AB-2258 Health care coverage: cost sharing. (2023-2024)

Date Published: 09/30/2024 09:00 PM

Assembly Bill No. 2258

CHAPTER 708

An act to amend Section 1367.002 of the Health and Safety Code, and to amend Section 10112.2 of the Insurance Code, relating to health care coverage.

[Approved by Governor September 27, 2024. Filed with Secretary of State September 27, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2258, Zbur. Health care coverage: cost sharing.

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 provides for the regulation of health insurers by the Department of Insurance. Existing law requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings.

This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would authorize the Insurance Commissioner to impose a civil penalty of not more than $5,000 against an insurer for each violation of these provisions, or not more than $10,000 per violation if the violation was willful.

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 Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.002 of the Health and Safety Code is amended to read:

1367.002. (a) A group or individual nongrandfathered health care service plan contract shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for any of the following:

(1) Evidence-based items or services that have in effect a rating of “A” or “B” in the recommendations of the United States Preventive Services Task Force, as periodically updated.

(2) Immunizations that have in effect a recommendation, as periodically updated, from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration for purposes of this paragraph.

(5) For the purposes of this section:

(A) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(B) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, shall not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is required by this section, regardless of whether or not the integral item or service is billed separately from an item or service that is required by this section.

(6) A health care service plan contract shall not impose cost sharing for office visits associated with the preventive care services described in this section if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

(b) This section does not prohibit a health care service plan contract from doing either of the following:

(1) Providing coverage for preventive items or services in addition to those required by subdivision (a).

(2) Denying coverage for services that are not recommended by the United States Preventive Services Task Force, except as provided in subdivision (d).

(c) A health care service plan shall provide coverage pursuant to subdivision (a) for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(1) A health care service plan that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a plan year shall provide coverage through the last day of the plan year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the plan year.

(2) Notwithstanding paragraph (1), if a recommendation or guideline described in paragraph (1) of subdivision (a) that was in effect on the first day of a plan year is downgraded to a “D” rating, or if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, a health care service plan is not required to cover the item or service through the last day of the plan year.

(d) A health care service plan contract issued, amended, or renewed on or after January 1, 2025, shall cover items and services pursuant to this section in accordance with any applicable requirement of this chapter, including, but not limited to, Section 1342.74 on prophylaxis of HIV infection, Section 1367.34 as added by Section 3 of Chapter 486 of the Statutes of 2021 on home test kits for sexually transmitted diseases, Section 1367.66 on cervical cancer screening, and Section 1367.668 on colorectal cancer screening.

(e) This section does not apply to a specialized health care service plan that does not cover an essential health benefit, as defined in Section 1367.005. This section shall only apply to a health savings account-eligible health care service plan to the extent it does not fail to be treated as a high deductible health plan under Section 223 of Title 26 of the United States Code.

(f) The department shall coordinate with the Department of Insurance if it adopts regulations to implement this section.

SEC. 2. Section 10112.2 of the Insurance Code is amended to read:

10112.2. (a) A group or individual nongrandfathered health insurance policy shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for any of the following:

(1) Evidence-based items or services that have in effect a rating of “A” or “B” in the recommendations of the United States Preventive Services Task Force, as periodically updated.

(2) Immunizations that have in effect a recommendation, as periodically updated, from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration for purposes of this paragraph.

(5) For the purposes of this section:

(A) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(B) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is required by this section, regardless of whether or not the integral item or service is billed separately from an item or service that is required by this section.

(6) A health insurance policy shall not impose cost sharing for office visits associated with the preventive care services described in this section if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

(b) This section does not prohibit a health insurance policy from doing either of the following:

(1) Providing coverage for preventive items or services in addition to those required by subdivision (a).

(2) Denying coverage for services that are not recommended by the United States Preventive Services Task Force, except as provided in subdivision (d).

(c) A health insurer shall provide coverage pursuant to subdivision (a) for policy years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(1) A health insurer that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a policy year shall provide coverage through the last day of the policy year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the policy year.

(2) Notwithstanding paragraph (1), if a recommendation or guideline described in paragraph (1) of subdivision (a) that was in effect on the first day of a policy year is downgraded to a “D” rating, or if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a policy year, a health insurer is not required to cover the item or service through the last day of the policy year.

(d) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall cover items and services pursuant to this section in accordance with any applicable requirement of this part, including, but not limited to, Section 10123.18 on cervical cancer screening, Section 10123.1933 on prophylaxis of HIV infection, Section 10123.207 on colorectal cancer screening, and Section 10123.208 on home test kits for sexually transmitted diseases.

(e) This section does not apply to a specialized health insurance policy that does not cover an essential health benefit, as defined in Section 10112.27. This section shall only apply to a health savings account-eligible health insurance policy to the extent it does not fail to be treated as a high deductible health insurance policy under Section 223 of Title 26 of the United States Code.

(f) The department shall coordinate with the Department of Managed Health Care if it adopts regulations to implement this section.

(g) The commissioner may exercise the authority provided by this code and the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code) to implement and enforce this section and all sections related to preventive services, including those referenced herein. If the commissioner assesses a civil penalty for a violation, any hearing that is requested by the insurer may be conducted by an administrative law judge of the Administrative Hearing Bureau of the

department under the formal procedure of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. A civil penalty shall not exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, shall not exceed ten thousand dollars ($10,000) for each violation. This subdivision does not impair or restrict the commissioner's authority pursuant to another provision of this code or the Administrative Procedure Act.

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