Abbreviated Analysis:

Analysis of California Assembly Bill 1246

Requirements regarding Basic Health Care Services and Medical Necessity for Prescription Drugs

Summary to the 2019-2020 California State Legislature, April 4, 2019

AT A GLANCE

The version of California Assembly Bill (AB) 1246 analyzed by CHBRP includes language — applicable only to the health insurance of enrollees in large-group market policies regulated by the California Department of Insurance (CDI) — requiring coverage of basic health care services (BHCS) as described in the Health and Safety Code. In addition, the bill includes language requiring that, when a pharmacy benefit is present, prescription drug coverage comply with medical necessity as defined in the Health and Safety Code. In general, CDI-regulated policies are governed by the Insurance Code and it is health care service plans regulated by the California Department of Managed Health Care (DMHC) that are governed by the Health and Safety Code.

CHBRP estimates that, in 2020, of the 24 million Californians enrolled in state-regulated health insurance, 318,000 will have insurance impacted by AB 1246.

1. **Benefit coverage.**
   a. Basic Health Care Services (BHCS). Requiring coverage of BHCS would establish a minimum set of benefits for enrollees in CDI-regulated large-group market policies and would create a single minimum for all large-group market plans and policies, whether regulated by DMHC or CDI. However, as CHBRP is unaware of any substantive benefit difference between large-group market DMHC-regulated plans (already required to cover BHCS) and large-group market CDI-regulated polices, no measurable impact is anticipated for the impacted 318,000 enrollees.
   b. Medical necessity and outpatient prescription drugs. Defining medical necessity through the Health and Safety Code would establish a single definition for all large-group market plans and policies, whether regulated by DMHC or CDI. However, as CHBRP is unaware of any substantive difference in the current application of medical necessity definitions between large-group market DMHC-regulated plans (already subject to the Health and Safety Code) and large-group market CDI-regulated polices, no measurable impact is anticipated for the impacted 88.9% of the 318,000 enrollees in CDI-regulated large-group policies that include a pharmacy benefit.
2. **Utilization and expenditures.** As no substantive change in benefit coverage is expected, no change in utilization or expenditures is projected.

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[1] conduct an evidence-based assessment of the impacts of AB 1246.

BILL SUMMARY

Applicable only to the health insurance of enrollees in large-group policies regulated by the California Department of Insurance (CDI), AB 1246 includes language that would require coverage of basic health care services (BHCS), as BHCS are defined in subdivision (b) of Section 1345 of the Health and Safety Code and Section 1300.67 of Title 28 of the California Code of Regulations (see following Context section for list of benefits). In addition, for these enrollees, when a pharmacy benefit is present, medically necessary prescription drug coverage would be required, with the definitions of medical necessity as described in Section 1342.7 of the Health and Safety Code.

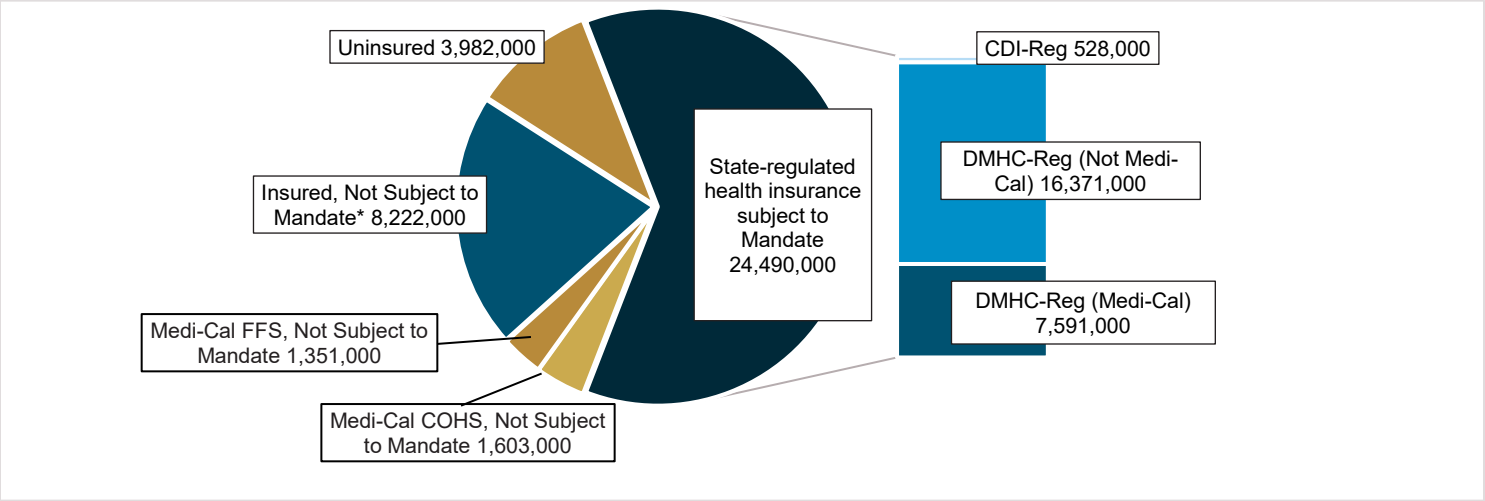
The text of AB 1246 can be found in Appendix A.

[1] CHBRP's authorizing statute is available at http://chbrp.org/faqs.php.

POPULATION AFFECTED

As displayed in Figure 1, in 2020 approximately 24.5 million (61.8% of all Californians) will be enrolled in health insurance regulated by CDI or in health plans regulated by DMHC. In 2020, the 528,000 enrollees in all CDI-regulated policies will represent about 1% of California's population.[2] Within this group, approximately 318,000 will be enrolled in CDI-regulated large-group policies and approximately 88.9% of these enrollees will have a pharmacy benefit regulated by CDI.[3]

Figure 1. 2020 Health Insurance by Regulator in California



Source: California Health Benefit Review Program, 2019
Notes: *Such as enrollees in Medicare, and self-insured products
Key: FFS = Fee for Service; COHS = County-Organized Health System; CDI = California Department of Insurance; DMHC = California Department of Managed Health Care

CONTEXT

AB 1246 addresses both minimum benefit coverage and the determination of medical necessity when outpatient prescription drugs are covered. The bill would require equivalency in these two areas for the large-group market, whether regulated by CDI or DMHC. Currently, DMHC requires minimum benefit coverage through the basic health care services requirement. AB 1246 would place the same requirements on policies regulated by CDI.

Minimum Benefit Coverage

DMHC regulates health plans, which are subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended, which was codified in the Health and Safety Code.[4] The Knox-Keene Act requires all health plans, except specialized health care service plans, to provide coverage for all medically necessary basic health care services, establishing a specified minimum set of benefits. This requirement is based on several sections of the Knox-Keene Act rather than one straightforward provision. Basic health care services are defined[5] as inclusive of the following:

- Physician services, including consultation and referral;

[2] See *Estimates of Sources of Health Insurance*, available as a resource at http://chbrp.org/other_publications/index.php
[3] See *Estimates of Pharmacy Benefit Coverage in California*, available as a resource at http://chbrp.org/other_publications/index.php
[4] Health and Safety Code Section 1340 et seq.
[5] Health and Safety Code Section 1345(b) and Section 1300.67 of Title 28 of the California Code of Regulations

- Hospital inpatient services and ambulatory care services;
- Diagnostic laboratory and diagnostic and therapeutic radiologic services;
- Home health services;
- Preventive health services;
- Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage and ambulance transport services provided through the 911 emergency response system; and
- Hospice care.

Although the Knox-Keene Act does not explicitly state that "basic health care services" means all "medically necessary" basic health care services, numerous provisions within the Knox-Keene Act reference "medical necessity" and that place requirements on plans in terms of what they must do when denying, delaying, or modifying coverage based on a decision for medical necessity[6] and the California Code of Regulations indicates that "the basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve…"[7]

CDI does not require coverage of a specified minimum set of benefits, but does require that polices provide minimum value, as specified by Insurance Code section 10112.9 subject to the exception in subdivision (a)(3).

Both DMHC and CDI require compliance with any applicable benefit mandates — written into the Health and Safety Code for DMHC-regulated plans and into the Insurance Code for CDI-regulated policies, and written into federal law for both. There are 74 state benefit mandate laws and 10 federal benefit mandate laws. A full list is included in the CHBRP resource *Health Insurance Benefit Mandates in State and Federal Law*. [8] It should be noted, however, that applicability of these laws varies by market segment (large-group, small-group, or individual market) or by size of group (e.g., more than 100 enrollees).

For DMHC-regulated plans, the "benefit floor" is coverage of basic health care services as well as coverage compliant with any applicable additional coverage as specified by a benefit mandate law.

For CDI-regulated policies, the "benefit floor" is as specified in the policy's evidence of coverage (EOC) document as well as coverage compliant with any applicable additional coverage as specified by a benefit mandate law.

Pharmacy Benefit and Medical Necessity

Coverage of outpatient prescription drugs is generally referred to as inclusion of a pharmacy benefit – and the presence of a pharmacy benefit is not universal for enrollees in DMHC-regulated plans or for enrollees in CDI-regulated policies. [9]

Coverage of outpatient prescription drugs is not a basic health care services requirement and DMHC does not require that health plans include a pharmacy benefit. Not all plans include one.

Similarly, CDI does not require that health policies include a pharmacy benefit and not all policies include one.

[6] Health and Safety Code Section 1367.01
[7] Section 1300.67 of Title 28 of the California Code of Regulations
[8] Available at http://chbrp.org/other_publications/index.php.
[9] See *Estimates of Pharmacy Benefit Coverage in California*, available as a resource at http://chbrp.org/other_publications/index.php.

Benefit mandate laws, when they address the coverage of one or more outpatient prescription drugs, generally (as AB 1246 would be) are applicable only to plans and polices that include a pharmacy benefit.

As is the case with other covered benefits, medical necessity for covered outpatient prescription drugs is initially indicated by a provider and then reviewed by the enrollee's plan or insurer. If the DMHC-regulated plan or CDI-regulated insurer denies coverage based on a lack of medical necessity, the enrollee may challenge the decision. As required by law,[10] both DMHC and CDI maintain an independent medical review (IMR) process available to enrollees. Through the IMR process, decisions regarding medical necessity by plans and policies are either upheld or overturned.

IMPACTS

Benefit Coverage, Utilization and Cost

In general, CDI enforces the Insurance Code and DMHC enforces the portions of the Health and Safety Code relevant to health plans. AB 1246 would make CDI-regulated large-group health insurance subject to both the Insurance Code and to specified portions of the Health and Safety Code, specifying related coverage of basic health care services and related determination of medical necessity for covered outpatient prescription drugs.

Benefit Coverage

At the current time, CHBRP is unaware of any substantive difference in minimum benefit coverage between large-group policies regulated by CDI and large-group plans regulated by DMHC, despite a lack of law that explicitly requires CDI-regulated insurance policies to provide a minimum set of covered benefits. Similarly, CHBRP is unaware of any substantive difference in determination of medical necessity for covered outpatient drugs.

Other analyses have also found substantially similar benefit coverage available in CDI-regulated policies and DMHC-regulated plans, including a recent review of regulation of health insurance in California (Kelch) and the initial analysis of potential benchmark plans (part of determining the state's essential health benefits) (Milliman, 2012).

Therefore, CHBRP would expect no measurable change in benefit coverage should AB 1246 either be or not be implemented.

Utilization and Expenditures

As no measurable benefit coverage change is expected, regardless of whether AB 1246 is implemented, no measurable changes in utilization or expenditures (premiums and other enrollee expenses) are expected.

Medi-Cal

As DHCS does not purchase enrollment for Medi-Cal beneficiaries in CDI-regulated large-group policies, there would be no impact on Medi-Cal regardless of whether AB 1246 is implemented.

CalPERS

As no CalPERS enrollees are in CDI-regulated large-group policies, there would be no impact on CalPERS regardless of whether AB 1246 is implemented.

[10] Chapter 979 (A.B. 1663), Statutes of 1995, California Health and Safety Code §1370.4 and California Insurance Code §10145.3 and Chapter 533 (A.B. 55), Statutes of 1999, California Health and Safety Code, Article 5.5 (commencing with §1374.30) and California Insurance Code, Article 3.5 (commencing with §10169).

Number of Uninsured in California

No impact on the uninsured is expected regardless of whether AB 1246 is implemented.

Essential Health Benefits and the Affordable Care Act

The Affordable Care Act's requirement to cover essential health benefits (EHBs), is applicable only to nongrandfathered small-group and individual markets.[11] In 2020, CHBRP estimates that about 5.1 million Californians will be enrolled in plans or policies regulated by DMHC or CDI that are required to cover EHBs. However, as AB 1246 is applicable only to the CDI-regulated large-group market, which is not required to cover EHBs, AB 1246 would not interact with the EHBs coverage requirement.

[11] Resources on EHBs and other ACA impacts are available on the CHBRP website: http://www.chbrp.org/other_publications/index.php.

APPENDIX A TEXT OF BILL ANALYZED

The California Assembly Committee on Health requested that CHBRP analyze the language related to basic health care services and medical necessity for prescription drugs as present in the February 21, 2019, version of AB 1246.

ASSEMBLY BILL **No. 1246**

Introduced by Assembly Member Limón

February 21, 2019

An act to add Section 10112.285 to the Insurance Code, relating to healthcare coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1246, as introduced, Limón. Healthcare coverage: basic health care services.
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. Existing law also provides for the regulation of health insurers by the Department of Insurance.

Existing law requires all health care service plan contracts, and, if applicable, specialized health care service plan contracts, to provide subscribers and enrollees with certain basic health care services, as defined, including physician services and hospital inpatient services, except as specified. Existing law affirms the authority of the Department of Managed Health Care to regulate the provision of medically necessary prescription drug benefits by a health care service plan to the extent the plan provides coverage for those benefits.

Existing law requires individual or small group health insurance policies issued, amended, or renewed on or after January 1, 2017, to include coverage for essential health benefits, as defined, including medically necessary basic health care services.

This bill would require large group health insurance policies, except certain specialized health insurance policies, issued, amended, or renewed on or after January 1, 2020, to include coverage for medically necessary basic health care services and, to the extent the policy covers prescription drugs, coverage for medically necessary prescription drugs.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: no Local Program: no

BILL TEXT

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

SECTION 1.

Section 10112.285 is added to the Insurance Code, immediately following Section 10112.28, to read:

10112.285. (a) A large group health insurance policy issued, amended, or renewed on or after January 1, 2020, shall include coverage for medically necessary basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code and Section 1300.67 of Title 28 of the California Code of Regulations.

(b) To the extent a large group health insurance policy covers prescription drugs, a large group health insurance policy issued, amended, or renewed on or after January 1, 2020, shall cover medically necessary prescription drugs, as described in Section 1342.7 of the Health and Safety Code.

(c) This section does not prohibit a large group health insurance policy from covering additional benefits.

(d) This section does not apply to a specialized health insurance policy that covers only dental or vision services.

REFERENCES

Kelch D. Health Insurance Oversight in California: Observations on the Post-ACA Environment. 2015. Available at: https://stateofreform.com/wp-content/uploads/2015/07/CAL-MCO-merger-report.pdf. Accessed March 2019.

Milliman. Robert Cosway of Milliman to David Panush, Director, Government Relations, California Health Benefit Exchange. *California Health Benefit Exchange: Comparison of Potential Essential Health Benefit Benchmarks.* 2012. Available at: https://www.healthexchange.ca.gov/data-research/2011-Federal-Exchange-Guidance/library/Milliman-Essential_Health_Benefits_Comparison-Cost_of_Services2-21-2012.pdf. Accessed March 2019.

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM COMMITTEES AND STAFF

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** coordinates the efforts of the Faculty Task Force, works with Task Force members in preparing parts of the analysis, and manages all external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit.

The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. CHBRP is grateful for the valuable assistance of its National Advisory Council. CHBRP assumes full responsibility for the report and the accuracy of its contents.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, in the Office of the Vice Chancellor for Research.

CHBRP gratefully acknowledges the efforts of the team contributing to this analysis:

Bruce Abbott, MLS, of the University of California, conducted the literature search. Chris Girod, FSA, MAAA, of Milliman, prepared the cost impact analysis. John Lewis, MPA, of CHBRP staff prepared the Policy Context and synthesized the individual sections into a single report. A member of the CHBRP Faculty Task Force, Ed Yellin, PhD, of the University of California, San Francisco, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org