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

Introduced January 5, 2012, Chaptered September 30, 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.

Specifically, this bill:

1) Requires an individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2014, to, at a minimum, include coverage for EHBs, which means all of the following:

> A) The benefits and services covered by the Kaiser Foundation Health Plan Group HMO $30 deductible plan (Kaiser plan) contract as this contract was offered during the first quarter of 2012, including all of the following:

(1) Health benefits covered by the plan contract within the 10 categories identified in the Patient Protection and Affordable Care Act (ACA);

(2) Mandated benefits pursuant to statutes enacted before December 31, 2011, as specified; and,

(3) Health benefits covered by the Kaiser plan that are not otherwise required to be covered under existing law, as specified.

B) Coverage of mental health and substance abuse disorder services along with any scope and duration limits imposed on the benefits, in compliance with the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAE), and all regulations, or guidance, as specified. In addition, MHPAE applies to a policy subject to EHB.

C) Habilitative services and health care devices means medically necessary health care services that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services, include but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

D) Pediatric vision care with same benefits covered under the Federal Employees Dental and Vision Insurance Program, and pediatric oral care with the same benefits covered under Healthy Families including medically necessary orthodontic care pursuant to the federal Children's Health Insurance Program Reauthorization.

2) States that an EHB is required to be provided under this bill only to the extent that federal law or policy does not require the state to defray the costs of the benefit. Provides that nothing in this bill shall obligate the state to incur costs for the coverage of benefits that are not essential health benefits, as defined.

3) States that this bill shall only be implemented to the extent EHBs are required pursuant to the ACA.

4) Clarifies that where there are any conflicts or omissions in the Kaiser benchmark plan as compared to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) that were enacted prior to December 31, 2011, Knox-Keene requirements shall be controlling except in the case of home health services benefits, as specified.

5) Makes clear that the Insurance Commissioner's authority for enforcement of unfair practices applies, as specified.

6) Clarifies that nothing in this bill shall be construed to exempt a health insurer or a health insurance policy from meeting other applicable requirements of law.

7) Makes emergency regulation authority inoperative on March 1, 2016.

8) Makes this bill contingent upon the enactment of AB 1453 (Monning).

Senate Bill No. 951

Passed the Senate August 29, 2012

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Secretary of the Senate

Passed the Assembly August 28, 2012

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2012, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Section 10112.27 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 951, 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 provides for the regulation of health insurers by the Department of Insurance and requires health insurance policies to cover various benefits.

This bill would require an individual or small group 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 health benefits covered by particular benchmark plans. The bill would prohibit treatment limits imposed on these benefits from exceeding the corresponding limits imposed by the benchmark plans and would generally prohibit an insurer from making substitutions of the benefits required to be covered. The bill would specify that these provisions apply regardless of whether the policy is offered inside or outside the Exchange but would provide that they do not apply to grandfathered plans or plans that cover excepted benefits, as specified. The bill would prohibit a health insurer, when issuing, delivering, renewing, offering, selling,

or marketing a policy, from indicating or implying that the policy covers essential health benefits unless the policy covers essential health benefits as provided in the bill. The bill would authorize the Department of Insurance to adopt emergency regulations implementing these provisions until March 1, 2016, and enact other related provisions.

These provisions would only be implemented to the extent essential health benefits are required pursuant to PPACA. The bill would provide that it shall become operative only if AB 1453 is also enacted.

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 as defined under Section 1251 of PPACA, 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 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 pursuant to PPACA and as outlined in this section. This section shall exclusively govern what benefits a health insurer must cover

as essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: 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.

(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2012, as follows, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code and in Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha feto protein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials); Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient

hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to the extent otherwise required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health and Safety Code, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) Where there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that were enacted prior to December 31, 2011, the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code shall be controlling, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall be deemed to not be in conflict with Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a policy subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(3) With respect to habilitative services, in addition to any habilitative services identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2012. The pediatric vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–12, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), nothing in this section shall be construed to permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) as long as the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) No health insurer, or its agent, producer, or representative, shall issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all of the requirements of this section. This subdivision shall be enforced in the same manner as Section 790.03, including through the means specified in Sections 790.035 and 790.05.

(f) 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.

(g) Nothing in this section shall be construed to exempt a health insurer or a health insurance policy from meeting other applicable requirements of law.

(h) 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.

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

(1) A policy that provides excepted benefits as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA or any binding rules, regulation, or guidance issued pursuant to that section.

(j) Nothing in this section shall be implemented in a manner that conflicts with a requirement of PPACA.

(k) This section shall be implemented only to the extent essential health benefits are required pursuant to PPACA.

(*l*) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(m) Nothing in this section shall obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(n) An insurer is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(o) (1) The commissioner may adopt emergency regulations implementing this section. The commissioner may, on a one-time basis, readopt any emergency regulation authorized by this section

that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of regulations under this subdivision.

(4) This subdivision shall become inoperative on March 1, 2016.

(p) Nothing in this section shall impose on health insurance policies the cost sharing or network limitations of the plans identified in subdivision (a) except to the extent otherwise required to comply with provisions of this code, including this section, and as otherwise applicable to all health insurance policies offered to individuals and small groups.

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

(1) "Habilitative services" means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(2) (A) "Health benefits," unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued

pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) "Health benefits" does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) "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.

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

SEC. 3. This act shall become operative only if Assembly Bill 1453 of the 2011–12 Regular Session is also enacted and becomes operative.