§ 1367.0085. Actuarial value for nongrandfathered bronze level high deductible health plan

Notwithstanding paragraph (1) of subdivision (b) of Section 1367.008 and paragraph (1) of subdivision (b) of Section 1367.009, the actuarial value for a nongrandfathered bronze level health plan that either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, may range from plus 5 percent to minus 2 percent.

HISTORY:
Added Stats 2019 ch 38 § 16 (SB 78), effective June 27, 2019. Amended Stats 2020 ch 12 § 3 (AB 80), effective June 29, 2020.

§ 1367.009. Levels of coverage for nongrandfathered small group mar- ket; Determination of actuarial value for nongrandfathered small employer health care service plans

(a) Levels of coverage for the nongrandfathered small group market are defined as follows:

(1) Bronze level: A health care service plan contract in the bronze level shall provide a level of coverage that is actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan contract.

(2) Silver level: A health care service plan contract in the silver level shall provide a level of coverage that is actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan contract.

(3) Gold level: A health care service plan contract in the gold level shall provide a level of coverage that is actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan contract.

(4) Platinum level: A health care service plan contract in the platinum level shall provide a level of coverage that is actuarially equivalent to 90

percent of the full actuarial value of the benefits provided under the plan contract.

(b) Actuarial value for nongrandfathered small employer health care service plan contracts shall be determined in accordance with the following:

(1) Actuarial value shall not vary by more than plus or minus 2 percent.

(2) Actuarial value shall be determined on the basis of essential health benefits as defined in Section 1367.005 and as provided to a standard, nonelderly population. For this purpose, a standard population shall not include those receiving coverage through the Medi-Cal or Medicare programs.

(3) The department may use the actuarial value methodology developed consistent with Section 1302(d) of PPACA.

(4) The actuarial value for pediatric dental benefits, whether offered by a full service plan or a specialized plan, shall be consistent with federal law and guidance applicable to the plan type.

(5) The department, in consultation with the Department of Insurance and the Exchange, shall consider whether to exercise state-level flexibility with respect to the actuarial value calculator in order to take into account the unique characteristics of the California health care coverage market, including the prevalence of health care service plans, total cost of care paid for by the plan, price of care, patterns of service utilization, and relevant demographic factors.

(6) Employer contributions toward health reimbursement accounts and health savings accounts shall count toward the actuarial value of the product in the manner specified in federal rules and guidance.

(c) "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.

HISTORY:

Added Stats 2013 ch 316 § 7 (SB 639), effective January 1, 2014.