**SENATE RULES COMMITTEE** SB 639
Office of Senate Floor Analyses
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THIRD READING

Bill No: SB 639
Author: Hernandez (D)
Amended: 5/28/13
Vote: 21

SENATE HEALTH COMMITTEE: 6-2, 4/17/13
AYES: Hernandez, Beall, De León, DeSaulnier, Monning, Wolk
NOES: Anderson, Nielsen
NO VOTE RECORDED: Pavley

SENATE APPROPRIATIONS COMMITTEE: 5-2, 5/23/13
AYES: De León, Hill, Lara, Padilla, Steinberg
NOES: Walters, Gaines

**SUBJECT:** Health care coverage

**SOURCE:** Health Access California

**DIGEST:** This bill implements provisions of the federal Patient Protection and Affordable Care Act (ACA) by requiring health plans and carriers to provide for maximum out-of-pocket limits, establishes small group deductibles, and defines the precious metal tiers level of coverage required. Prohibits any product from being offered other than those with a standardized product design in the individual market.

**ANALYSIS:** Existing federal law:

1. Establishes the ACA, which imposes various requirements, some of which take effect on January 1, 2014, on states, carriers, employers, and individuals regarding health care coverage.

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2. Establishes annual limits on deductibles for employer-sponsored plans and defines levels of coverage for non-grandfathered individual and small group markets known as bronze, silver, gold, and platinum.

3. Defines "grandfathered plan" as any group or individual health insurance product that was in effect on March 23, 2010.

4. Establishes essential health benefits (EHB) to be provided in the small group and individual market.

5. Requires a health insurance issuer offering group or individual coverage that provides emergency services to cover emergency services without the need for prior authorization and at the same cost sharing requirements as a participating provider regardless of whether that provider is a participating provider.

Existing state law:

1. Provides for regulation of health insurers by the Department of Insurance (CDI) under the Insurance Code and provides for the regulation of health plans by the Department of Managed Health Care (DMHC) pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). Collectively referred to as carriers.

2. Establishes the California Health Benefits Exchange (Covered California) to facilitate the purchase of qualified health plans (QHPs) through Covered California by qualified individuals and qualified small employers by January 1, 2014.

3. Designates the Kaiser Small Group HMO as California's benchmark plan to serve as the EHB standard, as required by the ACA.

This bill:

1. Requires non-grandfathered products in the individual or small group markets to provide a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of EHBs and requires non-grandfathered products in the large group market to provide a limit on annual out-of-pocket expenses for all covered benefits, including out-of-network emergency care. Establishes an exception for the first plan year commencing on January 1, 2014 for large group products.

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2. Requires the limit on annual out-of-pocket expenses to apply to any copayment, coinsurance, deductible, incentive payment, and any other form of cost sharing for all covered benefits, including prescription drugs.

3. Prohibits products in the small group market from having a deductible that exceeds $2,000 for a single individual or $4,000 all other cases.

4. Allows plans in the small group market to offer products at the bronze level of coverage, described in #5, with a higher deductible than described in #3.

5. Defines levels of coverage for the non-grandfathered individual and small group markets to be the following:

   A. Bronze level: Actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan contract.

   B. Silver level: Actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan contract.

   C. Gold level: Actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan contract.

   D. Platinum level: Actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan contract.

6. Prohibits a non-grandfathered product in the individual market from being offered at any of the levels described above unless it is a standardized product.

7. Defines actuarial value to be determined based on EHBs and as provided to a standard, non-elderly population, and does not include those receiving coverage through Medi-Cal or Medicare programs. Prohibits the actuarial value from varying by more than plus or minus 2%.

8. Allows DMHC and CDI to use the actuarial value methodology developed under the ACA.

9. Requires DMHC, in consultation with CDI and Covered California to consider developing and using a state actuarial value calculator.

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10. Requires all products in the non-grandfathered individual market to have any deductible on a service apply to the same services for any product in the same level of coverage whether regulated by DMHC or CDI.

11. Authorizes a carrier to offer supplemental benefits for services that are not included in EHBs such as adult dental, adult vision, acupuncture, or chiropractic, if the carrier demonstrates that those benefits will not affect the risk adjustment scores or the reinsurance amounts for the product or the plan.

12. Requires issuers offering group or individual coverage that provides emergency services to cover this services without the need for prior authorization and at the same cost sharing levels as a participating provider regardless of whether that provider is a participating provider.

Comments

ACA Rules for Benefits and Cost-Sharing. The ACA requires carriers to provide EHBs with standardized tiers of cost-sharing. Under the ACA, out-of-pocket limits for health plans are subject to the limit that currently applies to health savings account-QHPs, which is $6,050 for single coverage in 2012 and approximately $13,000 for a family.

The ACA requires carriers offering non-grandfathered health plans inside and outside of the Exchange in the individual and small group markets to assure that any offered product must meet distinct levels of coverage called "metal tiers." Each metal tier corresponds to an actuarial value, calculated based on the cost-sharing features of the plan. Actuarial value is the percentage of health care costs that would be paid for by a person's health plan coverage, versus out-of-pocket costs at the point of service (e.g., co-payments, co-insurance or the deductible). For example, a health plan with an actuarial value of 60% will pay for 60% of an average individual's health care costs (using a standard population), while the individual would be responsible for the remaining 40%.

Prior Legislation

SB 961 (Hernandez, 2012) and AB 1461 (Monning, 2012) were identical bills that would have reformed California's individual market similar to the provisions in SB 2X1 (Hernandez, 2013). SB 961 and AB 1461 were vetoed by Governor Brown.

AB 1083 (Monning, Chapter 854, Statutes of 2012) establishes reforms in the small group health insurance market to implement the ACA.

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SB 951 (Hernandez, Chapter 866, Statutes of 2012) and AB 1453 (Monning, Chapter 854, Statutes of 2012) designates the Kaiser Small Group HMO as California's benchmark plan to serve as the EHB standard, as required by the ACA.

SB 51 (Alquist, Chapter 644, Statutes of 2011) establishes enforcement authority in California law to implement provisions of the ACA related to medical loss ratio requirements on health plans and health insurers and enacts prohibitions on annual and lifetime benefits.

AB 2244 (Feuer, Chapter 656, Statutes of 2010) requires guaranteed issue of health plan and health insurance products for children beginning in January 1, 2011.

SB 900 (Alquist), Chapter 659, Statutes of 2010, and AB 1602 (Perez), Chapter 655, Statutes of 2010, establishes the Covered California.

SB 890 (Alquist, 2010) would have required carriers to categorize all individual market products into tiers based on actuarial level, as specified, and would have required carriers to meet federal annual and lifetime limits and the medical loss ratio requirements. SB 890 was vetoed by Governor Schwarzenegger.

AB 1X1 (Nunez, 2008) would have enacted the Health Care Security and Cost Reduction Act, a comprehensive health reform proposal. AB 1X1 died in the Senate Health Committee.

**FISCAL EFFECT**: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- One-time costs of $400,000 to review plan filings and ongoing costs of $60,000 for enforcement of the bill's provisions by DMHC (Managed Care Fund).

- Potential ongoing costs in the tens of thousands to low hundreds of thousands for enforcement of this bill's provisions by CDI. (Insurance Fund).

**SUPPORT:** (Verified 5/29/13)

Health Access California (source)

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AFSCME, AFL-CIO
American Cancer Society Cancer Action Network
California Black Health Network
California Church IMPACT
California Federation of Teachers
California Partnership
California Public Interest Research Group
Children Now
Congress of California Seniors
Consumers Union
United Nurses Associations of California/Union of Health Care Professionals
United Ways of California
Western Center on Law and Poverty

**OPPOSITION:** (Verified 5/29/13)

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Association of Health Underwriters
California Chamber of Commerce

**ARGUMENTS IN SUPPORT:** Health Access California (HAC) writes that the ACA requires numerous changes with respect to cost sharing in the individual and small group markets and this bill implements and improves these provisions of federal law. This bill will require carriers to only sell standardized products in the individual and small group markets inside and outside the Covered California. HAC argues that this step protects consumers who purchase coverage outside the Covered California by assuring that the products offered to them have undergone the same intense public scrutiny as the products offered inside the Covered California. It also protects the Covered California from adverse selection; instead of insurers designing products to select their customers based on risk status, insurers will be forced to compete on price and quality. HAC contends that this bill does not eliminate innovation in benefit design but instead requires public scrutiny and debate by Covered California before benefit designs can be imposed on consumers. California Partnership writes that "in order to reduce poverty and better the lives of low-income communities, it is necessary to provide and assure affordable health care insurance to low-income individuals and families. SB 639 (Hernandez) implements and improves on the ACA." Western Center on Law and Poverty writes that this bill "will ensure consumers know their out of pocket costs both inside and outside of Covered California."

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According to the author's office, Californians purchasing health care coverage in the individual market face a vast array of products to choose from with markedly different benefit design that makes price comparison difficult. As a result, products being offered inside Covered California will be standardized so consumers can make "apples to apples" comparisons when selecting a product.

**ARGUMENTS IN OPPOSITION:** The California Association of Health Plans (CAHP) writes that "while health plans support the concept behind this measure, upon further review however, the provisions of the bill differ from the out-of-pocket requirements in federal law and restrict the use of incentives. CAHP writes that existing law contains provisions intended to protect the market from adverse selection, including the requirement that QHPs offer coverage through Covered California to offer exchange look-alike products in the "outside" market." CAHP argues "current law does not eliminate consumer choice of other products as this bill will do thereby making it harder for some individuals to obtain coverage that best suits their needs." America's Health Insurance Plans (AHIP) writes that "the standardization of health products is not only unnecessary but also impedes the ability of carriers to provide benefit packages aimed at meeting the preferences and needs of consumers. AHIP argues benefit design flexibility is an important element to assuring affordability and high-quality care."

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SUPPORT/OPPOSITION: SEE ABOVE

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