SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2021-2022 Regular Session

SB 280 (Limón)
Version: February 1, 2021
Hearing Date: March 23, 2021
Fiscal: Yes
Urgency: No
TSG

SUBJECT

Health insurance: large group health insurance

DIGEST

This bill requires large group health insurance policies to cover medically necessary basic health care services. It also codifies the federal prohibition on discriminatory marketing practices and benefit designs in the large group health insurance market within the state Insurance Code and establishes penalties for violating that prohibition.

EXECUTIVE SUMMARY

For regulatory purposes, health insurance policies are divided into three market segments: individual, small group, and large group. This bill would apply two legal provisions to large group health insurance policies that the Insurance Code currently, only applies to individual and small group policies. First, existing law mandates that individual and small group health insurance policies cover certain basic health care services when medically necessary. This bill applies the same requirements to large group health insurance policies, thus creating greater parity across the health insurance market while also more closely aligning the minimum health care services required of large group health insurance policies with those required of managed health care plans. Second, existing provisions in the state Insurance Code prohibit individual and small group health insurance policies from using marketing practices or benefit designs to either: (a) discourage people with significant health needs from enrolling in the policies, or (b) discriminate against customers based on their race, color, national origin, disability, age sex, gender identify, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. These prohibitions reflect federal law. This bill would codify, in state law, that those same prohibitions apply to large group health insurance policies, and also establish penalties for violations.

The bill is sponsored by California Insurance Commissioner Ricardo Lara. Support comes from health consumer advocates. There is no known opposition. The bill passed out of the Senate Insurance Committee by a vote of 11-0.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Establishes the California Department of Insurance (CDI), led by the Insurance Commissioner, to regulate health and other insurers. (Ins. Code § 106 *et seq*.)

2) Establishes the Department of Managed Health Care (DMHC) to regulate health care plans under the Knox-Keene Health Care Service Plan Act of 1975. (Health & Saf. Code § 1340, *et seq*.)

3) Requires individual and small group insurance policies and managed care plans to cover specified basic health care services when medically necessary. (Health & Saf. Code §1367.005 and Ins. Code § 10112.27.)

4) Prohibits, in the individual and small group insurance markets, a carrier or agent or broker from, directly or indirectly, employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminating based on the individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. (Cal. Ins. C. §§ 10965.5(a)(3), 10753.05(h)(3).)

This bill:

1) Requires a large group health insurance policy issued, amended, or renewed on or after July 1, 2022, to cover medically necessary basic health care services.

2) Defines "basic health care services" as all the following:
   a) physician services, including consultation and referral;
   b) hospital inpatient services and ambulatory care service;
   c) diagnostic laboratory and diagnostic and therapeutic radiologic services;
   d) home health services;
   e) preventive health services;
   f) emergency health care services, including ambulance and ambulance transport services and out-of-area coverage, as defined; and
   g) hospice care, as specified.

4) Allows a large group health insurance policy to cover additional benefits.

5) Permits the Insurance Commissioner to adopt regulations to implement (1) through (4), above, after consulting with DMHC to ensure consistency, to the extent practical, with specified DMHC regulations mandating basic minimum health care services as part of managed care plans.

6) Makes (1) through (5), above, applicable to any individual or small group health insurance policy in the event that current laws establishing similar requirements in those market segments are no longer in effect.

7) Exempts specialized health insurance policies that cover only dental or vision benefits from (1) through (6), above.

8) Prohibits, in the large group health insurance market segment, an insurer and its officials, employees, agents, and representatives from, directly or indirectly, employing marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminating based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

9) Makes an insurer that violates (8), above, liable for an administrative penalty of not more than $2,500 for the first violation, and not more than $5,000 for each subsequent violation, and an insurer that violates (8), above, with a frequency that indicates a general business practice or commits a knowing violation liable for an administrative penalty of not less than $15,000, and not more than $100,000 for each violation.

10) Exempts both of the following from (8) and (9), above:
    a) specified large group health insurance policies that predate passage of the federal Affordable Care Act (so-called "grandfathered" policies); and
    b) specialized health insurance policies that cover only dental or vision benefits.

COMMENTS

1. Background

Most health care coverage in California comes in one of two forms: health insurance policies or managed care plans. The former are primarily governed by the Insurance Code and regulated by the California Department of Insurance (CDI). The latter are primarily governed by the Health & Safety Code and regulated by the Department of Managed Health Care (DMHC). Health care coverage is further broken down into market segments: individual, small group, and large group. Within this basic framework, the intent behind this bill is to establish greater parity across all market segments as well as between managed health care plans and health insurance policies with respect to: (1) the minimum suite of services that must be provided to consumers; and (2) prohibitions on discriminatory marketing practices or benefit designs.

2. Basic medical care services that plans and policies must provide

Under existing law, managed care plans are required, at a minimum, to provide a basic suite of medical services to their enrollees whenever those services are medically necessary. (Health & Saf. Code §1367.005.) In broad strokes, those services include: physician services such as consultation and referral; hospital inpatient services and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; certain hospice care; and emergency health care services, including ambulance transport services and out-of-area coverage. Very similar minimum coverage requirements exist for individual and small group health insurance policies as well. (Ins. Code § 10112.27.) By contrast, large group health insurance policies, which cover approximately 384,000 Californians according to the CDI, are not subject to these requirements to provide a minimum set of services.

As sponsor of the bill, CDI points out that this disparity between large group health insurance policies and other forms of health care coverage creates a market imbalance. Since they do not necessarily have to meet the same threshold level of service, large group health insurance policies have a competitive advantage over their managed care counterparts. Moreover, the absence of minimum required suite of basic care in the large group insurance policy context means that CDI cannot currently obligate such policies to cover services that may have important individual and public health consequences, the way it is empowered to do in the context of individual and small group policies. According to the author of the bill:

> Large group policies filed with CDI routinely limit or exclude coverage for essential medical care that constitutes basic health care services. Examples include women's reproductive services, obesity care, organ and tissue transplants, and life-threatening complications caused by excluded services such as cosmetic surgery.

This bill would impose on large group health insurance policies the same requirement to provide a basic suite of health care services that currently applies to the individual and small group market segments. Because this basic set of services is quite similar to what managed care plans must also provide, the bill would also result in greater parity between the two types of health care coverage in the large group market.

3. Prohibitions on discriminatory marketing practices and benefits designs

As one of its changes to the American health care system, the Affordable Care Act (ACA, also commonly known as "Obamacare") sought to establish new limitations on health insurance companies' ability to steer away consumers who were likely to need to more care and would therefore incur greater costs. ACA also made clear that health

insurance companies could not treat consumers differently based on their membership in certain protected classes. A key federal regulation implementing ACA set out the new law as follows:

> A health insurance issuer and its officials, employees, agents and representatives […] cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, expected length of life, degree of medical dependency, quality of life, or other health conditions. (45 CFR § 147.104(e).)

By operation of the Supremacy Clause of the U.S. Constitution, these federal regulations automatically applied in California. (U.S. Const., art. VI, para. 2.) Nonetheless, when California set about implementing ACA at the state level, the Legislature incorporated these same prohibitions, nearly word for word, into the state statutes regulating health insurance policies, but with two key distinctions. First, California only incorporated the ACA anti-discrimination language with respect to individual and small group health insurance policies. The same language was not incorporated into the state Insurance Code provisions governing large group health insurance. Second, California included gender identity and sexual orientation on the list of protected categories. According to the bill's sponsor, the federal regulations did so, too, for a time, but they were removed under the Trump Administration. (84 Fed. Reg. 27846, 27855 (proposed June 14, 2019); final rule, 85 Fed. Reg. 37160, 37247 (June 19, 2020).)

This bill would, with respect to large group health insurance policies, codify the ACA's anti-discrimination language, including the protections for gender identity and sexual orientation, in state law. At the same time, the bill would add an enforcement mechanism in the form of administrative penalties that CDI could levy against large group health policies that it finds to be in violation.

The change would help to ensure that, going forward, large group health insurance policies cannot discriminate in their marketing practices or benefit design on the basis of gender identity or sexual orientation, regardless of whether those categories are included among federal protections or not. Additionally, the author states that these tools would give CDI greater ability to address discriminatory practices across all three health insurance market segments. According to the author:

> CDI's attorneys who review health insurance policies for compliance with the law often encounter discriminatory benefit designs that are easily eliminated by citing the ACA's anti-discrimination provision, such as exclusions and limitations that are based on health condition. […] Discriminatory prescription

> drug benefit design was common before the ACA and persists in California's large group market because some insurers still consider health condition as a factor in assigning prescription drugs to the specialty drug tier, which is subject to the highest cost sharing, in their prescription drug formularies.
>
> Prescription drug benefits that impose excessively high cost sharing on drugs for expensive health conditions discourage enrollment of people with those conditions […] and provide less generous coverage once people who suffer from those conditions are enrolled. Common examples include drugs for HIV, multiple sclerosis, preventing transplant rejection, and autoimmune conditions such as rheumatoid arthritis. CDI has had much success in rooting out discriminatory prescription benefit designs from the individual and small group markets. Formal statutory authority to enforce the law coupled with penalties would greatly aid CDI's enforcement efforts in the large group market.

4. Other laws prohibiting discrimination in the health insurance arena

For context, it may be worth noting that the anti-discrimination provisions proposed in this bill are only one of a number of state statutes that prohibit discrimination in the field of health coverage. Managed health care plans are subject to very similar anti-discrimination provisions. (Health & Saf. Code § 1365.5.) Health insurance policies must comply with anti-discrimination provisions in the Insurance Code that apply to all forms of insurance. Those provisions protect insurance consumers against discrimination based upon religion, ancestry, and genetic characteristics in addition to the categories that this bill names. (Ins. Code § 10140(a) and (b).)

More broadly, the entire health care field is presumably also subject to one of California's signature civil rights laws, the Unruh Act. That Act bars "all business establishments of any kind whatsoever" from discriminating in the provision of "accommodations, advantages, facilities, privileges, or services." (Civ. Code § 51(b).) The Unruh Act lists a series of characteristics that it explicitly protects from discriminatory treatment: sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status. (*Ibid*.) The courts have ruled that this list is not exhaustive, however. Instead, the Unruh Act has been interpreted to outlaw all forms of arbitrary discrimination in the way California businesses treat their consumers. (*Marina Point, Ltd. v. Wolfson* (1982) 30 Cal. 3d 721.)

Ultimately, the combined applicability of these statutes means that, while this bill would codify prohibitions on discrimination in the marketing and benefit design of health insurance policies based on just a few different categories – specifically race,

color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions – those protections fall within an umbrella of anti-discrimination laws that provide even broader protection to health insurance consumers.

5. Arguments in support of the bill

According to the author:

> The pandemic has underscored the need for CDI to have authority to nimbly respond to unexpected real-world conditions that call for robust regulation of health insurance benefits, especially as COVID-19 continues to devastate the health and well-being of Californians in enduring and unpredictable ways. The current inequity in the requirement to cover basic health care services disadvantages consumers with large group health insurance, who are not entitled under state law to coverage of minimum benefits as medically necessary, including physician services, hospitalization, outpatient services, and laboratory tests. Further, as we continue to learn more about the long-term health consequences of COVID-19, banning discrimination in large group health insurance benefit design and marketing will protect against discriminatory practices that could arise in the future.
>
> The expansion of consumer protections in SB 280 will help ensure that Californians who are covered by large group health insurance are protected by the same law that applies to all other ACA-compliant health coverage regulated by both CDI and DMHC today.

As sponsor of the bill, California Insurance Commissioner Ricardo Lara writes:

> Because the Insurance Code does not include the ACA's ban on discriminatory marketing practices and benefit designs as applied to large group health insurance, CDI can rely only on federal law in this portion of the market. Consistent with state anti-discrimination law applicable to individual and small group health insurance, SB 280 includes sexual orientation and gender identity as prohibited bases for discrimination. Examples of discriminatory benefit designs that would be actionable under SB 280 include adverse tiering of HIV drugs, in which most drugs for HIV are assigned to the highest cost sharing tiers of an insurer's prescription drug formulary, and discriminatory limitations and exclusions for

> gender affirming medical care in health insurance policies. In contrast to the individual and small group health insurance markets, both of these discriminatory practices unfortunately still exist in California's large group market today.
>
> SB 280 would deter, and enable CDI to act against, discriminatory health insurer business practices that adversely impact consumers, including those discriminatory practices based on gender identity or sexual orientation.

In support, Health Access California writes:

> SB 280 (Limón) would "level up" the playing field to ensure California consumers with state-regulated coverage have the same comprehensive benefits and consumer protections, no matter which department regulates their coverage. SB 280 would align existing benefit standards and consumer protections to hundreds of thousands more Californians that are already available to millions of Californians. The bill would also codify important consumer protections into state law to guarantee that people's coverage is not reduced to sub-standard, junk coverage if federal ACA protections related to large employer coverage are ever rolled back.

SUPPORT

California Insurance Commissioner Ricardo Lara (sponsor)
APLA Health
CaliforniaHealth+ Advocates
Health Access California

OPPOSITION

None received

RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation:

AB 1246 (Limón, 2019) would have required large group health insurance policies regulated by the CDI to include medically necessary basic health care services consistent with the minimum health care services required of managed health care plans. AB 1246 was held in the Senate Appropriations Committee.

SB 2 X1 (Hernandez, Ch. 2, Stats. 2013), together with AB 2 X1, below, established health insurance market reforms contained in the ACA specific to individual purchasers, such as prohibiting health plans and insurers from denying coverage based on preexisting conditions; and made conforming changes to small employer health insurance laws resulting from final federal regulations.

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PRIOR VOTES:

Senate Insurance Committee (Ayes 11, Noes 0)

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