§ 1367.007. Limitation on deductible for small employer health care service plan

(a)(1) For a small employer health care service plan contract offered, sold, or renewed on or after January 1, 2014, the deductible under the plan shall not exceed:

(A) Two thousand dollars ($2,000) in the case of a plan contract covering a single individual.

(B) Four thousand dollars ($4,000) in the case of any other plan contract.

(2) The dollar amounts in this section shall be indexed consistent with Section 1302(c)(4) of PPACA and any federal rules or guidance pursuant to that section.

(3) The limitation in this subdivision shall be applied in a manner that does not affect the actuarial value of any small employer health care service plan contract.

(4) For small group products at the bronze level of coverage, as defined in Section 1367.008, the department may permit plans to offer a higher deductible in order to meet the actuarial value requirement of the bronze level. In making this determination, the department shall consider affordability of cost sharing for enrollees and shall also consider whether enrollees may be deterred from seeking appropriate care because of higher cost sharing.

(b) Nothing in this section shall be construed to allow a plan contract to have a deductible that applies to preventive services as defined in Section 1367.002.

(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 § 5 (SB 639), effective January 1, 2014. Amended Stats 2015 ch 641 § 2 (AB 1305), effective January 1, 2016.

§ 1367.008. Levels of coverage for nongrandfathered individual mar- ket; Determination of actuarial value for nongrandfathered indi- vidual health care service plans; Catastrophic plan

(a) Levels of coverage for the nongrandfathered individual 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 individual 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.

(c)(1) A catastrophic plan is a health care service plan contract that provides no benefits for any plan year until the enrollee has incurred cost-sharing

expenses in an amount equal to the annual limit on out-of-pocket costs as specified in Section 1367.006 except that it shall provide coverage for at least three primary care visits. A carrier that is not participating in the Exchange shall not offer, market, or sell a catastrophic plan in the individual market.

(2) A catastrophic plan may be offered only in the individual market and only if consistent with this paragraph. Catastrophic plans may be offered only if either of the following apply:

(A) The individual purchasing the plan has not yet attained 30 years of age before the beginning of the plan year.

(B) The individual has a certificate of exemption from Section 5000(A) of the Internal Revenue Code because the individual is not offered affordable coverage or because the individual faces hardship.

(d) "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 § 6 (SB 639), effective January 1, 2014.