Loss of minimum essential coverage" includes loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations. "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to Section 1389.21.

(2) He or she gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.

(3) He or she becomes a resident of California.

(4) He or she is mandated to be covered pursuant to a valid state or federal court order.

(5) With respect to individual health benefit plans offered through the Exchange, the individual meets any of the requirements listed in Section 155.420(d)(3) of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 63 days from the date of a triggering event identified in subdivision (d) to apply for coverage from a health care service plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 63 days from the date of a triggering event to select a plan offered through the Exchange.

(f) (1) With respect to individual health benefit plans offered outside the Exchange, after an individual submits a completed application form for a plan, the health care service plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with

Section 1399.855. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the initial open enrollment period described in subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014, except that coverage for an individual under 19 years of age shall, at the option of the subscriber, become effective as required under Section 1399.826. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of

the month, coverage under the plan shall become effective no later than the first day of the following month.

(B) When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(C) Notwithstanding subparagraph (A) or (B), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(D) Notwithstanding subparagraph (A) or (B), in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the following month.

(5) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage selected pursuant to this section shall be the same as the applicable date specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(g) On or after January 1, 2014, a health care service plan shall not condition the issuance or offering of an individual health benefit plan on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

(h) A health care service plan offering coverage in the individual market shall not reject the request of a subscriber during an open enrollment period to include a dependent of the subscriber as a dependent on an existing individual health benefit plan that provides dependent coverage.

(i) This section shall not apply to a grandfathered health plan.

1399.851. (a) Commencing January 1, 2014, no health care service plan or solicitor shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct an individual to refrain from filing an application for individual coverage with a plan because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the individual.

(2) Encourage or direct an individual to seek individual coverage from another plan or health insurer or the California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the plan's approved service area, of the individual.

(b) Commencing January 1, 2014, a health care service plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

(c) This section shall not apply to a grandfathered health plan.

1399.853. (a) All individual health benefit plans shall conform to the requirements of Sections 1365, 1366.3, 1367.001, and 1373.6, and shall be renewable at the option of the enrollee except as permitted to be canceled, rescinded, or not renewed pursuant to Section 1365.

(b) Any plan that ceases to offer for sale new individual health benefit plans pursuant to Section 1365 shall continue to be governed by this article with respect to business conducted under this article.

1399.855. (a) With respect to individual health benefit plans issued, amended, or renewed on or after January 1, 2014, a health care service plan may use only the following characteristics of an individual, and any dependent thereof, for purposes of establishing the rate of the individual health benefit plan covering the individual

and the eligible dependents thereof, along with the health benefit plan selected by the individual:

(1) Age, as described in regulations adopted by the department in conjunction with the Department of Insurance that do not prevent the application of PPACA. Rates based on age shall be determined based on the individual's birthday and shall not vary by more than three to one for adults.

(2) Geographic region. With respect to the 2014 plan year, the geographic regions for purposes of rating shall be the same as those used by a health benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code). For subsequent plan years, the geographic regions for purposes of rating shall be determined by the Exchange in consultation with the department, the Department of Insurance, and other private and public purchasers of health care coverage.

(3) Family size, as described in PPACA.

(b) The rate for a health benefit plan subject to this section shall not vary by any factor not described in this section.

(c) The rating period for rates subject to this section shall be no less than 12 months.

(d) This section shall not apply to a grandfathered health plan.

1399.857. A health care service plan shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to this article in the case of any of the following:

(a) To an individual who does not work or reside within the plan's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual because of its obligations to existing enrollees.

(2) A health care service plan that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a health benefit plan in the area in which the plan is not offering coverage to individuals to new

employer groups until the plan notifies the director that it has the ability to deliver services to individuals, and certifies to the director that from the date of the notice it will enroll all individuals requesting coverage in that area from the plan.

(3) Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity has become impaired.

1399.859. The director may require a health care service plan to discontinue the offering of individual health benefit plans or acceptance of applications from any individual upon a determination by the director that the plan does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375.1), and the rules adopted under those provisions.

SEC. 6. Section 10198.7 of the Insurance Code is amended to read:

10198.7. (a) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No health benefit plan that covers one or two individuals and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any

other entity shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a health benefit plan for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age. *A health benefit plan for group coverage issued, amended, or renewed on or after January 1, 2014, shall not impose any preexisting condition provision upon any individual.*

(2) Notwithstanding subdivision (b), a health benefit plan for individual coverage that is *not* a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age. *A health benefit plan for individual coverage that is issued, amended, or renewed on or after January 1, 2014, and that is not a grandfathered health plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any individual.*

(d) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) A carrier that does not utilize a preexisting condition provision in health plans that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No carrier may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition

provision contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any person, all health benefit plans shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A health benefit plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any affiliation or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated or, an employer's contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period.

(g) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(h) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act, 42 U.S.C. Sec. 300gg(e).

(i) A group health benefit plan may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

(j) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

SEC. 7. The heading of Chapter 9.7 (commencing with Section 10950) of Part 2 of Division 2 of the Insurance Code is amended to read:

CHAPTER 9.7. ~~INDIVIDUAL~~ *CHILD* ACCESS TO HEALTH INSURANCE

SEC. 8. Section 10954 of the Insurance Code is amended to read:

10954. (a) A carrier may use the following characteristics of an eligible child for purposes of establishing the rate of the health benefit plan for that child, where consistent with federal regulations under PPACA: age, geographic region, and family composition, plus the health benefit plan selected by the child or the responsible party for a child.

(b) From the effective date of this chapter to December 31, 2013, inclusive, rates for a child applying for coverage shall be subject to the following limitations:

(1) During any open enrollment period or for late enrollees, the rate for any child due to health status shall not be more than two times the standard risk rate for a child.

(2) The rate for a child shall be subject to a 20-percent surcharge above the highest allowable rate on a child applying for coverage who is not a late enrollee and who failed to maintain coverage with any carrier or health care service plan for the 90-day period prior to the date of the child's application. The surcharge shall apply for the 12-month period following the effective date of the child's coverage.

(3) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a carrier may rate a child based on health status during any period other than an open enrollment period if the child is not a late enrollee.

(4) If expressly permitted under PPACA and any rules, regulations, or guidance issued pursuant to that act, a carrier may condition an offer or acceptance of coverage on any preexisting condition or other health status-related factor for a period other than an open enrollment period and for a child who is not a late enrollee.

(c) For any individual health benefit plan issued, sold, or renewed prior to December 31, 2013, the carrier shall provide to a child or responsible party for a child a notice that states the following:

"Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now."

(d) A child who applied for coverage between September 23, 2010, and the end of the initial enrollment period shall be deemed to have maintained coverage during that period.

~~(e) Effective January 1, 2014, except for individual grandfathered health plan coverage, the rate for any child shall be identical to the standard risk rate.~~

~~(f)~~

(e) Carriers may require documentation from applicants relating to their coverage history.

SEC. 9. Section 10961 is added to the Insurance Code, to read:

10961. This chapter shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

SEC. 10. Chapter 9.8 (commencing with Section 10965) is added to Part 2 of Division 2 of the Insurance Code, to read:

CHAPTER 9.8. INDIVIDUAL ACCESS TO HEALTH INSURANCE

10965. For purposes of this chapter, the following definitions shall apply:

(a) "Dependent" means the spouse or child of an individual, subject to applicable terms of the health benefit plan.

(b) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

(c) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(d) "Health benefit plan" means any individual or group health insurance policy or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(e) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any subsequent rules or regulations issued pursuant to that law.

(f) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) "Qualified health plan" has the same meaning as that term is defined in Section 1301 of PPACA.

(h) "Rating period" means the period for which premium rates established by an insurer are in effect.

10965.1. Every health insurer offering individual health benefit plans shall, in addition to complying with the provisions of this part and rules adopted thereunder, comply with the provisions of this chapter.

10965.3. (a) (1) On and after January 1, 2014, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's health benefit plans that are sold in the individual market to all individuals in each service area in which the insurer provides or arranges for the provision of health care services. An

insurer shall limit enrollment to open enrollment periods and special enrollment periods as provided in subdivisions (c) and (d).

(2) A health insurer that offers qualified health plans through the Exchange shall be deemed to be in compliance with paragraph (1) with respect to an individual health benefit plan offered through the Exchange in those geographic regions in which the insurer offers health benefit plans through the Exchange.

(b) An individual health benefit plan issued, amended, or renewed shall not impose any preexisting condition provision upon any individual.

(c) A health insurer shall provide an initial open enrollment period from October 1, 2013, to March 31, 2014, inclusive, and annual enrollment periods for plan years on or after January 1, 2015, from October 15 to December 7, inclusive, of the preceding calendar year.

(d) Subject to subdivision (e), a health insurer shall allow an individual to enroll in or change individual health benefit plans as a result of the following triggering events:

(1) He or she loses minimum essential coverage. For purposes of this paragraph, both of the following definitions shall apply:

(A) "Minimum essential coverage" has the same meaning as that term is defined in subsection (f) of Section 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

(B) "Loss of minimum essential coverage" includes loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations. "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission, subject to Section 10384.17.

(2) He or she gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption.

(3) He or she becomes a California resident.

(4) He or she is mandated to be covered pursuant to a valid state or federal court order.

(5) With respect to individual health benefit plans offered through the Exchange, the individual meets any of the requirements listed in Section 155.420(d)(3) of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 63 days from the date of a triggering event identified in subdivision (d) to apply for coverage from a health benefit plan subject to this section. With respect to individual health benefit plans offered through the Exchange, an individual shall have 63 days from the date of a triggering event to select a plan offered through the Exchange.

(f) (1) With respect to individual health benefit plans offered outside the Exchange, after an individual submits a completed application form for a plan, the insurer shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 10965.9. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the initial open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014, except that coverage for an individual under 19 years of age shall, at the option of the policyholder, become effective as required under Section 10951. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, and December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during the annual open enrollment period described in subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15, coverage shall become effective as of the following January 1. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day

of the following month. When that payment is delivered or postmarked between December 16 and December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan offered outside the Exchange for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month.

(B) When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(C) Notwithstanding subparagraph (A) or (B), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(D) Notwithstanding subparagraph (A) or (B), in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the following month.

(5) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage selected pursuant to this section shall be the same as the applicable date specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations.

(g) On or after January 1, 2014, a health insurer shall not condition the issuance or offering of an individual health benefit plan on any of the following factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(9) Any other health status-related factor as determined by department.

(h) A health insurer offering coverage in the individual market shall not reject the request of a policyholder during an open enrollment period to include a dependent of the policyholder as a dependent on an existing individual health benefit plan that provides dependent coverage.

(i) This section shall not apply to a grandfathered health plan.

10965.5. (a) Commencing January 1, 2014, no health insurer or agent or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct an individual to refrain from filing an application for individual coverage with an insurer because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the insurer's approved service area, of the individual.

(2) Encourage or direct an individual to seek individual coverage from another health care service plan or health insurer or the California Health Benefit Exchange because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the insurer's approved service area, of the individual.

(b) Commencing January 1, 2014, a health insurer shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a broker or agent that provides for or results in the compensation paid to a broker or agent for the sale of an individual health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision does not apply to a compensation arrangement that provides compensation to a broker or agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.

(c) This section shall not apply to a grandfathered health plan.

10965.7. (a) All individual health benefit plans shall conform to the requirements of Sections 10112.1, 10127.18, 10273.4, and

12682.1, and shall be renewable at the option of the insured except as permitted to be canceled, rescinded, or not renewed pursuant to Section 10273.4.

(b) Any insurer that ceases to offer for sale new individual health benefit plans pursuant to Section 10273.4 shall continue to be governed by this chapter with respect to business conducted under this chapter.

10965.9. (a) With respect to individual health benefit plans issued, amended, or renewed on or after January 1, 2014, a health insurer may use only the following characteristics of an individual, and any dependent thereof, for purposes of establishing the rate of the individual health benefit plan covering the individual and the eligible dependents thereof, along with the health benefit plan selected by the individual:

(1) Age, as described in regulations adopted by the department in conjunction with the Department of Managed Health Care that do not prevent the application of PPACA. Rates based on age shall be determined based on the individual's birthday and shall not vary by more than three to one for adults.

(2) Geographic region. With respect to the 2014 plan year, the geographic regions for purposes of rating shall be the same as those used by a health benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code). For subsequent plan years, the geographic regions for purposes of rating shall be determined by the Exchange in consultation with the department, the Department of Managed Health Care, and other private and public purchasers of health care coverage.

(3) Family size, as described in PPACA.

(b) The rate for a health benefit plan subject to this section shall not vary by any factor not described in this section.

(c) The rating period for rates subject to this section shall be no less than 12 months.

(d) This section shall not apply to a grandfathered health plan.

10965.11. A health insurer shall not be required to offer an individual health benefit plan or accept applications for the plan pursuant to this chapter in the case of any of the following:

(a) To an individual who does not work or reside within the insurer's approved service areas.

(b) (1) Within a specific service area or portion of a service area, if the insurer reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have sufficient health care delivery resources to ensure that health care services will be available and accessible to the individual because of its obligations to existing insureds.

(2) A health insurer that cannot offer an individual health benefit plan to individuals because it is lacking in sufficient health care delivery resources within a service area or a portion of a service area may not offer a health benefit plan in the area in which the insurer is not offering coverage to individuals to new employer groups until the insurer notifies the commissioner that it has the ability to deliver services to individuals, and certifies to the commissioner that from the date of the notice it will enroll all individuals requesting coverage in that area from the insurer.

(3) Nothing in this chapter shall be construed to limit the commissioner's authority to develop and implement a plan of rehabilitation for a health insurer whose financial viability or organizational and administrative capacity has become impaired.

10965.13. The commissioner may require a health insurer to discontinue the offering of individual health benefit plans or acceptance of applications from any individual upon a determination by the commissioner that the insurer does not have sufficient financial viability or organizational and administrative capacity to ensure the delivery of health care services to its insureds. In determining whether the conditions of this section have been met, the commissioner shall consider, but not be limited to, the insurer's compliance with the requirements of this part and the rules adopted under those provisions.

~~SECTION 1. Section 1374.59 is added to the Health and Safety Code, to read:~~

~~1374.59. (a) To the extent required by federal law, every health care service plan contract, except a specialized health care service plan contract, shall comply with the following provisions related to the offer, sale, issuance, and renewal of health care service plan contracts, consistent with federal law and implementing rules, regulations, and federal guidance:~~

~~(1) Guaranteed availability of coverage pursuant to Section 2702 of the Public Health Service Act (42 U.S.C. Sec. 300gg-1).~~

~~(2) Guaranteed renewability of coverage pursuant to Section 2703 of the Public Health Service Act (42 U.S.C. Sec. 300gg-2).~~

~~(3) The portability and nondiscrimination provisions in Sections 2701, 2704, and 2705 of the Public Health Service Act (42 U.S.C. Secs. 300gg, 300gg-3, and 300gg-4).~~

~~(b) The department shall consult and coordinate with the Insurance Commissioner in the implementation and enforcement of this section to ensure uniform and consistent rules, regulations, guidance, and enforcement for health care service plans sold to individuals in this state.~~

~~(c) In implementing this section, the department shall, in addition to the requirements in subdivision (b), consult and coordinate with the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.~~

~~SEC. 2.~~

SEC. 11. 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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AB 154 (Beall) – Health Care Coverage: Mental Health Services

Introduced January 18, 2011, Amended January 23, 2012

Requires health plans and health insurers to cover the diagnosis and medically necessary treatment of a mental illness, as defined, of a person of any age, with specified exceptions, and not limited to coverage for severe mental illness (SMI) as in existing law. Specifically, this bill:

1) Requires health plans and those health insurance policies that provide coverage for hospital, medical, or surgical expenses, to provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions, including but not limited to maximum lifetime benefits, copayments, and individual and family deductibles. Existing law only requires such coverage for SMIs, as defined.

2) Defines mental illness as a mental disorder classified in the Diagnostic and Statistical Manual IV (DSM-IV) and includes coverage for substance abuse. Requires the benefits provided under this bill to include outpatient services; inpatient hospital services; partial hospital services; and, prescription drugs, if the plan contract already includes coverage for prescription drugs.

3) Excludes treatment of nicotine addiction and certain illnesses under the "V" code designation in the DSM-IV, such as adult antisocial behavior and bereavement, among others, from the definition in 2) above.

4) Requires, following publication of each subsequent volume of the DSM-IV, the definition of "mental illness" to be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the DSM-IV.

5) Requires any revision to the definition of "mental illness" pursuant to 4) above to be established by regulation promulgated jointly by the Department of Managed Health Care (DMHC) and the Department of Insurance.

6) Allows a health plan or health insurer to provide coverage for all or part of the mental health coverage required by this bill through a specialized health care service plan or mental health plan and prohibits the health plan or health insurer from being required to obtain an additional or specialized license for this purpose.

7) Requires a health plan or health insurer to provide the mental health coverage required by this bill in its entire service area and in emergency situations, as specified.

8) Permits a health plan and health insurer to utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other share-of-cost requirements, to the extent allowed by law or regulation, in the provision of benefits required by this bill.

9) Clarifies that nothing in this bill shall be construed to deny or restrict in any way DMHC's authority to ensure a health plan's compliance with this bill when the plan provides prescription drug coverage.

10) Clarifies that, with regard to health insurance policies, any action a health insurer takes to implement this bill, including, but not limited to, contracting with preferred provider organizations, shall not be deemed as an action that would otherwise require licensure as a health care service plan, as specified.

11) Exempts contracts between the Department of Health Care Services and a health plan for enrolled Medi-Cal beneficiaries and plans administered by Managed Risk Medical Insurance Board from the provisions of this bill.

12) Prohibits a health care benefit plan, contract, or health insurance policy with the Board of Administration of the Public Employees' Retirement System from applying to this bill unless board elects to purchase a plan, contract, or policy that provides mental health benefits mandated under this bill.

13) Exempts accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only plans or insurance policies, except behavioral health-only policies, from the provisions of this bill.

14) Prohibits this bill from being deemed to require a qualified health plan that participates in the California Health Benefit Exchange to provide any greater coverage than is required under the minimum essential benefits package set forth in the federal Patient Protection and Affordable Care Act (PPACA).

According to the author, individuals struggling with mental illness quickly exhaust limited coverage and personal savings and become dependent upon taxpayer-supported benefits. The author notes that annual national costs for mental illness are an estimated $23 billion in lost work days to employers and another $150 billion in treatment, social services, and lost productivity. The author maintains that many people in our society with mental illness and substance abuse problems are unable to obtain treatment and, as a result, wind up in counties' indigent health care pool, emergency rooms, and state and county jails. This bill is intended to end discrimination against patients with mental health/substance abuse (MH/SA) issues by requiring treatment and coverage of these illnesses that is equitable to coverage provided for other medical illnesses. Since SMI services are already covered under current law, this bill focuses on the incremental effect of extending parity to non-SMI and substance abuse disorders, with certain exceptions.

AMENDED IN ASSEMBLY JANUARY 23, 2012

AMENDED IN ASSEMBLY MARCH 24, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 154

Introduced by Assembly Member Beall
(Coauthors: Assembly Members Ammiano and Dickinson)

January 18, 2011

An act to add Section 22856 to the Government Code, to add Section ~~1374.74~~ *1374.76* to the Health and Safety Code, and to add Section 10144.8 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as amended, Beall. Health care coverage: mental health services.

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, a health care service plan contract and a health insurance policy are required to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age. Existing law does not define *the term* "severe mental illnesses" for this purpose but describes it as including several conditions.

This bill would expand this coverage requirement for certain health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, ~~2012~~ *2013*, to include the diagnosis and treatment of a mental illness of a person of any age and

would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV *(DSM-IV)*, including substance abuse but excluding nicotine dependence and specified diagnoses defined in the manual, subject to regulatory revision, as specified. The bill would specify that this requirement does not apply to a health care benefit plan, contract, or health insurance policy with the Board of Administration of the Public Employees' Retirement System unless the board elects to purchase a plan, contract, or policy that provides mental health coverage.

This bill would also exempt certain health care service contracts entered into by the Managed Risk Medical Insurance Board from its provisions.

Because this bill would expand coverage requirements for 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 22856 is added to the Government Code, to read:

22856. The board may purchase a health care benefit plan or contract or a health insurance policy that includes mental health coverage as described in Section ~~1374.74~~ *1374.76* of the Health and Safety Code or Section 10144.8 of the Insurance Code.

SEC. 2. Section ~~1374.74~~ *1374.76* is added to the Health and Safety Code, *immediately following Section 1374.74,* to read:

~~1374.74.~~

1374.76. (a) A health care service plan contract issued, amended, or renewed on or after January 1, ~~2012~~ *2013*, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions

as specified in subdivision (c) of Section 1374.72. The benefits provided under this section shall include all those set forth in subdivision (b) of Section 1374.72.

(b) (1) "Mental illness" for the purposes of this section means a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV *(DSM-IV)*, published by the American Psychiatric Association, and includes substance abuse, but excludes treatment of the following diagnoses, all as defined in the manual:

(A) Noncompliance With Treatment (V15.81).
(B) Partner Relational Problem (V61.1).
(C) Physical/Sexual Abuse of an Adult (V61.12).
(D) Parent-Child Relational Problem (V61.20).
(E) Child Neglect (V61.21).
(F) Physical/Sexual Abuse of a Child (V61.21).
(G) Sibling Relational Problem (V61.8).
(H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).
(I) Occupational Problem (V62.29).
(J) Academic Problem (V62.3).
(K) Acculturation Problem (V62.4).
(L) Relational Problems (V62.81).
(M) Bereavement (V62.82).
(N) Physical/Sexual Abuse of an Adult (V62.83).
(O) Borderline Intellectual Functioning (V62.89).
(P) Phase of Life Problem (V62.89).
(Q) Religious or Spiritual Problem (V62.89).
(R) Malingering (V65.2).
(S) Adult Antisocial Behavior (V71.01).
(T) Child or Adolescent Antisocial Behavior (V71.02).
(U) There is not a Diagnosis or a Condition on Axis I (V71.09).
(V) There is not a Diagnosis on Axis II (V71.09).
(W) Nicotine Dependence (305.10).

(2) Following publication of each subsequent volume of the manual, the definition of "mental illness" shall be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the manual.

(3) Any revision to the definition of "mental illness" pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Insurance.

(c) (1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan and shall not be required to obtain an additional or specialized license for this purpose.

(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) In the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, copayments, or other cost sharing to the extent permitted by law or regulation.

(d) Nothing in this section shall be construed to deny or restrict in any way the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription drugs.

(e) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(f) This section shall not apply to a health care benefit plan or contract entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) unless the board elects, pursuant to Section 22856 of the Government Code, to purchase a health care benefit plan or contract that provides mental health coverage as described in this section.

(g) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only health care service plan contracts.

(h) This section shall not apply to contracts between the Managed Risk Medical Insurance Board and health care service plans pursuant to the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of the Insurance Code) or the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of the Insurance Code).

SEC. 3. Section 10144.8 is added to the Insurance Code, to read:

10144.8. (a) A policy of health insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after January 1, ~~2012~~ *2013*, shall provide coverage for the diagnosis and medically necessary treatment of a mental illness of a person of any age, including a child, under the same terms and conditions applied to other medical conditions as specified in subdivision (c) of Section 10144.5. The benefits provided under this section shall include all those set forth in subdivision (b) of Section 10144.5.

(b) (1) "Mental illness" for the purposes of this section means a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV *(DSM-IV)*, published by the American Psychiatric Association, and includes substance abuse, but excludes treatment of the following diagnoses, all as defined in the manual:

(A) Noncompliance With Treatment (V15.81).
(B) Partner Relational Problem (V61.1).
(C) Physical/Sexual Abuse of an Adult (V61.12).
(D) Parent-Child Relational Problem (V61.20).
(E) Child Neglect (V61.21).
(F) Physical/Sexual Abuse of a Child (V61.21).
(G) Sibling Relational Problem (V61.8).
(H) Relational Problem Related to a Mental Disorder or General Medical Condition (V61.9).
(I) Occupational Problem (V62.29).
(J) Academic Problem (V62.3).
(K) Acculturation Problem (V62.4).
(L) Relational Problems (V62.81).
(M) Bereavement (V62.82).
(N) Physical/Sexual Abuse of an Adult (V62.83).
(O) Borderline Intellectual Functioning (V62.89).
(P) Phase of Life Problem (V62.89).
(Q) Religious or Spiritual Problem (V62.89).

(R) Malingering (V65.2).
(S) Adult Antisocial Behavior (V71.01).
(T) Child or Adolescent Antisocial Behavior (V71.02).
(U) There is not a Diagnosis or a Condition on Axis I (V71.09).
(V) There is not a Diagnosis on Axis II (V71.09).
(W) Nicotine Dependence (305.10).

(2) Following publication of each subsequent volume of the manual, the definition of "mental illness" shall be subject to revision to conform to, in whole or in part, the list of mental disorders defined in the then-current volume of the manual.

(3) Any revision to the definition of "mental illness" pursuant to paragraph (2) shall be established by regulation promulgated jointly by the department and the Department of Managed Health Care.

(c) (1) For the purpose of compliance with this section, a health insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan and shall not be required to obtain an additional or specialized license for this purpose.

(2) A health insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health insurers are not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) In the provision of benefits required by this section, a health insurer may utilize case management, managed care, or utilization review to the extent permitted by law or regulation.

(4) Any action that a health insurer takes to implement this section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(d) This section shall not apply to accident-only, specified disease, hospital indemnity, or Medicare supplement insurance policies, or specialized health insurance policies, except behavioral health-only policies.

(e) This section shall not apply to a policy of health insurance purchased by the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) unless the board elects, pursuant to Section 22856 of the Government Code, to purchase a policy of health insurance that covers mental health services as described in this section.

SEC. 4. This act shall not be deemed to require a qualified health plan that participates in the California Health Benefit Exchange to provide any greater coverage than is required pursuant to the minimum essential benefits package, as set forth in Section 1311 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 5. 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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