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AMENDED IN SENATE SEPTEMBER 7, 2007
AMENDED IN SENATE SEPTEMBER 5, 2007
AMENDED IN SENATE JULY 18, 2007
AMENDED IN SENATE JULY 3, 2007
AMENDED IN ASSEMBLY MARCH 28, 2007
CALIFORNIA LEGISLATURE—2007—08 REGULAR SESSION

ASSEMBLY BILL

No. 2

Introduced by Assembly Member Dymally

December 4, 2006

An act to amend Sections 1367.15 and 1373.6 of, to amend and repeal Section 1373.622 of, to add Sections 1356.2, 1373.63, and 1399.819 to, and to amend, repeal, and add Section 1366.35 of, the Health and Safety Code, and to amend Sections 10176.10, 12682.1, 12700, 12705, 12711, 12723, 12725, 12737, and 12739 of, to amend and repeal Section 10127.16 of, to amend, repeal, and add Sections 10785, 12712, and 12726 of, to add
An act to add Sections 1356.2, 1373.63, and 1399.819 to the Health and Safety Code, and to amend Sections 12700, 12705, 12711, 12712, 12718, 12723, 12725, 12726, and 12739 of, to add Sections 1827.86, 10127.19, 10901.10, 12711.3, 12714.1, and 12738 to, to add Chapter 9 (commencing with Section 12739.5) to Part 6.5 of Division 2 of, and to repeal and add Section 12718 12737 of, the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2, as amended, Dymally. Health care coverage.

(1) Existing law establishes the California Major Risk Medical Insurance Program (MRMIP) that is administered by the Managed Risk Medical Insurance Board (MRMIB) to provide major risk medical coverage to persons who, among other matters, have been rejected for coverage by at least one private health plan. 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 also provides for the regulation of health insurers by the Department of Insurance. ~~Under a pilot program ending on December 31, 2007, existing~~ Existing law requires a health care service plan and a health insurer to ~~offer a standard benefit plan~~ *continue to provide coverage* to certain individuals *who were members of a pilot program that ended on December 31, 2007*, and requires MRMIB to make payments from the Major Risk Medical Insurance Fund, a continuously appropriated fund, to health care service plans and insurers for the provision of health services ~~under to those standard benefit plans~~ *individuals*.

~~This bill would require a health care service plan and a health insurer to continue until January 1, 2009, to provide coverage to each individual who was terminated from the pilot program, with the benefits and premium for that coverage being determined by MRMIB, and to send those individuals a notice developed by MRMIB. The bill would, effective January 1, 2009, require a health care service plan and a health insurer to elect to either make available all of its group or individual health benefit plans to individuals in each service area, or to alternatively pay a fee covering based on its market share, as specified, in an amount that, as determined by MRMIB, of MRMIP's costs and an advisory committee, is necessary to cover program costs and demand for the program. The bill would require plans and insurers that elect not to pay the fee to annually submit their proposed health benefit plan rates for approval to the Director of Managed Health Care or the Insurance Commissioner, as applicable. Because the fee would be deposited in the fund, the bill would make an appropriation by increasing the amount of revenue in a continuously appropriated fund. The bill would authorize the board, with the approval of the Department of Finance, to obtain loans from the General Fund for expenses related to administration of~~

the fund. The bill would require MRMIB to appoint a panel to advise it regarding implementation of the fees. ~~The bill would make conversion coverage and coverage for a federally eligible defined individual, on and after January 1, 2009, available through MRMIP, as specified, upon a waiver being obtained from the federal government and would make individuals with that coverage as well as those who were covered under the pilot program on or after July 1, 2008, eligible for enrollment in MRMIP, as specified.~~ The bill would specify the manner in which the premium is calculated for a health care service plan contract or a health insurance policy that offers services through a preferred provider arrangement for a federally eligible defined individual. ~~The bill would revise other provisions governing MRMIP.~~ The bill would enact other related provisions.

~~(2) Existing law prohibits a health care service plan and a health insurer from closing a block of business, as defined, without taking specified actions. Under existing law particular types of coverage are exempt from these provisions.~~

~~This bill would specify that continuation coverage and certain guarantee issue coverage are also exempt from these provisions pertaining to a block of business closure.~~

~~(3) Existing law authorizes MRMIB to adopt rules and regulations, as specified:~~

~~This bill would require MRMIB to perform specified duties, including establishing guidelines for disease management, case management, care management, and other cost management strategies. The bill would make a provision inoperative on January 1, 2009, that ensures that MRMIP subsidy amounts not exceed the amounts deposited annually into the fund.~~

~~(4)~~

~~(2) Existing law requires specified amounts to be deposited in the fund from the Cigarette and Tobacco Products Surtax Fund.~~

~~This bill would increase those amounts, thereby making an appropriation.~~

~~The bill would make related changes, and would exempt MRMIB, the Department of Managed Health Care, and the Department of Insurance from certain procedural requirements necessary to adopt rules and regulations.~~

~~(5)~~

~~(3) Because the bill would increase the amount of revenue paid into the Major Risk Medical Insurance Fund and would expand the purposes~~

for which it may be expended under MRMIP, the bill would make an appropriation. The bill would also impose a state-mandated local program by imposing new requirements on health care service plans, the willful violation of which would be a crime.

(6)

(4) 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: yes. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature hereby finds and declares all of
2 the following:

3 (a) For coverage of health care costs and expenses, Californians
4 rely on a private health care coverage market where private health
5 care service plans and health insurers make health care coverage
6 available to individual and group purchasers.

7 (b) An essential feature of a market-based approach to the
8 provision of health care coverage is that willing buyers are able
9 to purchase coverage.

10 (c) Underwriting and product rating practices in the private
11 individual health care coverage market result in thousands of
12 individuals who are unable to purchase health care coverage at
13 any price.

14 (d) The underwriting and rating practices of health care service
15 plans and health insurers that deny health care coverage to group
16 purchasers on the basis of potential risk or increase the premiums
17 for group purchasers on the basis of potential risk, result in groups
18 without health care coverage, causing thousands of employed
19 individuals to seek individual health care coverage.

20 (e) When uninsurable persons cannot purchase health care
21 coverage and cannot pay for the costs of their health care, it
22 increases the level of uncompensated care in the state. These
23 uncompensated care costs are ultimately borne by public and
24 private providers and result in a cost shift to all purchasers of health
25 care coverage.

1 (f) Since 1991, California has provided a mechanism for
2 individuals without group coverage, who are not otherwise eligible
3 for publicly sponsored health care coverage, to purchase subsidized
4 health care coverage if they have been denied coverage or offered
5 only high-cost individual coverage because of industry rating and
6 underwriting practices. The Major Risk Medical Insurance Program
7 (MRMIP), administered by the Managed Risk Medical Insurance
8 Board, offers coverage to medically uninsurable persons through
9 willing private health plans participating in the program on a
10 voluntary basis. MRMIP offers comprehensive coverage for
11 uninsurable individuals at premium rates significantly higher than
12 standard market rates and subsidizes the costs of coverage not paid
13 by subscriber premiums through an allocation of state funds.

14 (g) California is one of only three states that fund high-risk
15 pools solely with subscriber premiums and state funds, resulting
16 in caps on pool enrollment. Other states address the problem of
17 uninsurable persons through various regulatory means, including
18 requiring health care plans and health insurers to guarantee
19 coverage to individuals regardless of their health status, often at
20 regulated rates, or by establishing an insurer of last resort that must
21 accept all individuals for coverage. Thirty-two states establish a
22 high-risk pool that provides coverage for such persons, similar to
23 MRMIP, and of those, 27 impose regulatory fees on health insurers
24 to fund all or part of the costs of the high-risk pools.

25 (h) It is therefore the intent of the Legislature to establish
26 MRMIP as the state-sponsored health care coverage program for
27 all high-risk and medically uninsurable persons and to provide
28 coverage through MRMIP for all individuals otherwise unable to
29 obtain private health care coverage due to a preexisting health
30 condition who are willing to voluntarily pay premiums and enroll
31 in MRMIP. The Legislature further intends to reduce and
32 potentially eliminate the need for a high-risk pool in California by
33 ensuring that private individual health care coverage is guaranteed
34 available to any individual willing to pay for that coverage
35 regardless of his or her health status or medical condition. The
36 Legislature intends to require every entity that offers health
37 coverage in this state to make available to all individuals
38 standardized coverage at standardized rates. The Legislature further
39 intends that health care service plans and health insurers required
40 to provide individual coverage on a guaranteed issue basis may

1 elect, instead, to pay a fee to the state so that the state may arrange
2 for and subsidize the costs of health care coverage for those persons
3 who are denied private health care coverage because of their health
4 history, health status, or health condition.

5 (i) It is not the intent of the Legislature to provide coverage
6 through MRMIP for persons able to obtain adequate health care
7 coverage in the private market.

8 SEC. 2. Section 1356.2 is added to the Health and Safety Code,
9 to read:

10 1356.2. (a) In addition to the other fees and reimbursements
11 required to be paid under this chapter, each licensed health care
12 service plan, except for a specialized health care service plan,
13 electing to pay the fee under Chapter 9 (commencing with Section
14 12739.5) of Part 6.5 of Division 2 of the Insurance Code, shall pay
15 the fee to the director in the amount as determined by the Managed
16 Risk Medical Insurance Board. The timely payment of the fee and
17 the timely submission of information pursuant to Section 12739.7
18 of the Insurance Code shall be deemed to be among the
19 prerequisites for obtaining and retaining a license as a health care
20 service plan. The director shall transmit fees collected pursuant to
21 this section to the Managed Risk Medical Insurance Board, in a
22 manner determined by that board, within 30 days after the date on
23 which the director receives those fees. The director shall permit
24 health care service plans subject to the fee to remit payment on a
25 quarterly basis.

26 (b) A health care service plan that has elected not to pay its
27 share of program costs pursuant to Chapter 9 (commencing with
28 Section 12739.5) of Part 6.5 of Division 2 of the Insurance Code,
29 shall demonstrate to the satisfaction of the director that it is in
30 compliance with subdivision (a) of Section 1373.63.

31 ~~SEC. 3. Section 1366.35 of the Health and Safety Code is~~
32 ~~amended to read:~~

33 ~~1366.35. (a) A health care service plan providing coverage~~
34 ~~for hospital, medical, or surgical benefits under an individual health~~
35 ~~care service plan contract may not, with respect to a federally~~
36 ~~eligible defined individual desiring to enroll in individual health~~
37 ~~care coverage, decline to offer coverage to, or deny enrollment of,~~
38 ~~the individual or impose any preexisting condition exclusion with~~
39 ~~respect to the coverage.~~

1 ~~(b) For purposes of this section, “federally eligible defined~~
2 ~~individual” means an individual who, as of the date on which the~~
3 ~~individual seeks coverage under this section, meets all of the~~
4 ~~following conditions:~~

5 ~~(1) Has had 18 or more months of creditable coverage, and~~
6 ~~whose most recent prior creditable coverage was under a group~~
7 ~~health plan, a federal governmental plan maintained for federal~~
8 ~~employees, or a governmental plan or church plan as defined in~~
9 ~~the federal Employee Retirement Income Security Act of 1974~~
10 ~~(29 U.S.C. Sec. 1002).~~

11 ~~(2) Is not eligible for coverage under a group health plan,~~
12 ~~Medicare, or Medi-Cal, and does not have other health care~~
13 ~~coverage.~~

14 ~~(3) Was not terminated from his or her most recent creditable~~
15 ~~coverage due to nonpayment of premiums or fraud.~~

16 ~~(4) If offered continuation coverage under COBRA or~~
17 ~~Cal-COBRA, has elected and exhausted that coverage.~~

18 ~~(e) Every health care service plan shall comply with applicable~~
19 ~~federal statutes and regulations regarding the provision of coverage~~
20 ~~to federally eligible defined individuals, including any relevant~~
21 ~~application periods.~~

22 ~~(d) A health care service plan shall offer the following health~~
23 ~~benefit plan contracts under this section that are designed for, made~~
24 ~~generally available to, are actively marketed to, and enroll,~~
25 ~~individuals: (1) either the two most popular products as defined~~
26 ~~in Section 300gg-41(e)(2) of Title 42 of the United States Code~~
27 ~~and Section 148.120(e)(2) of Title 45 of the Code of Federal~~
28 ~~Regulations or (2) the two most representative products as defined~~
29 ~~in Section 300gg-41(e)(3) of Title 42 of the United States Code~~
30 ~~and Section 148.120(e)(3) of Title 45 of the Code of Federal~~
31 ~~Regulations, as determined by the plan in compliance with federal~~
32 ~~law. A health care service plan that offers only one health benefit~~
33 ~~plan contract to individuals, excluding health benefit plans offered~~
34 ~~to Medi-Cal or Medicare beneficiaries, shall be deemed to be in~~
35 ~~compliance with this article if it offers that health benefit plan~~
36 ~~contract to federally eligible defined individuals in a manner~~
37 ~~consistent with this article.~~

38 ~~(e) (1) In the case of a health care service plan that offers health~~
39 ~~care coverage in the individual market through a network plan,~~
40 ~~the plan may do both of the following:~~

1 ~~(A) Limit the individuals who may be enrolled under that~~
2 ~~coverage to those who live, reside, or work within the service area~~
3 ~~for the network plan.~~

4 ~~(B) Within the service area of the plan, deny coverage to~~
5 ~~individuals if the plan has demonstrated to the director that the~~
6 ~~plan will not have the capacity to deliver services adequately to~~
7 ~~additional individual enrollees because of its obligations to existing~~
8 ~~group contractholders and enrollees and individual enrollees, and~~
9 ~~that the plan is applying this paragraph uniformly to individuals~~
10 ~~without regard to any health status related factor of the individuals~~
11 ~~and without regard to whether the individuals are federally eligible~~
12 ~~defined individuals.~~

13 ~~(2) A health care service plan, upon denying health care~~
14 ~~coverage in any service area in accordance with subparagraph (B)~~
15 ~~of paragraph (1), may not offer coverage in the individual market~~
16 ~~within that service area for a period of 180 days after the coverage~~
17 ~~is denied.~~

18 ~~(f) (1) A health care service plan may deny health care coverage~~
19 ~~in the individual market to a federally eligible defined individual~~
20 ~~if the plan has demonstrated to the director both of the following:~~

21 ~~(A) The plan does not have the financial reserves necessary to~~
22 ~~underwrite additional coverage.~~

23 ~~(B) The plan is applying this subdivision uniformly to all~~
24 ~~individuals in the individual market and without regard to any~~
25 ~~health status-related factor of the individuals and without regard~~
26 ~~to whether the individuals are federally eligible individuals.~~

27 ~~(2) A health care service plan, upon denying individual health~~
28 ~~care coverage in any service area in accordance with paragraph~~
29 ~~(1), may not offer that coverage in the individual market within~~
30 ~~that service area for a period of 180 days after the date the coverage~~
31 ~~is denied or until the issuer has demonstrated to the director that~~
32 ~~the plan has sufficient financial reserves to underwrite additional~~
33 ~~coverage, whichever is later.~~

34 ~~(g) The requirement pursuant to federal law to furnish a~~
35 ~~certificate of creditable coverage shall apply to health care coverage~~
36 ~~offered by a health care service plan in the individual market in~~
37 ~~the same manner as it applies to a health care service plan in~~
38 ~~connection with a group health benefit plan.~~

39 ~~(h) A health care service plan shall compensate a life agent or~~
40 ~~fire and casualty broker-agent whose activities result in the~~

1 enrollment of federally eligible defined individuals in the same
2 manner and consistent with the renewal commission amounts as
3 the plan compensates life agents or fire and casualty broker agents
4 for other enrollees who are not federally eligible defined
5 individuals and who are purchasing the same individual health
6 benefit plan contract.

7 (i) Every health care service plan shall disclose as part of its
8 COBRA or Cal-COBRA disclosure and enrollment documents,
9 an explanation of the availability of guaranteed access to coverage
10 under the Health Insurance Portability and Accountability Act of
11 1996, including the necessity to enroll in and exhaust COBRA or
12 Cal-COBRA benefits in order to become a federally eligible
13 defined individual.

14 (j) No health care service plan may request documentation as
15 to whether or not a person is a federally eligible defined individual
16 other than is permitted under applicable federal law or regulations.

17 (k) This section shall not apply to coverage defined as excepted
18 benefits pursuant to Section 300gg(c) of Title 42 of the United
19 States Code.

20 (l) This section shall apply to health care service plan contracts
21 offered, delivered, amended, or renewed on or after January 1,
22 2001.

23 (m) This section shall remain in effect only until January 1,
24 2009, and as of that date is repealed, unless a later enacted statute,
25 that is enacted before January 1, 2009, deletes or extends that date.

26 SEC. 4. Section 1366.35 is added to the Health and Safety
27 Code, to read:

28 1366.35. (a) A health care service plan providing coverage
29 for hospital, medical, or surgical benefits under an individual health
30 care service plan contract may not, with respect to a federally
31 eligible defined individual desiring to enroll in individual health
32 care coverage, decline to offer coverage to, or deny enrollment of,
33 the individual or impose any preexisting condition exclusion with
34 respect to the coverage.

35 (b) For purposes of this section, "federally eligible defined
36 individual" means an individual who, as of the date on which the
37 individual seeks coverage under this section, meets all of the
38 following conditions:

39 (1) Has had 18 or more months of creditable coverage, and the
40 individual's most recent prior creditable coverage was under a

1 ~~group health plan, a federal governmental plan maintained for~~
2 ~~federal employees, or a governmental plan or church plan as~~
3 ~~defined in the federal Employee Retirement Income Security Act~~
4 ~~of 1974 (29 U.S.C. Sec. 1002):~~

5 ~~(2) Is not eligible for coverage under a group health plan,~~
6 ~~Medicare, or Medi-Cal, and does not have other health care~~
7 ~~coverage.~~

8 ~~(3) Was not terminated from his or her most recent creditable~~
9 ~~coverage due to nonpayment of premiums or fraud.~~

10 ~~(4) If offered continuation coverage under COBRA or~~
11 ~~Cal-COBRA, has elected and exhausted that coverage.~~

12 ~~(e) Every health care service plan shall comply with applicable~~
13 ~~federal statutes and regulations regarding the provision of coverage~~
14 ~~to federally eligible defined individuals, including any relevant~~
15 ~~application periods.~~

16 ~~(d) A health care service plan shall offer the following health~~
17 ~~benefit plan contracts under this section that are designed for, made~~
18 ~~generally available to, are actively marketed to, and enroll,~~
19 ~~individuals: (1) either the two most popular products as defined~~
20 ~~in Section 300gg-41(e)(2) of Title 42 of the United States Code~~
21 ~~and Section 148.120(e)(2) of Title 45 of the Code of Federal~~
22 ~~Regulations or (2) the two most representative products as defined~~
23 ~~in Section 300gg-41(e)(3) of Title 42 of the United States Code~~
24 ~~and Section 148.120(e)(3) of Title 45 of the Code of Federal~~
25 ~~Regulations, as determined by the plan in compliance with federal~~
26 ~~law. A health care service plan that offers only one health benefit~~
27 ~~plan contract to individuals, excluding health benefit plans offered~~
28 ~~to Medi-Cal or Medicare beneficiaries, shall be deemed to be in~~
29 ~~compliance with this article if it offers that health benefit plan~~
30 ~~contract to federally eligible defined individuals in a manner~~
31 ~~consistent with this article.~~

32 ~~(e) (1) In the case of a health care service plan that offers health~~
33 ~~care coverage in the individual market through a network plan,~~
34 ~~the plan may do both of the following:~~

35 ~~(A) Limit the individuals who may be enrolled under that~~
36 ~~coverage to those who live, reside, or work within the service area~~
37 ~~for the network plan.~~

38 ~~(B) Within the service area of the plan, deny coverage to~~
39 ~~individuals if the plan has demonstrated to the director that the~~
40 ~~plan will not have the capacity to deliver services adequately to~~

1 additional individual enrollees because of its obligations to existing
2 group contractholders and enrollees and individual enrollees, and
3 that the plan is applying this paragraph uniformly to individuals
4 without regard to any health status-related factor of the individuals
5 and without regard to whether the individuals are federally eligible
6 defined individuals.

7 (2) A health care service plan, upon denying health care
8 coverage in any service area in accordance with subparagraph (B)
9 of paragraph (1), may not offer coverage in the individual market
10 within that service area for a period of 180 days after the coverage
11 is denied.

12 (f) (1) A health care service plan may deny health care coverage
13 in the individual market to a federally eligible defined individual
14 if the plan has demonstrated to the director both of the following:

15 (A) The plan does not have the financial reserves necessary to
16 underwrite additional coverage.

17 (B) The plan is applying this subdivision uniformly to all
18 individuals in the individual market and without regard to any
19 health status-related factor of the individuals and without regard
20 to whether the individuals are federally eligible individuals.

21 (2) A health care service plan, upon denying individual health
22 care coverage in any service area in accordance with paragraph
23 (1), may not offer that coverage in the individual market within
24 that service area for a period of 180 days after the date the coverage
25 is denied or until the issuer has demonstrated to the director that
26 the plan has sufficient financial reserves to underwrite additional
27 coverage, whichever is later.

28 (g) The requirement pursuant to federal law to furnish a
29 certificate of creditable coverage shall apply to health care coverage
30 offered by a health care service plan in the individual market in
31 the same manner as it applies to a health care service plan in
32 connection with a group health benefit plan.

33 (h) A health care service plan shall compensate a life agent or
34 fire and casualty broker-agent whose activities result in the
35 enrollment of federally eligible defined individuals in the same
36 manner and consistent with the renewal commission amounts as
37 the plan compensates life agents or fire and casualty broker-agents
38 for other enrollees who are not federally eligible defined
39 individuals and who are purchasing the same individual health
40 benefit plan contract.

1 ~~(i) Every health care service plan shall disclose as part of its~~
2 ~~COBRA or Cal-COBRA disclosure and enrollment documents,~~
3 ~~an explanation of the availability of guaranteed access to coverage~~
4 ~~under the Health Insurance Portability and Accountability Act of~~
5 ~~1996, including the necessity to enroll in and exhaust COBRA or~~
6 ~~Cal-COBRA benefits in order to become a federally eligible~~
7 ~~defined individual.~~

8 ~~(j) No health care service plan may request documentation as~~
9 ~~to whether or not a person is a federally eligible defined individual~~
10 ~~other than is permitted under applicable federal law or regulations.~~

11 ~~(k) This section shall not apply to coverage defined as excepted~~
12 ~~benefits pursuant to Section 300gg(c) of Title 42 of the United~~
13 ~~States Code.~~

14 ~~(l) Notwithstanding any other provisions of this article or of~~
15 ~~Article 11.5 (commencing with Section 1399.801), a health care~~
16 ~~service plan is not required to offer coverage pursuant to~~
17 ~~subdivision (a) or (d) to an individual who qualifies as a federally~~
18 ~~eligible defined individual on or after January 1, 2009.~~

19 ~~(m) (1) A health care service plan shall inform all individuals~~
20 ~~applying for coverage pursuant to this section or Section 300gg-41~~
21 ~~of Title 42 of the United States Code that if they are eligible for~~
22 ~~this coverage, the coverage will be provided through the California~~
23 ~~Major Risk Medical Insurance Program (Part 6.5 (commencing~~
24 ~~with Section 12700) of Division 2 of the Insurance Code) and that~~
25 ~~they are required to apply for that coverage within 63 days of~~
26 ~~becoming eligible for it.~~

27 ~~(2) A health care service plan shall disclose, as part of its~~
28 ~~COBRA or Cal-COBRA disclosure and enrollment documents,~~
29 ~~an explanation of the availability of guaranteed access to coverage~~
30 ~~under the California Major Risk Medical Insurance Program~~
31 ~~pursuant to paragraph (2) of subdivision (b) of Section 12725 of~~
32 ~~the Insurance Code.~~

33 ~~(n) Subdivisions (l) and (m) shall be operative only if the state~~
34 ~~receives a waiver from the federal Centers for Medicare and~~
35 ~~Medicaid Services, or any other applicable federal agency,~~
36 ~~permitting the state to operate an acceptable alternative mechanism~~
37 ~~pursuant to Section 2744 of the Public Health Service Act (42~~
38 ~~U.S.C. Sec. 300gg-44) by enrolling federally defined eligible~~
39 ~~individuals into the California Major Risk Medical Insurance~~
40 ~~Program in lieu of coverage described in subdivisions (a) and (d).~~

1 ~~(o) Nothing in this section shall be construed to permit a health~~
2 ~~care service plan to terminate coverage for an otherwise eligible~~
3 ~~individual enrolled in a health benefit plan contract pursuant to~~
4 ~~this section prior to January 1, 2009.~~

5 ~~(p) This section shall apply to a health care service plan contract~~
6 ~~offered, delivered, amended, or renewed on or after January 1,~~
7 ~~2009.~~

8 ~~(q) This section shall become operative on January 1, 2009.~~

9 ~~SEC. 5. Section 1367.15 of the Health and Safety Code is~~
10 ~~amended to read:~~

11 ~~1367.15. (a) This section shall apply to individual health care~~
12 ~~service plan contracts and plan contracts sold to employer groups~~
13 ~~with fewer than two eligible employees as defined in subdivision~~
14 ~~(b) of Section 1357 covering hospital, medical, or surgical~~
15 ~~expenses, that is issued, amended, delivered, or renewed on or~~
16 ~~after January 1, 1994.~~

17 ~~(b) As used in this section, “block of business” means individual~~
18 ~~plan contracts or plan contracts sold to employer groups with fewer~~
19 ~~than two eligible employees as defined in subdivision (b) of Section~~
20 ~~1357, with distinct benefits, services, and terms. A “closed block~~
21 ~~of business” means a block of business for which a health care~~
22 ~~service plan ceases to actively offer or sell new plan contracts.~~

23 ~~(c) No block of business shall be closed by a health care service~~
24 ~~plan unless the plan takes either of the following actions:~~

25 ~~(1) The plan permits an enrollee to receive health care services~~
26 ~~from any block of business that is not closed and that provides~~
27 ~~comparable benefits, services, and terms, with no additional~~
28 ~~underwriting requirement.~~

29 ~~(2) The plan pools the experience of the closed block of business~~
30 ~~with all appropriate blocks of business that are not closed for the~~
31 ~~purpose of determining the premium rate of any plan contract~~
32 ~~within the closed block, with no rate penalty or surcharge beyond~~
33 ~~that which reflects the experience of the combined pool.~~

34 ~~(d) A block of business shall be presumed closed if either of~~
35 ~~the following is applicable:~~

36 ~~(1) There has been an overall reduction in that block of 12~~
37 ~~percent in the number of in force plan contracts for a period of 12~~
38 ~~months.~~

39 ~~(2) That block has less than 1,000 enrollees in this state. This~~
40 ~~presumption shall not apply to a block of business initiated within~~

1 the previous 24 months, but notification of that block shall be
2 provided to the director pursuant to subdivision (e).

3 The fact that a block of business does not meet one of the
4 presumptions set forth in this subdivision shall not preclude a
5 determination that it is closed as defined in subdivision (b).

6 (e) A health care service plan shall notify the director in writing
7 within 30 days of its decision to close a block of business or, in
8 the absence of an actual decision to close a block of business,
9 within 30 days of its determination that a block of business is
10 within the presumption set forth in subdivision (d). When the plan
11 decides to close a block, the written notice shall fully disclose all
12 information necessary to demonstrate compliance with the
13 requirements of subdivision (e). When the plan determines that a
14 block is within the presumption, the written notice shall fully
15 disclose all information necessary to demonstrate that the
16 presumption is applicable. In the case of either notice, the plan
17 shall provide additional information within 15 days after any
18 request of the director.

19 (f) A health care service plan shall preserve for a period of not
20 less than five years in an identified location and readily accessible
21 for review by the director all books and records relating to any
22 action taken by a plan pursuant to subdivision (e).

23 (g) No health care service plan shall offer or sell any contract,
24 or provide misleading information about the active or closed status
25 of a block of business, for the purpose of evading this section.

26 (h) A health care service plan shall bring any blocks of business
27 closed prior to the effective date of this section into compliance
28 with the terms of this section no later than December 31, 1994.

29 (i) This section shall not apply to health care service plan
30 contracts providing small employer health coverage to individuals
31 or employer groups with fewer than two eligible employees if that
32 coverage is provided pursuant to Article 3.1 (commencing with
33 Section 1357) and, with specific reference to coverage for
34 individuals or employer groups with fewer than two eligible
35 employees, is approved by the director pursuant to Section 1357.15,
36 provided a plan electing to sell coverage pursuant to this
37 subdivision shall do so until such time as the plan ceases to market
38 coverage to small employers and complies with subdivision (e) of
39 Section 1357.11.

1 ~~(j) This section shall not apply to coverage of Medicare services~~
2 ~~pursuant to contracts with the United States government, Medicare~~
3 ~~supplement, dental, vision, or conversion coverage or to coverage~~
4 ~~provided pursuant to Section 300gg-41 of Title 42 of the United~~
5 ~~States Code prior to January 1, 2009, or to continuation coverage~~
6 ~~provided pursuant to Section 1373.6 or 1373.621 prior to July 1,~~
7 ~~2009.~~

8 ~~SEC. 6. Section 1373.6 of the Health and Safety Code is~~
9 ~~amended to read:~~

10 ~~1373.6. This section does not apply to a specialized health care~~
11 ~~service plan contract or to a plan contract that primarily or solely~~
12 ~~supplements Medicare. The director may adopt rules consistent~~
13 ~~with federal law to govern the discontinuance and replacement of~~
14 ~~plan contracts that primarily or solely supplement Medicare.~~

15 ~~(a) (1) Every group contract entered into, amended, or renewed~~
16 ~~on or after September 1, 2003, that provides hospital, medical, or~~
17 ~~surgical expense benefits for employees or members shall provide~~
18 ~~that an employee or member whose coverage under the group~~
19 ~~contract has been terminated by the employer shall be entitled to~~
20 ~~convert to nongroup membership, without evidence of insurability,~~
21 ~~subject to the terms and conditions of this section.~~

22 ~~(2) If the health care service plan provides coverage under an~~
23 ~~individual health care service plan contract, other than conversion~~
24 ~~coverage under this section, it shall offer one of the two plans that~~
25 ~~it is required to offer to a federally eligible defined individual~~
26 ~~pursuant to Section 1366.35. The plan shall provide this coverage~~
27 ~~at the same rate established under Section 1399.805 or 1399.819~~
28 ~~for a federally eligible defined individual. A health care service~~
29 ~~plan that is federally qualified under the federal Health~~
30 ~~Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) may~~
31 ~~charge a rate for the coverage that is consistent with the provisions~~
32 ~~of that act.~~

33 ~~(3) If the health care service plan does not provide coverage~~
34 ~~under an individual health care service plan contract, it shall offer~~
35 ~~a health benefit plan contract that is the same as a health benefit~~
36 ~~contract offered to a federally eligible defined individual pursuant~~
37 ~~to Section 1366.35. The health care service plan may offer either~~
38 ~~the most popular health maintenance organization model plan or~~
39 ~~the most popular preferred provider organization plan, each of~~
40 ~~which has the greatest number of enrolled individuals for its type~~

1 of plan as of January 1 of the prior year, as reported by plans that
2 provide coverage under an individual health care service plan
3 contract to the department or the Department of Insurance by
4 January 31, 2003, and annually thereafter. A health care service
5 plan subject to this paragraph shall provide this coverage with the
6 same cost-sharing terms and at the same premium as a health care
7 service plan providing coverage to that individual under an
8 individual health care service plan contract pursuant to Section
9 1399.805 or 1399.819. The health care service plan shall file the
10 health benefit plan it will offer, including the premium it will
11 charge and the cost-sharing terms of the plan, with the Department
12 of Managed Health Care.

13 (b) A conversion contract shall not be required to be made
14 available to an employee or member if termination of his or her
15 coverage under the group contract occurred for any of the following
16 reasons:

17 (1) The group contract terminated or an employer's participation
18 terminated and the group contract is replaced by similar coverage
19 under another group contract within 15 days of the date of
20 termination of the group coverage or the subscriber's participation.

21 (2) The employee or member failed to pay amounts due the
22 health care service plan.

23 (3) The employee or member was terminated by the health care
24 service plan from the plan for good cause.

25 (4) The employee or member knowingly furnished incorrect
26 information or otherwise improperly obtained the benefits of the
27 plan.

28 (5) The employer's hospital, medical, or surgical expense benefit
29 program is self-insured.

30 (e) A conversion contract is not required to be issued to any
31 person if any of the following facts are present:

32 (1) The person is covered by or is eligible for benefits under
33 Title XVIII of the United States Social Security Act.

34 (2) The person is covered by or is eligible for hospital, medical,
35 or surgical benefits under any arrangement of coverage for
36 individuals in a group, whether insured or self-insured.

37 (3) The person is covered for similar benefits by an individual
38 policy or contract.

1 ~~(4) The person has not been continuously covered during the~~
2 ~~three-month period immediately preceding that person's~~
3 ~~termination of coverage.~~

4 ~~(d) Benefits of a conversion contract shall meet the requirements~~
5 ~~for benefits under this chapter.~~

6 ~~(e) Unless waived in writing by the plan, written application~~
7 ~~and first premium payment for the conversion contract shall be~~
8 ~~made not later than 63 days after termination from the group. A~~
9 ~~conversion contract shall be issued by the plan which shall be~~
10 ~~effective on the day following the termination of coverage under~~
11 ~~the group contract if the written application and the first premium~~
12 ~~payment for the conversion contract are made to the plan not later~~
13 ~~than 63 days after the termination of coverage, unless these~~
14 ~~requirements are waived in writing by the plan.~~

15 ~~(f) The conversion contract shall cover the employee or member~~
16 ~~and his or her dependents who were covered under the group~~
17 ~~contract on the date of their termination from the group.~~

18 ~~(g) A notification of the availability of the conversion coverage~~
19 ~~shall be included in each evidence of coverage. However, it shall~~
20 ~~be the sole responsibility of the employer to notify its employees~~
21 ~~of the availability, terms, and conditions of the conversion coverage~~
22 ~~which responsibility shall be satisfied by notification within 15~~
23 ~~days of termination of group coverage. Group coverage shall not~~
24 ~~be deemed terminated until the expiration of any continuation of~~
25 ~~the group coverage. For purposes of this subdivision, the employer~~
26 ~~shall not be deemed the agent of the plan for purposes of~~
27 ~~notification of the availability, terms, and conditions of conversion~~
28 ~~coverage. On and after January 1, 2009, the notification required~~
29 ~~by this subdivision shall explain that, in lieu of conversion coverage~~
30 ~~provided by the health care service plan, an individual eligible for~~
31 ~~conversion coverage is entitled to receive that coverage through~~
32 ~~the California Major Risk Medical Insurance Program pursuant to~~
33 ~~Section 12725 of the Insurance Code.~~

34 ~~(h) As used in this section, "hospital, medical, or surgical~~
35 ~~benefits under state or federal law" do not include benefits under~~
36 ~~Chapter 7 (commencing with Section 14000) or Chapter 8~~
37 ~~(commencing with Section 14200) of Part 3 of Division 9 of the~~
38 ~~Welfare and Institutions Code, or Title XIX of the United States~~
39 ~~Social Security Act.~~

1 (i) ~~Every group contract entered into, amended, or renewed~~
2 ~~before September 1, 2003, shall be subject to the provisions of this~~
3 ~~section as it read prior to its amendment by Assembly Bill 1401~~
4 ~~of the 2001-02 Regular Session.~~

5 (j) ~~On and after January 1, 2009, a health care service plan shall~~
6 ~~not be subject to the requirements described in subdivisions (a),~~
7 ~~(d), and (f) insofar as those subdivisions require the health care~~
8 ~~service plan to offer and sell coverage to an individual who would~~
9 ~~otherwise become eligible for that coverage on or after January 1,~~
10 ~~2009, under this section.~~

11 ~~SEC. 7. Section 1373.622 of the Health and Safety Code is~~
12 ~~amended to read:~~

13 ~~1373.622. (a) After the termination of the pilot program under~~
14 ~~Section 1373.62, a health care service plan shall continue to provide~~
15 ~~coverage to each individual who was terminated from the Major~~
16 ~~Risk Medical Insurance Program pursuant to subdivision (f) of~~
17 ~~Section 12725 of the Insurance Code during the term of the pilot~~
18 ~~program and who enrolled or applied to enroll in a standard benefit~~
19 ~~plan within 63 days of termination. The Managed Risk Medical~~
20 ~~Insurance Board shall determine the benefits and the premium~~
21 ~~amounts for that continuation of coverage and shall continue to~~
22 ~~pay the amount described in Section 1376.62 for each of those~~
23 ~~individuals. A health care service plan shall not be required to~~
24 ~~offer the coverage described in Section 1373.62 after the~~
25 ~~termination of the pilot program to individuals not already enrolled~~
26 ~~in the pilot program.~~

27 ~~(b) If the state fails to expend, pursuant to this section, sufficient~~
28 ~~funds for the state's contribution amount to any health care service~~
29 ~~plan, the health care service plan may increase the monthly~~
30 ~~payments that its subscribers are required to pay for any standard~~
31 ~~benefit plan to the amount that the Managed Risk Medical~~
32 ~~Insurance Board would charge without a state subsidy for the same~~
33 ~~plan issued to the same individual within the program.~~

34 ~~(c) On or before September 1, 2008, a health care service plan~~
35 ~~with one or more individuals enrolled in a standard benefit plan~~
36 ~~pursuant to subdivision (a) shall send all enrolled individuals and~~
37 ~~individuals enrolled on or after July 1, 2008, the notice and~~
38 ~~certification developed by the Managed Risk Medical Insurance~~
39 ~~Board pursuant to paragraph (2) of subdivision (g) of Section~~
40 ~~12725 of the Insurance Code.~~

1 ~~(d) This section shall remain in effect only until January 1, 2009,~~
2 ~~and as of that date is repealed, unless a later enacted statute, that~~
3 ~~is enacted before January 1, 2009, deletes or extends that date.~~

4 ~~SEC. 8.~~

5 *SEC. 3.* Section 1373.63 is added to the Health and Safety
6 Code, to read:

7 1373.63. (a) On and after January 1, 2009, except as provided
8 in subdivision (e), every health care service plan, except for a
9 specialized health care service plan, licensed in California, that
10 provides individual or group coverage, shall fairly and affirmatively
11 offer, market, and sell all of the benefit plans the health plan offers,
12 whether available for groups or individuals, to individuals in each
13 service area for which the plan provides or arranges for the
14 provision of health care services.

15 (b) The amount paid by any individual for any benefit plan
16 offered shall not vary because of the age, geographic location,
17 health status, or claims experience of the individual. Every health
18 plan shall annually submit to the director for review and approval
19 the proposed rates for all of the benefit plans the health plan offers
20 to individuals pursuant to this section.

21 (c) A health care service plan shall not deny or condition the
22 offering or effectiveness, or the premium rates charged, for benefit
23 plans required to be offered by this section on the health status,
24 claims experience, receipt of health care, or medical condition of
25 the applicant.

26 (d) Health plan contracts issued pursuant to this section shall
27 be guaranteed renewable.

28 (e) A health care service plan shall not be subject to the
29 requirements of this section if it instead elects to pay the fee under
30 Section 12739.5 of the Insurance Code instead of offering a
31 standard benefit plan under this section.

32 (f) The director may take all action authorized under this chapter,
33 including, but not limited to, the imposition of fines or penalties
34 against a health care service plan that does not comply with this
35 section or Section 1356.2.

36 ~~SEC. 9.~~

37 *SEC. 4.* Section 1399.819 is added to the Health and Safety
38 Code, to read:

39 1399.819. On and after January 1, 2009, the premium for a
40 health care service plan contract that offers services through a

1 preferred provider arrangement pursuant to this article or Article
2 4.6 (commencing with Section 1366.35) shall be calculated as
3 described in this article, except that it shall be based on the benefit
4 design for the California Major Risk Medical Insurance Program
5 (Part 6.5 (commencing with Section 12700) of Division 2 of the
6 Insurance Code) in effect on December 31, 2008.

7 ~~SEC. 10.~~

8 *SEC. 5.* Section 1827.86 is added to the Insurance Code, to
9 read:

10 1827.86. (a) Every admitted health insurer that provides health
11 insurance and that elects to pay the fee under Chapter 9
12 (commencing with Section 12739.5) of Part 6.5 shall pay the fee
13 to the commissioner in the amount as determined by the Managed
14 Risk Medical Insurance Board. The commissioner shall permit
15 health insurers subject to the fee to remit payment on a quarterly
16 basis. The timely payment of the fee and the timely submission of
17 information pursuant to Section 12739.7 shall be deemed to be
18 among the prerequisites for obtaining and retaining a certificate
19 of authority or license issued by the commissioner, and in addition,
20 deficiencies with respect to the timely payment or submission of
21 information shall be grounds for the imposition of sanctions or the
22 institution of disciplinary proceedings by the commissioner. The
23 commissioner shall transmit fees collected pursuant to this section
24 to the Managed Risk Medical Insurance Board, in a manner
25 determined by that board, within 30 days after the date on which
26 the commissioner receives those fees.

27 (b) A health insurer that has elected not to pay its share of
28 program costs pursuant to Chapter 9 (commencing with Section
29 12739.5) of Part 6.5, shall demonstrate to the satisfaction of the
30 commissioner that it is in compliance with subdivision (a) of
31 Section 10127.19.

32 (c) The requirements of this section shall not apply to a Medicare
33 supplement, vision-only, dental-only, or CHAMPUS supplement
34 insurance or to hospital indemnity, hospital-only, accident-only,
35 or specified disease insurance that does not pay benefits on a fixed
36 benefit, cash payment only basis or to short-term limited duration
37 health insurance.

38 ~~SEC. 11.~~ Section 10127.16 of the Insurance Code is amended
39 to read:

1 ~~10127.16. (a) After the termination of the pilot program under~~
2 ~~Section 10127.15, a health insurer shall continue to provide~~
3 ~~coverage to each individual who was terminated from the Major~~
4 ~~Risk Medical Insurance Program, pursuant to subdivision (f) of~~
5 ~~Section 12725 during the term of the pilot program and who~~
6 ~~enrolled or applied to enroll in a standard benefit plan within 63~~
7 ~~days of termination. The Managed Risk Medical Insurance Board~~
8 ~~shall determine the benefits and the premium amounts for that~~
9 ~~continuation of coverage and shall continue to pay the amount~~
10 ~~described in Section 10127.15 for each of those individuals. A~~
11 ~~health insurer shall not be required to offer the coverage described~~
12 ~~in Section 10127.15 after the termination of the pilot program to~~
13 ~~individuals not already enrolled in the pilot program.~~

14 ~~(b) If the state fails to expend, pursuant to this section, sufficient~~
15 ~~funds for the state's contribution amount to any health insurer, the~~
16 ~~health insurer may increase the monthly payments that its~~
17 ~~subscribers are required to pay for any standard benefit plan to the~~
18 ~~amount that the Managed Risk Medical Insurance Board would~~
19 ~~charge without a state subsidy for the same insurance product~~
20 ~~issued to the same individual within the program.~~

21 ~~(c) On or before September 1, 2008, a health insurer with one~~
22 ~~or more individuals enrolled in a standard benefit plan pursuant~~
23 ~~to subdivision (a) shall send all enrolled individuals and individuals~~
24 ~~enrolled on or after July 1, 2008, the notice and certification~~
25 ~~developed by the Managed Risk Medical Insurance Board pursuant~~
26 ~~to paragraph (2) of subdivision (g) of Section 12725.~~

27 ~~(d) This section shall remain in effect only until January 1, 2009,~~
28 ~~and as of that date is repealed, unless a later enacted statute, that~~
29 ~~is enacted before January 1, 2009, deletes or extends that date.~~

30 ~~SEC. 12.~~

31 ~~SEC. 6.~~ Section 10127.19 is added to the Insurance Code, to
32 read:

33 10127.19. (a) On and after January 1, 2009, except as provided
34 in subdivision (e), every health insurer that provides individual or
35 group health insurance as defined in Section 106 to residents of
36 this state shall fairly and affirmatively offer, market, and sell all
37 of the benefit plans the insurer offers, whether available to groups
38 or individuals in each service area for which the insurer provides
39 coverage of health care services.

1 (b) The amount paid by any individual for the standard benefit
2 plan shall not vary because of the age, geographic location, health
3 status, or claims experience of the individual. Every health insurer
4 shall annually submit to the commissioner for review and approval
5 the proposed rates for all of the benefit plans the insurer offers to
6 individuals.

7 (c) A health insurer shall not deny or condition the offering or
8 effectiveness, or the premium rates charged, for benefits required
9 to be offered by this section on the health status, claims experience,
10 receipt of health care, or medical condition of the applicant.

11 (d) Health insurance policies issued pursuant to this section
12 shall be guaranteed renewable.

13 (e) A health insurer shall not be subject to the requirements of
14 this section if it instead elects to pay the fee under Section 12739.5
15 instead of offering benefits under this section.

16 (f) The commissioner may take all action authorized under this
17 chapter, including, but not limited to, the imposition of fines or
18 penalties against a health insurer that does not comply with this
19 section or Section 1827.86.

20 ~~SEC. 13.— Section 10176.10 of the Insurance Code is amended~~
21 ~~to read:~~

22 ~~10176.10. (a) On or after January 1, 1994, no disability insurer~~
23 ~~issuing policies covering hospital, surgical, or medical expenses~~
24 ~~delivered or renewed in this state or certificates of group disability~~
25 ~~insurance delivered or renewed in this state pursuant to a master~~
26 ~~group policy delivered or renewed in another state, to individuals,~~
27 ~~or to employer groups with fewer than two eligible employees, as~~
28 ~~defined in subdivision (f) of Section 10700, shall close a block of~~
29 ~~business without complying with this section.~~

30 ~~(b) As used in this section, “block of business” means individual,~~
31 ~~group, or blanket disability insurance contracts covering hospital,~~
32 ~~medical, or surgical expenses of a particular policy form that has~~
33 ~~distinct benefits or marketing methods. “Closed block of business”~~
34 ~~means a block of business for which an insurer ceases to actively~~
35 ~~market and sell new contracts under a particular policy form in~~
36 ~~this state.~~

37 ~~(c) Notwithstanding subdivision (b), a block of business shall~~
38 ~~be presumed closed if either of the following applies:~~

1 ~~(1) There has been an overall reduction of 12 percent in the~~
2 ~~number of in force policies of a particular form for a period of 12~~
3 ~~months.~~

4 ~~(2) The block has less than 2,000 insureds nationally or 1,000~~
5 ~~insureds in California. This presumption shall not apply to a block~~
6 ~~of business initiated within the previous 24 months, but notification~~
7 ~~of that block shall be provided to the commissioner. The~~
8 ~~notification shall not be subject to the approval required by~~
9 ~~subdivision (d).~~

10 ~~An insurer may present evidence for consideration by the~~
11 ~~commissioner that the presumption in the particular case is~~
12 ~~incorrect. Should the determination be made that the block is~~
13 ~~closed, the insurer shall be given those remedy options contained~~
14 ~~in subdivision (d). The fact that a block of business does not meet~~
15 ~~one of the presumptions set forth in this subdivision shall not~~
16 ~~preclude a determination that it is closed as defined in subdivision~~
17 ~~(b).~~

18 ~~(d) An insurer shall notify the commissioner within 30 days of~~
19 ~~its decision to close a block or, in the absence of an actual decision~~
20 ~~to close a block of business, within 30 days of its determination~~
21 ~~that the block is within the presumptions set forth in subdivision~~
22 ~~(e). The commissioner may notify an insurer that he or she has~~
23 ~~determined that the presumptions contained in subdivision (e)~~
24 ~~apply to a block. No insurer providing disability insurance covering~~
25 ~~hospital, medical, or surgical expenses shall close a policy form~~
26 ~~or group certificate without notification to the commissioner. That~~
27 ~~notification shall include a plan to permit an insured to move to~~
28 ~~any open block, providing comparable benefits with no additional~~
29 ~~underwriting requirement or, alternatively, the insurer shall be~~
30 ~~required to pool the closed block's experience with all appropriate~~
31 ~~open forms for purposes of renewal rate determination, with no~~
32 ~~rate penalty or surcharge, beyond that which reflects the experience~~
33 ~~of the combined pool. When the insurer chooses to pool, the notice~~
34 ~~shall include the insurer's plan for pooling the closed block's~~
35 ~~experience. The insurer may implement the pooling plan if 30 days~~
36 ~~expire after the submission is filed without written notice from the~~
37 ~~commissioner specifying the reasons for his or her opinion that~~
38 ~~the pooling plan does not comply with the requirements of this~~
39 ~~section, or, prior to that time, if the commissioner provides the~~

1 insurer written notice that the pooling plan complies with the
2 requirements of this section.

3 The approval shall be based upon consideration of the
4 accumulative recent and expected future experience of the closed
5 form and those with which the closed form is to be combined.

6 (e) No insurer shall offer or sell any form nor provide misleading
7 information about the active or closed status of its business for the
8 purpose of evading this section.

9 (f) An insurer shall bring any blocks of business closed prior to
10 the effective date of this section into compliance with the terms
11 of this section no later than December 31, 1994.

12 (g) This section shall not apply to small employer carriers
13 providing small employer health insurance to individuals or
14 employer groups with fewer than two eligible employees if that
15 coverage is provided pursuant to Chapter 8 (commencing with
16 Section 10700), and with specific reference to coverage for
17 individuals or employer groups with fewer than two eligible
18 employees, is approved by the commissioner pursuant to Section
19 10705, provided a carrier electing to sell coverage pursuant to this
20 subdivision shall continue to do so until such time as the carrier
21 ceases to market coverage to small employers and complies with
22 subdivision (e) of Section 10713.

23 (h) This section shall not apply to accident only coverage,
24 coverage of Medicare services pursuant to contracts with the United
25 States government, Medicare supplement coverage, long-term care
26 insurance, dental, vision, or conversion coverage, coverage issued
27 as a supplement to liability insurance, or automobile medical
28 payment insurance or to coverage provided pursuant to Section
29 300gg-41 of Title 42 of the United States Code prior to January
30 1, 2009, or to continuation coverage provided pursuant to Part 6.1
31 (commencing with Section 12670) prior to January 1, 2009.

32 SEC. 14. Section 10785 of the Insurance Code is amended to
33 read:

34 10785. (a) A health insurer that covers hospital, medical, or
35 surgical expenses under an individual health benefit plan as defined
36 in subdivision (a) of Section 10198.6 may not, with respect to a
37 federally eligible defined individual desiring to enroll in individual
38 health insurance coverage, decline to offer coverage to, or deny
39 enrollment of, the individual or impose any preexisting condition
40 exclusion with respect to the coverage.

1 ~~(b) For purposes of this section, “federally eligible defined~~
2 ~~individual” means an individual who, as of the date on which the~~
3 ~~individual seeks coverage under this section, meets all of the~~
4 ~~following conditions:~~

5 ~~(1) Has had 18 or more months of creditable coverage, and~~
6 ~~whose most recent prior creditable coverage was under a group~~
7 ~~health plan, a federal governmental plan maintained for federal~~
8 ~~employees, or a governmental plan or church plan as defined in~~
9 ~~the federal Employee Retirement Income Security Act of 1974~~
10 ~~(29 U.S.C. Sec. 1002).~~

11 ~~(2) Is not eligible for coverage under a group health plan,~~
12 ~~Medicare, or Medi-Cal, and does not have other health insurance~~
13 ~~coverage.~~

14 ~~(3) Was not terminated from his or her most recent creditable~~
15 ~~coverage due to nonpayment of premiums or fraud.~~

16 ~~(4) If offered continuation coverage under COBRA or~~
17 ~~Cal-COBRA, has elected and exhausted that coverage.~~

18 ~~(e) Every health insurer that covers hospital, medical, or surgical~~
19 ~~expenses shall comply with applicable federal statutes and~~
20 ~~regulations regarding the provision of coverage to federally eligible~~
21 ~~defined individuals, including any relevant application periods.~~

22 ~~(d) A health insurer shall offer the following health benefit plans~~
23 ~~under this section that are designed for, made generally available~~
24 ~~to, are actively marketed to, and enroll, individuals: (1) either the~~
25 ~~two most popular products as defined in Section 300gg-41(e)(2)~~
26 ~~of Title 42 of the United States Code and Section 148.120(e)(2)~~
27 ~~of Title 45 of the Code of Federal Regulations or (2) the two most~~
28 ~~representative products as defined in Section 300gg-41(e)(3) of~~
29 ~~Title 42 of the United States Code and Section 148.120(e)(3) of~~
30 ~~Title 45 of the Code of Federal Regulations, as determined by the~~
31 ~~insurer in compliance with federal law. An insurer that offers only~~
32 ~~one health benefit plan to individuals, excluding health benefit~~
33 ~~plans offered to Medi-Cal or Medicare beneficiaries, shall be~~
34 ~~deemed to be in compliance with this chapter if it offers that health~~
35 ~~benefit plan contract to federally eligible defined individuals in a~~
36 ~~manner consistent with this chapter.~~

37 ~~(e) (1) In the case of a health insurer that offers health benefit~~
38 ~~plans in the individual market through a network plan, the insurer~~
39 ~~may do both of the following:~~

1 ~~(A) Limit the individuals who may be enrolled under that~~
2 ~~coverage to those who live, reside, or work within the service area~~
3 ~~for the network plan.~~

4 ~~(B) Within the service area covered by the health benefit plan,~~
5 ~~deny coverage to individuals if the insurer has demonstrated to the~~
6 ~~commissioner that the insured will not have the capacity to deliver~~
7 ~~services adequately to additional individual insureds because of~~
8 ~~its obligations to existing group policyholders, group~~
9 ~~contractholders and insureds, and individual insureds, and that the~~
10 ~~insurer is applying this paragraph uniformly to individuals without~~
11 ~~regard to any health status-related factor of the individuals and~~
12 ~~without regard to whether the individuals are federally eligible~~
13 ~~defined individuals.~~

14 ~~(2) A health insurer, upon denying health insurance coverage~~
15 ~~in any service area in accordance with subparagraph (B) of~~
16 ~~paragraph (1), may not offer health benefit plans through a network~~
17 ~~in the individual market within that service area for a period of~~
18 ~~180 days after the coverage is denied.~~

19 ~~(f) (1) A health insurer may deny health insurance coverage in~~
20 ~~the individual market to a federally eligible defined individual if~~
21 ~~the insurer has demonstrated to the commissioner both of the~~
22 ~~following:~~

23 ~~(A) The insurer does not have the financial reserves necessary~~
24 ~~to underwrite additional coverage.~~

25 ~~(B) The insurer is applying this subdivision uniformly to all~~
26 ~~individuals in the individual market and without regard to any~~
27 ~~health status-related factor of the individuals and without regard~~
28 ~~to whether the individuals are federally eligible defined individuals.~~

29 ~~(2) A health insurer, upon denying individual health insurance~~
30 ~~coverage in any service area in accordance with paragraph (1),~~
31 ~~may not offer that coverage in the individual market within that~~
32 ~~service area for a period of 180 days after the date the coverage is~~
33 ~~denied or until the insurer has demonstrated to the commissioner~~
34 ~~that the insurer has sufficient financial reserves to underwrite~~
35 ~~additional coverage, whichever is later.~~

36 ~~(g) The requirement pursuant to federal law to furnish a~~
37 ~~certificate of creditable coverage shall apply to health benefits~~
38 ~~plans offered by a health insurer in the individual market in the~~
39 ~~same manner as it applies to an insurer in connection with a group~~
40 ~~health benefit plan policy or group health benefit plan contract.~~

1 ~~(h) A health insurer shall compensate a life agent or fire and~~
2 ~~casualty broker-agent whose activities result in the enrollment of~~
3 ~~federally eligible defined individuals in the same manner and~~
4 ~~consistent with the renewal commission amounts as the insurer~~
5 ~~compensates life agents or fire and casualty broker-agents for other~~
6 ~~enrollees who are not federally eligible defined individuals and~~
7 ~~who are purchasing the same individual health benefit plan.~~

8 ~~(i) Every health insurer shall disclose as part of its COBRA or~~
9 ~~Cal-COBRA disclosure and enrollment documents, an explanation~~
10 ~~of the availability of guaranteed access to coverage under the~~
11 ~~Health Insurance Portability and Accountability Act of 1996,~~
12 ~~including the necessity to enroll in and exhaust COBRA or~~
13 ~~Cal-COBRA benefits in order to become a federally eligible~~
14 ~~defined individual.~~

15 ~~(j) No health insurer may request documentation as to whether~~
16 ~~or not a person is a federally eligible defined individual other than~~
17 ~~is permitted under applicable federal law or regulations.~~

18 ~~(k) This section shall not apply to coverage defined as excepted~~
19 ~~benefits pursuant to Section 300gg(e) of Title 42 of the United~~
20 ~~States Code.~~

21 ~~(l) This section shall apply to policies or contracts offered,~~
22 ~~delivered, amended, or renewed on or after January 1, 2001.~~

23 ~~(m) This section shall remain in effect only until January 1,~~
24 ~~2009, and as of that date is repealed, unless a later enacted statute,~~
25 ~~that is enacted before January 1, 2009, deletes or extends that date.~~

26 ~~SEC. 15. Section 10785 is added to the Insurance Code, to~~
27 ~~read:~~

28 ~~10785. (a) A health insurer that covers hospital, medical, or~~
29 ~~surgical expenses under an individual health benefit plan as defined~~
30 ~~in subdivision (a) of Section 10198.6 shall not, with respect to a~~
31 ~~federally eligible defined individual desiring to enroll in individual~~
32 ~~health insurance coverage, decline to offer coverage to, or deny~~
33 ~~enrollment of, the individual or impose any preexisting condition~~
34 ~~exclusion with respect to the coverage.~~

35 ~~(b) For purposes of this section, “federally eligible defined~~
36 ~~individual” means an individual who, as of the date on which the~~
37 ~~individual seeks coverage under this section, meets all of the~~
38 ~~following conditions:~~

39 ~~(1) Has had 18 or more months of creditable coverage, and the~~
40 ~~individual’s most recent prior creditable coverage was under a~~

1 ~~group health plan, a federal governmental plan maintained for~~
2 ~~federal employees, or a governmental plan or church plan as~~
3 ~~defined in the federal Employee Retirement Income Security Act~~
4 ~~of 1974 (29 U.S.C. Sec. 1002):~~

5 ~~(2) Is not eligible for coverage under a group health plan,~~
6 ~~Medicare, or Medi-Cal, and does not have other health insurance~~
7 ~~coverage.~~

8 ~~(3) Was not terminated from his or her most recent creditable~~
9 ~~coverage due to nonpayment of premiums or fraud.~~

10 ~~(4) If offered continuation coverage under COBRA or~~
11 ~~Cal-COBRA, has elected and exhausted that coverage.~~

12 ~~(e) Every health insurer that covers hospital, medical, or surgical~~
13 ~~expenses shall comply with applicable federal statutes and~~
14 ~~regulations regarding the provision of coverage to federally eligible~~
15 ~~defined individuals, including any relevant application periods.~~

16 ~~(d) A health insurer shall offer the following health benefit plans~~
17 ~~under this section that are designed for, made generally available~~
18 ~~to, are actively marketed to, and enroll, individuals: (1) either the~~
19 ~~two most popular products as defined in Section 300gg-41 (c)(2)~~
20 ~~of Title 42 of the United States Code and Section 148.120(c)(2)~~
21 ~~of Title 45 of the Code of Federal Regulations or (2) the two most~~
22 ~~representative products as defined in Section 300gg-41(e)(3) of~~
23 ~~Title 42 of the United States Code and Section 148.120(e)(3) of~~
24 ~~Title 45 of the Code of Federal Regulations, as determined by the~~
25 ~~insurer in compliance with federal law. An insurer that offers only~~
26 ~~one health benefit plan to individuals, excluding health benefit~~
27 ~~plans offered to Medi-Cal or Medicare beneficiaries, shall be~~
28 ~~deemed to be in compliance with this chapter if it offers that health~~
29 ~~benefit plan contract to federally eligible defined individuals in a~~
30 ~~manner consistent with this chapter.~~

31 ~~(e) (1) In the case of a health insurer that offers health benefit~~
32 ~~plans in the individual market through a network plan, the insurer~~
33 ~~may do both of the following:~~

34 ~~(A) Limit the individuals who may be enrolled under that~~
35 ~~coverage to those who live, reside, or work within the service area~~
36 ~~for the network plan.~~

37 ~~(B) Within the service area covered by the health benefit plan,~~
38 ~~deny coverage to individuals if the insurer has demonstrated to the~~
39 ~~commissioner that the insured will not have the capacity to deliver~~
40 ~~services adequately to additional individual insureds because of~~

1 its obligations to existing group policyholders, group
2 contractholders and insureds, and individual insureds, and that the
3 insurer is applying this paragraph uniformly to individuals without
4 regard to any health status-related factor of the individuals and
5 without regard to whether the individuals are federally eligible
6 defined individuals.

7 (2) A health insurer, upon denying health insurance coverage
8 in any service area in accordance with subparagraph (B) of
9 paragraph (1), may not offer health benefit plans through a network
10 in the individual market within that service area for a period of
11 180 days after the coverage is denied.

12 (f) (1) A health insurer may deny health insurance coverage in
13 the individual market to a federally eligible defined individual if
14 the insurer has demonstrated to the commissioner both of the
15 following:

16 (A) The insurer does not have the financial reserves necessary
17 to underwrite additional coverage.

18 (B) The insurer is applying this subdivision uniformly to all
19 individuals in the individual market and without regard to any
20 health status-related factor of the individuals and without regard
21 to whether the individuals are federally eligible defined individuals.

22 (2) A health insurer, upon denying individual health insurance
23 coverage in any service area in accordance with paragraph (1),
24 may not offer that coverage in the individual market within that
25 service area for a period of 180 days after the date the coverage is
26 denied or until the insurer has demonstrated to the commissioner
27 that the insurer has sufficient financial reserves to underwrite
28 additional coverage, whichever is later.

29 (g) The requirement pursuant to federal law to furnish a
30 certificate of creditable coverage shall apply to health benefits
31 plans offered by a disability insurer in the individual market in the
32 same manner as it applies to an insurer in connection with a group
33 health benefit plan policy or group health benefit plan contract.

34 (h) A health insurer shall compensate a life agent or fire and
35 casualty broker-agent whose activities result in the enrollment of
36 federally eligible defined individuals in the same manner and
37 consistent with the renewal commission amounts as the insurer
38 compensates life agents or fire and casualty broker-agents for other
39 enrollees who are not federally eligible defined individuals and
40 who are purchasing the same individual health benefit plan.

1 (i) ~~Every health insurer shall disclose as part of its COBRA or~~
2 ~~Cal-COBRA disclosure and enrollment documents, an explanation~~
3 ~~of the availability of guaranteed access to coverage under the~~
4 ~~Health Insurance Portability and Accountability Act of 1996,~~
5 ~~including the necessity to enroll in and exhaust COBRA or~~
6 ~~Cal-COBRA benefits in order to become a federally eligible~~
7 ~~defined individual.~~

8 (j) ~~No health insurer may request documentation as to whether~~
9 ~~or not a person is a federally eligible defined individual other than~~
10 ~~is permitted under applicable federal law or regulations.~~

11 (k) ~~This section shall not apply to coverage defined as excepted~~
12 ~~benefits pursuant to Section 300gg(c) of Title 42 of the United~~
13 ~~States Code.~~

14 (l) ~~Notwithstanding any other provision of this chapter, a health~~
15 ~~insurer is not required to offer coverage pursuant to subdivision~~
16 ~~(a) or (d) to an individual who qualifies as a federally eligible~~
17 ~~defined individual on or after January 1, 2009.~~

18 (m) (1) ~~A health insurer shall inform all individuals applying~~
19 ~~for coverage pursuant to this section or Section 300gg-41 of Title~~
20 ~~42 of the United States Code that, if they are eligible for this~~
21 ~~coverage, the coverage will be provided through the California~~
22 ~~Major Risk Medical Insurance Program (Part 6.5 (commencing~~
23 ~~with Section 12700)) and that they are required to apply for that~~
24 ~~coverage within 63 days of becoming eligible for it.~~

25 (2) ~~A health insurer shall disclose, as part of its COBRA or~~
26 ~~Cal-CORBA disclosure and enrollment documents, an explanation~~
27 ~~of the availability of guaranteed access to coverage under the~~
28 ~~California Major Risk Medical Insurance Program pursuant to~~
29 ~~paragraph (2) of subdivision (b) of Section 12725.~~

30 (n) ~~Subdivisions (l) and (m) shall be operative only if the state~~
31 ~~receives a waiver from the federal Centers for Medicare and~~
32 ~~Medicaid Services, or any other applicable federal agency,~~
33 ~~permitting the state to operate an acceptable alternative mechanism~~
34 ~~pursuant to Section 2744 of the Public Health Service Act (42~~
35 ~~U.S.C. Sec. 300gg-44) by enrolling federally defined eligible~~
36 ~~individuals into the California Major Risk Medical Insurance~~
37 ~~Program in lieu of coverage described in subdivisions (a) and (d).~~

38 (o) ~~Nothing in this section shall be construed to permit a health~~
39 ~~insurer to terminate coverage for an otherwise eligible individual~~

1 enrolled in a health insurance policy pursuant to this section prior
2 to January 1, 2009.

3 ~~(p) This section shall apply to a policy or contract offered,~~
4 ~~delivered, amended, or renewed on or after January 1, 2009.~~

5 ~~(q) This section shall become operative on January 1, 2009.~~

6 ~~SEC. 16.~~

7 *SEC. 7.* Section 10901.10 is added to the Insurance Code, to
8 read:

9 10901.10. On and after January 1, 2009, the premium for a
10 health insurance policy that offers services through a preferred
11 provider arrangement pursuant to this chapter or Article 4.6
12 (commencing with Section 1366.35) of Chapter 2.2 of Division 2
13 of the Health and Safety Code, shall be calculated as described in
14 this chapter, except that it shall be based on the benefit design for
15 the California Major Risk Medical Insurance Program, (Part 6.5
16 (commencing with Section 12700)) in effect on December 31,
17 2008.

18 ~~SEC. 17.~~ Section 12682.1 of the Insurance Code is amended
19 to read:

20 ~~12682.1. This section does not apply to a policy that primarily~~
21 ~~or solely supplements Medicare. The commissioner may adopt~~
22 ~~rules consistent with federal law to govern the discontinuance and~~
23 ~~replacement of plan policies that primarily or solely supplement~~
24 ~~Medicare.~~

25 ~~(a) (1) Every group policy entered into, amended, or renewed~~
26 ~~on or after September 1, 2003, that provides hospital, medical, or~~
27 ~~surgical expense benefits for employees or members shall provide~~
28 ~~that an employee or member whose coverage under the group~~
29 ~~policy has been terminated by the employer shall be entitled to~~
30 ~~convert to nongroup membership, without evidence of insurability,~~
31 ~~subject to the terms and conditions of this section.~~

32 ~~(2) If the health insurer provides coverage under an individual~~
33 ~~health insurance policy, other than conversion coverage under this~~
34 ~~part, it shall offer one of the two health insurance policies that the~~
35 ~~insurer is required to offer to a federally eligible defined individual~~
36 ~~pursuant to Section 10785. The health insurer shall provide this~~
37 ~~coverage at the same rate established under Section 10901.3 or~~
38 ~~10901.10 for a federally eligible defined individual.~~

39 ~~(3) If the health insurer does not provide coverage under an~~
40 ~~individual health insurance policy, it shall offer a health benefit~~

1 plan contract that is the same as a health benefit contract offered
2 to a federally eligible defined individual pursuant to Section 10785.
3 The health insurer shall offer the most popular preferred provider
4 organization plan that has the greatest number of enrolled
5 individuals for its type of plan as of January 1 of the prior year, as
6 reported by plans by January 31, 2003, and annually thereafter,
7 that provide coverage under an individual health care service plan
8 contract to the department or the Department of Managed Health
9 Care. A health insurer subject to this paragraph shall provide this
10 coverage with the same cost-sharing terms and at the same
11 premium as a health insurer providing coverage to that individual
12 under an individual health insurance policy pursuant to Section
13 10901.3 or 10901.10. The health insurer shall file the health benefit
14 plan contract it will offer, including the premium it will charge
15 and the cost-sharing terms of the contract, with the Department of
16 Insurance.

17 (b) A conversion policy shall not be required to be made
18 available to an employee or insured if termination of his or her
19 coverage under the group policy occurred for any of the following
20 reasons:

21 (1) The group policy terminated or an employer's participation
22 terminated and the insurance is replaced by similar coverage under
23 another group policy within 15 days of the date of termination of
24 the group coverage or the employer's participation.

25 (2) The employee or insured failed to pay amounts due the health
26 insurer.

27 (3) The employee or insured was terminated by the health insurer
28 from the policy for good cause.

29 (4) The employee or insured knowingly furnished incorrect
30 information or otherwise improperly obtained the benefits of the
31 policy.

32 (5) The employer's hospital, medical, or surgical expense benefit
33 program is self-insured.

34 (e) A conversion policy is not required to be issued to any person
35 if any of the following facts are present:

36 (1) The person is covered by or is eligible for benefits under
37 Title XVIII of the United States Social Security Act.

38 (2) The person is covered by or is eligible for hospital, medical,
39 or surgical benefits under any arrangement of coverage for
40 individuals in a group, whether insured or self-insured.

1 ~~(3) The person is covered for similar benefits by an individual~~
2 ~~policy or contract.~~

3 ~~(4) The person has not been continuously covered during the~~
4 ~~three-month period immediately preceding that person's~~
5 ~~termination of coverage.~~

6 ~~(d) Benefits of a conversion policy shall meet the requirements~~
7 ~~for benefits under this chapter.~~

8 ~~(e) Unless waived in writing by the insurer, written application~~
9 ~~and first premium payment for the conversion policy shall be made~~
10 ~~not later than 63 days after termination from the group. A~~
11 ~~conversion policy shall be issued by the insurer that shall be~~
12 ~~effective on the day following the termination of coverage under~~
13 ~~the group contract if the written application and the first premium~~
14 ~~payment for the conversion contract are made to the insurer not~~
15 ~~later than 63 days after the termination of coverage, unless these~~
16 ~~requirements are waived in writing by the insurer.~~

17 ~~(f) The conversion policy shall cover the employee or insured~~
18 ~~and his or her dependents who were covered under the group policy~~
19 ~~on the date of their termination from the group.~~

20 ~~(g) A notification of the availability of the conversion coverage~~
21 ~~shall be included in each evidence of coverage or other legally~~
22 ~~required document explaining coverage. However, it shall be the~~
23 ~~sole responsibility of the employer to notify its employees of the~~
24 ~~availability, terms, and conditions of the conversion coverage~~
25 ~~which responsibility shall be satisfied by notification within 15~~
26 ~~days of termination of group coverage. Group coverage shall not~~
27 ~~be deemed terminated until the expiration of any continuation of~~
28 ~~the group coverage. For purposes of this subdivision, the employer~~
29 ~~shall not be deemed the agent of the insurer for purposes of~~
30 ~~notification of the availability, terms, and conditions of conversion~~
31 ~~coverage. On and after January 1, 2009, the notification required~~
32 ~~by this subdivision shall explain that, in lieu of conversion coverage~~
33 ~~provided by the insurer, an individual eligible for conversion~~
34 ~~coverage is entitled to receive that coverage through the California~~
35 ~~Major Risk Medical Insurance Program pursuant to Section 12725.~~

36 ~~(h) As used in this section, "hospital, medical, or surgical~~
37 ~~benefits under state or federal law" do not include benefits under~~
38 ~~Chapter 7 (commencing with Section 14000) or Chapter 8~~
39 ~~(commencing with Section 14200) of Part 3 of Division 9 of the~~

1 ~~Welfare and Institutions Code, or Title XIX of the United States~~
2 ~~Social Security Act.~~

3 ~~(i) On and after January 1, 2009, a health insurer shall not be~~
4 ~~subject to the requirements described in subdivisions (a), (d), and~~
5 ~~(f) insofar as those subdivisions require the health insurer to offer~~
6 ~~and sell coverage to an individual who would otherwise become~~
7 ~~eligible for that coverage on or after January 1, 2009, under this~~
8 ~~section.~~

9 ~~SEC. 18.~~

10 *SEC. 8.* Section 12700 of the Insurance Code is amended to
11 read:

12 12700. The Legislature finds and declares all of the following:

13 (a) That many Californians do not have employer-sponsored
14 group health care coverage and are unable to secure adequate health
15 care coverage for themselves and their dependents because of
16 preexisting medical conditions, and a number of
17 employer-sponsored groups have difficulty obtaining or
18 maintaining their health care coverage because some members of
19 the group either have, or are viewed as being at risk for having,
20 high medical costs.

21 (b) That, even where uninsured persons with preexisting
22 conditions are able to secure coverage, the cost of coverage is
23 prohibitively high or is secured only by waiving coverage for the
24 preexisting conditions for which they are most likely to need care.

25 (c) That adverse selection precludes private health plans
26 regulated by the State of California from enrolling medically
27 uninsurable persons in the face of the escalating health care costs,
28 and a highly competitive market.

29 (d) That left to face the cost of major medical care without health
30 care coverage, all but the extremely affluent uninsured persons
31 must ultimately look to publicly funded programs including the
32 Medi-Cal program or the Medically Indigent Services Program in
33 the event of severe illness or injury.

34 (e) That one prudent means of making comprehensive major
35 medical coverage available to individuals who are unable to
36 purchase private health care coverage when they are denied that
37 coverage because of their health risk, health history, or health
38 status, is to arrange for, and subsidize, private coverage using a
39 combination of public and private funding.

1 (f) That enrollment in affordable, comprehensive health care
2 coverage products compatible with their medical needs should be
3 available for purchase by all Californians, including those who
4 are, or are viewed by carriers as being, at high risk because of
5 preexisting medical conditions, and that information about these
6 coverage options should be readily available to consumers.

7 (g) That the structure of coverage for medically uninsurable
8 persons should encourage broad participation of private health
9 care service plans and health insurers in providing that coverage
10 and should, at a minimum, not create a disincentive for health care
11 service plans and health insurers to participate in the state's
12 program for high-risk and uninsurable persons.

13 (h) That on and after January 1, 2009, sufficient funding from
14 a combination of public and private sources shall be available so
15 that the program can provide health care coverage to all eligible
16 persons willing to pay premiums and without the need for waiting
17 lists.

18 ~~SEC. 19.~~

19 *SEC. 9.* Section 12705 of the Insurance Code is amended to
20 read:

21 12705. The following definitions apply for the purposes of this
22 part:

23 (a) "Applicant" means an individual who applies for major risk
24 medical coverage through the program.

25 (b) "Board" means the Managed Risk Medical Insurance Board.

26 (c) "Fund" means the Major Risk Medical Insurance Fund, from
27 which the program may authorize expenditures to pay for medically
28 necessary services that exceed subscribers' contributions, and for
29 administration of the program.

30 (d) "Major risk medical coverage" means the payment for
31 comprehensive, medically necessary services compatible with the
32 medical needs of medically uninsurable persons, provided by
33 institutional and professional providers and structured in a manner
34 that does not provide a disincentive for accessing needed health
35 care.

36 (e) "Participating health plan" means a health insurer holding
37 a valid outstanding certificate of authority from the Insurance
38 Commissioner or a health care service plan as defined under
39 subdivision (f) of Section 1345 of the Health and Safety Code,
40 that contracts with the board to administer major risk medical

1 coverage to program subscribers and pursuant to the terms of its
2 contract with the board, provides, arranges, pays for, or reimburses
3 the costs of health services.

4 (f) “Payer” means an entity described in Section 1373.63 of the
5 Health and Safety Code or Section 10127.19 that elects to pay its
6 share of program costs, as described in Chapter 9 (commencing
7 with Section 12739.5).

8 (g) “Plan rates” means the total monthly amount charged by a
9 participating health plan for a category of risk.

10 (h) “Program” means the California Major Risk Medical
11 Insurance Program.

12 (i) “Program costs” means the anticipated costs of operating the
13 program for the year, including, but not limited to, the cost of
14 providing covered benefits to all prospective eligible subscribers;
15 administrative costs, including the costs of staff and overhead
16 operations for the program; and a reasonable amount to establish
17 and maintain a prudent reserve for the program. For purposes of
18 this section, administrative costs for the program may not be
19 expended to support any other program administered by the board.

20 (j) “Subscriber” means an individual who is eligible for and
21 receives major risk medical coverage through the program, and
22 includes a member of a federally recognized California Indian
23 tribe.

24 (k) “Subscriber contribution” means the portion of participating
25 health plan rates paid by the subscriber, or paid on behalf of the
26 subscriber by a federally recognized California Indian tribal
27 government. If a federally recognized California Indian tribal
28 government makes a contribution on behalf of a member of the
29 tribe, the tribal government shall ensure that the subscriber is made
30 aware of all the health plan options available in the county where
31 the member resides.

32 ~~SEC. 20.~~

33 *SEC. 10.* Section 12711 of the Insurance Code is amended to
34 read:

35 12711. The board shall have the following authority:

36 (a) To determine the eligibility of applicants.

37 (b) To determine the major risk medical coverage to be provided
38 to program subscribers. The major risk medical coverage shall
39 comply with the provisions of Section 12718.

1 (c) To research and assess the needs of persons not adequately
2 covered by existing private and public health care delivery systems
3 and promote means of ensuring the availability of adequate health
4 care services.

5 (d) To approve subscriber contributions and plan rates, to
6 establish program contribution amounts and the types of covered
7 lives that shall be reported by plans and insurers, and to determine
8 and administer fees imposed pursuant to Chapter 9 (commencing
9 with Section 12739.5).

10 (e) To provide major risk medical coverage for subscribers or
11 to contract with a participating health plan or plans to provide or
12 administer major risk medical coverage for subscribers.

13 (f) To authorize expenditures from the fund to pay program
14 expenses which exceed subscriber contributions.

15 (g) To contract for administration of the program or any portion
16 thereof with any public agency, including any agency of state
17 government, or with any private entity.

18 (h) To issue rules and regulations to carry out the purposes of
19 this part.

20 (i) To authorize expenditures from the fund or from other
21 moneys appropriated in the annual Budget Act for purposes relating
22 to Section 10127.15 of this code or Section 1373.62 of the Health
23 and Safety Code.

24 (j) To apply for any federal funding the board determines to be
25 cost effective, and to negotiate with the federal Centers for
26 Medicare and Medicaid Services to secure the federal funding.

27 (k) To contract with a reinsurer to obtain reinsurance or stop-loss
28 coverage for the program.

29 (l) To establish reasonable participation requirements for
30 subscribers.

31 (m) To exercise all powers reasonably necessary to carry out
32 the powers and responsibilities expressly granted or imposed upon
33 it under this part.

34 ~~SEC. 21.~~

35 *SEC. 11.* Section 12711.3 is added to the Insurance Code, to
36 read:

37 12711.3. The board, subject to the approval of the Department
38 of Finance, may obtain loans from the General Fund for all
39 necessary and reasonable expenses related to the administration
40 of the fund. The board shall repay principal and interest, using the

1 pooled money investment account rate of interest, to the General
2 Fund no later than January 1, 2016.

3 ~~SEC. 22.~~

4 ~~SEC. 12.~~ Section 12712 of the Insurance Code is amended to
5 read:

6 12712. The board shall perform the following functions:

7 (a) Establish the scope and content of adequate major medical
8 coverage to be offered by the program, including guidelines, as
9 appropriate, for disease management, case management, care
10 management or other cost management strategies to ensure
11 cost-effective, high-quality health care services for subscribers.

12 (b) Determine reasonable minimum standards for participating
13 health plans.

14 (c) Determine the time, manner, method, and procedures for
15 withdrawing program approval from a plan or limiting subscriber
16 enrollment in a participating health plan.

17 (d) Research and assess the needs of persons without adequate
18 health coverage, and promote means of ensuring the availability
19 of adequate health care services.

20 (e) Administer the program so as to ensure that the program
21 subsidy amount does not exceed amounts transferred to the fund
22 pursuant to Chapter 8 (commencing with Section 12739).

23 (f) Issue appropriate rules and regulations for matters it may be
24 authorized or required to provide for by this part. In adopting these
25 rules and regulations, the board shall be guided by the needs and
26 welfare of persons unable to secure adequate health coverage for
27 themselves and their dependents, and prevailing practices among
28 private health plans.

29 ~~(g) This section shall remain in effect only until January 1, 2009,~~
30 ~~and as of that date is repealed, unless a later enacted statute, that~~
31 ~~is enacted before January 1, 2009, deletes or extends that date.~~

32 *(g) Implement strategies to ensure program integrity and to*
33 *ensure that the program serves the target population of uninsurable*
34 *individuals. Strategies may include, but are not limited to, ensuring*
35 *that applicants have provided adequate evidence of their inability*
36 *to obtain health care coverage and requiring subscribers to attest*
37 *that they do not have health care coverage that meets their medical*
38 *needs and is less costly than coverage available in the program.*

39 ~~SEC. 23.~~ Section 12712 is added to the Insurance Code, to
40 read:

1 12712. The board shall perform the following functions:

2 (a) Establish the scope and content of adequate major medical
3 coverage to be offered by the program, including guidelines, as
4 appropriate, for disease management, case management, care
5 management, or other cost management strategies to ensure
6 cost-effective, high-quality health care services for subscribers.

7 (b) Determine reasonable minimum standards for participating
8 health plans.

9 (c) Determine the time, manner, method, and procedures for
10 withdrawing program approval from a plan or limiting subscriber
11 enrollment in a participating health plan.

12 (d) Research and assess the needs of persons without adequate
13 health coverage, and promote means of ensuring the availability
14 of adequate health care services.

15 (e) Issue appropriate rules and regulations for matters it may be
16 authorized or required to provide for by this part. In adopting these
17 rules and regulations, the board shall be guided by the needs and
18 welfare of persons unable to secure adequate health coverage for
19 themselves and their dependents, and prevailing practices among
20 private health plans.

21 (f) Implement strategies to ensure program integrity and to
22 ensure that the program serves the target population of uninsurable
23 individuals. Strategies may include, but are not limited to, ensuring
24 that applicants have provided adequate evidence of their inability
25 to obtain health care coverage and requiring subscribers to attest
26 that they do not have health care coverage that meets their medical
27 needs and is less costly than coverage available to them in the
28 program.

29 (g) This section shall become operative on January 1, 2009.

30 ~~SEC. 24.~~

31 *SEC. 13.* Section 12714.1 is added to the Insurance Code, to
32 read:

33 12714.1. (a) The board shall appoint an eight-member panel
34 to advise it regarding implementation of the fees established
35 pursuant to Chapter 9 (commencing with Section 12739.5).
36 Appointments to the panel shall be completed, and the panel shall
37 be prepared to perform its duties, prior to February 1, 2008 2009.

38 (b) The membership of the panel shall be composed of all of
39 the following persons:

- 1 (1) Four representatives of health care service plans and health
2 insurers.
- 3 (2) Two representatives of medically uninsurable consumers.
- 4 (3) One physician and surgeon.
- 5 (4) One representative of the business community.
- 6 (c) The Director of the Department of Managed Health Care,
7 or his or her designee, and the commissioner, or his or her designee,
8 shall participate in the panel as nonvoting members.
- 9 (d) The panel members shall have demonstrated expertise in
10 the provision of health-related services to medically uninsurable
11 individuals.
- 12 (e) The initial term of the panel members shall be staggered,
13 with four members being appointed for a two-year term and four
14 members being appointed for a four-year term. Upon the expiration
15 of the initial term, all panel members shall be appointed for a
16 four-year term.
- 17 (f) The panel shall elect, from among its members, its chair who
18 shall regularly report to the board, during the board's public
19 meetings, on behalf of the panel.
- 20 (g) The panel shall have all of the following powers and duties:
- 21 (1) To advise the board on all policies, regulations, and program
22 operations that affect the fee described in Chapter 9 (commencing
23 with Section 12739.5).
- 24 (2) To review the budget for the program and advise the board
25 on appropriate fee amounts.
- 26 (3) To review program operations and make recommendations
27 to improve the quality and cost-effectiveness of health care
28 provided to subscribers in the program.
- 29 (4) To meet at least quarterly, unless deemed unnecessary by
30 the chair.
- 31 (h) The panel shall provide written recommendations to the
32 board. The board shall consider recommendations of the panel at
33 its next meeting following submission of the recommendations
34 and respond to the panel in writing when it rejects a written
35 recommendation made by the panel.
- 36 (i) All members of the advisory panel shall serve without
37 compensation. The representatives of medically uninsurable
38 consumers and the business community and the physician and
39 surgeon member shall be reimbursed for all necessary travel
40 expenses associated with the activities of the panel.

1 ~~SEC. 25.~~ Section 12718 of the Insurance Code is repealed.

2 ~~SEC. 26.~~ Section 12718 is added to the Insurance Code, to
3 read:

4 12718. (a) ~~Benefits under this chapter shall be determined by~~
5 ~~the board, in consultation with the advisory panel established~~
6 ~~pursuant to Section 12714.1, and shall be subject to required~~
7 ~~copayments and deductibles as the board may authorize. Benefits~~
8 ~~in the program shall provide comprehensive coverage, including~~
9 ~~lower subscriber cost sharing for primary and preventive health~~
10 ~~care services, and the medications necessary for the treatment and~~
11 ~~management of chronic health care conditions. Benefits, subscriber~~
12 ~~cost sharing and out-of-pocket costs shall be appropriate for a~~
13 ~~program serving high-risk and medically uninsurable persons, as~~
14 ~~determined by the board. To the greatest extent possible, the board~~
15 ~~shall establish benefits that are compatible with comprehensive~~
16 ~~coverage products offered in the individual health insurance market,~~
17 ~~but in no event shall benefits for the program be less than the~~
18 ~~minimum benefits required to be offered by health plans licensed~~
19 ~~under the Knox-Keene Health Care Service Plan Act of 1975~~
20 ~~(Chapter 2.2 (commencing with Section 1340) of Division 2 of~~
21 ~~the Health and Safety Code) plus coverage for prescription drugs.~~
22 ~~The board may offer more than one benefit design option with~~
23 ~~different subscriber cost sharing in the form of copayments,~~
24 ~~deductibles and annual out-of-pocket costs.~~

25 (b) ~~Major risk medical coverage in the program shall meet all~~
26 ~~of the following requirements:~~

27 (1) ~~Have no annual limits on total coverage.~~

28 (2) ~~Have a limit on covered benefits over the lifetime of each~~
29 ~~subscriber of no less than one million dollars (\$1,000,000).~~

30 (3) ~~The aggregate amount of deductible and copayments payable~~
31 ~~annually under this section shall not exceed two thousand five~~
32 ~~hundred dollars (\$2,500) for an individual and four thousand dollars~~
33 ~~(\$4,000) for a family.~~

34 *SEC. 14. Section 12718 of the Insurance Code is amended to*
35 *read:*

36 12718. (a) Benefits under this chapter or Chapter 5
37 (commencing with Section 12720) shall be subject to required
38 subscriber copayments and deductibles as the board may authorize.
39 Any authorized copayments shall not exceed 25 percent and any
40 authorized deductible shall not exceed an annual household

1 deductible amount of five hundred dollars (\$500). However, health
2 plans not utilizing a deductible may be authorized to charge an
3 office visit copayment of up to twenty-five dollars (\$25). *Benefits*
4 *in the program shall provide comprehensive coverage, including*
5 *low subscriber cost sharing for primary and preventive health*
6 *care services, and the medications necessary and appropriate for*
7 *the treatment and management of chronic health conditions.*
8 *Benefits, subscriber cost sharing, and out-of-pocket costs shall be*
9 *appropriate for a program serving high-risk and medically*
10 *uninsurable persons. To the greatest extent possible, the board*
11 *shall establish benefits that are compatible with comprehensive*
12 *coverage products available in the individual health insurance*
13 *market, but in no event shall the benefits for the program be less*
14 *than the minimum benefits required to be offered by health plans*
15 *licensed under the Knox-Keene Health Care Service Plan Act of*
16 *1975 (Chapter 2.2 (commencing with Section 1340) of Division 2*
17 *of the Health and Safety Code) plus coverage for prescription*
18 *drugs. The board may offer more than one benefit design option*
19 *with different subscriber cost sharing in the form of copayments,*
20 *deductibles, and annual out-of-pocket costs. If the board contracts*
21 *with participating health plans pursuant to Chapter 5 (commencing*
22 *with Section 12720), copayments or deductibles shall be authorized*
23 *in a manner consistent with the basic method of operation of the*
24 *participating health plans. The aggregate amount of deductible*
25 *and copayments payable annually under this section shall not*
26 *exceed two thousand five hundred dollars (\$2,500) for an individual*
27 *and four thousand dollars (\$4,000) for a family.*

28 *(b) Upon a finding by the board that adequate revenues are*
29 *available for the program, major risk medical coverage in the*
30 *program shall have no annual limits on total coverage and shall*
31 *not have a limit on covered benefits over the lifetime of each*
32 *subscriber of less than one million dollars (\$1,000,000).*

33 ~~SEC. 27.~~

34 *SEC. 15.* Section 12723 of the Insurance Code is amended to
35 read:

36 12723. If the board contracts with participating health plans
37 or insurers to provide or administer major risk coverage, the board
38 shall contract with either health insurers holding valid, outstanding
39 certificates of authority from the commissioner, or health care
40 service plans licensed under the Knox-Keene Health Care Service

1 Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340)
2 of Division 2 of the Health and Safety Code).

3 ~~SEC. 28.~~

4 ~~SEC. 16.~~ Section 12725 of the Insurance Code is amended to
5 read:

6 12725. (a) Each resident of the state meeting the eligibility
7 criteria of this section and who is unable to secure adequate private
8 health coverage is eligible to apply for major risk medical coverage
9 through the program. For these purposes, “resident” includes a
10 member of a federally recognized California Indian tribe.

11 (b) To be eligible for enrollment in the program, an applicant
12 ~~shall meet at least one of the following criteria:~~

13 ~~(1) Has shall have~~ been rejected for health care coverage by at
14 least one private health plan. An applicant shall be deemed to have
15 been rejected if the only private health coverage that the applicant
16 could secure would do one of the following:

17 ~~(A)~~

18 ~~(1)~~ Impose substantial waivers that the program determines
19 would leave a subscriber without adequate coverage for medically
20 necessary services.

21 ~~(B)~~

22 ~~(2)~~ Afford limited coverage that the program determines would
23 leave the subscriber without adequate coverage for medically
24 necessary services.

25 ~~(C)~~

26 ~~(3)~~ Afford coverage only at an excessive price, which the board
27 determines is significantly above standard average individual
28 coverage rates.

29 ~~(2) Is eligible for, or enrolled in, guaranteed individual coverage~~
30 ~~pursuant to Section 300gg-41 of Title 42 of the United States Code~~
31 ~~on or after January 1, 2009.~~

32 ~~(3) Has exhausted federal and state COBRA benefits under a~~
33 ~~group health care service plan contract or a group health insurance~~
34 ~~policy and is eligible for, or enrolled, in, conversion coverage~~
35 ~~pursuant to Section 1373.6 of the Health and Safety Code or~~
36 ~~Section 12682.1 on or after January 1, 2009.~~

37 ~~(4) During the period of January 1, 2009, to December 31, 2009,~~
38 ~~inclusive, is an individual who was enrolled on or after July 1,~~
39 ~~2008, in coverage that had been provided pursuant to Section~~
40 ~~1373.62 of the Health and Safety Code or Section 10127.15,~~

1 ~~pursuant to the pilot project established by Chapter 794 of the~~
2 ~~Statutes of 2002, and the person is otherwise eligible for the~~
3 ~~program as determined by the board.~~

4 (c) Rejection for policies or certificates of specified disease or
5 policies or certificates of hospital confinement indemnity, as
6 described in Section 10198.61, shall not be deemed to be rejection
7 for the purposes of eligibility for enrollment.

8 (d) The board may permit dependents of eligible subscribers to
9 enroll in major risk medical coverage through the program if the
10 board determines the enrollment can be carried out in an actuarially
11 and administratively sound manner.

12 (e) Notwithstanding the provisions of this section, the board
13 shall by regulation prescribe a period of time during which a
14 resident is ineligible for major risk medical coverage through the
15 program if the resident either voluntarily disenrolls from, or was
16 terminated for nonpayment of the premium from, a private health
17 plan after enrolling in that private health plan pursuant to either
18 Section 10127.15 or Section 1373.62 of the Health and Safety
19 Code. On and after January 1, 2009, the board shall not apply the
20 regulation it adopted pursuant to this subdivision.

21 ~~(f) For the period commencing September 1, 2003, to December~~
22 ~~31, 2007, inclusive, subscribers and their dependents receiving~~
23 ~~major risk coverage through the program may receive that coverage~~
24 ~~for no more than 36 consecutive months.~~

25 ~~(g) (1) On or before September 1, 2008, the board shall notify~~
26 ~~all individuals who have been disenrolled pursuant to subdivision~~
27 ~~(f), by writing to them at their last known address that, whether or~~
28 ~~not they are currently enrolled in coverage pursuant to Section~~
29 ~~1373.62 of the Health and Safety Code or Section 10127.15, they~~
30 ~~may be eligible to reenroll in the program through either the~~
31 ~~standard application process or through an abbreviated process~~
32 ~~developed by the board.~~

33 ~~(2) The board shall also develop the notice and certification to~~
34 ~~be sent by all health care service plans and health insurers pursuant~~
35 ~~to subdivision (e) of Section 1373.622 of the Health and Safety~~
36 ~~Code and subdivision (e) of Section 10127.16, to all individuals~~
37 ~~enrolled in standard benefit plans. The notice and certification~~
38 ~~shall provide the language and form in which health care service~~
39 ~~plans and health insurers shall inform individuals enrolled in~~
40 ~~standard benefit plans about the expiration of coverage under~~

1 ~~Section 1373.62 of the Health and Safety Code and Section~~
2 ~~10127.15, shall provide them with evidence of having been enrolled~~
3 ~~in standard benefit plans for purposes of reenrollment in the~~
4 ~~program, and shall describe the process for applying to reenroll in~~
5 ~~the program.~~

6 ~~(h)~~

7 (f) Notwithstanding the provisions of this section, the board
8 may by regulation prescribe a period of time during which an
9 individual is ineligible to apply for major risk medical coverage
10 through the program if the individual either voluntarily disenrolls
11 from a participating health plan or was terminated from a
12 participating health plan for nonpayment of the premium, unless
13 the board determines that an individual applying for the program
14 had good cause for disenrolling from a participating health plan
15 and reapplying for coverage in the program.

16 ~~SEC. 29.~~

17 *SEC. 17* Section 12726 of the Insurance Code is amended to
18 read:

19 12726. The board ~~may~~ *shall* permit the exclusion of coverage
20 or benefits for charges or expenses incurred by a subscriber during
21 the first six months of enrollment in the program for any condition
22 for which, during the six months immediately preceding enrollment
23 in the program medical advice, diagnosis, care, or treatment was
24 recommended or received as to the condition during that period.

25 However, the exclusion from coverage of this section shall be
26 waived to the extent to which the subscriber was covered under
27 any creditable coverage, as defined in Section 10900, that was
28 terminated, provided the subscriber has applied for enrollment in
29 the program not later than 63 days following termination of the
30 prior coverage, or within 180 days of termination of coverage if
31 the subscriber lost his or her previous creditable coverage because
32 the subscriber's employment ended, the availability of health
33 coverage offered through employment or sponsored by an employer
34 terminated, or an employer's contribution toward health coverage
35 terminated. The exclusion from coverage of this section shall also
36 be waived as to any condition of a subscriber previously receiving
37 coverage under a plan of another state similar to the program
38 established by this part if the subscriber was eligible for benefits
39 under that other-state coverage for the condition. ~~The board may~~
40 ~~establish alternative mechanisms applicable to enrollment in~~

1 participating health plans that do not utilize a preexisting condition
2 provision. These mechanisms may include, but are not limited to,
3 a postenrollment waiting period.

4 This section shall remain in effect only until January 1, 2009,
5 and as of that date is repealed, unless a later enacted statute, that
6 is enacted before January 1, 2009, deletes or extends that date. *The
7 board shall allow a participating health plan that does not utilize
8 a preexisting condition provision to impose a waiting or affiliation
9 period, not to exceed 90 days, before the coverage issued becomes
10 effective. During the waiting or affiliation period a subscriber
11 shall not be required to make the contribution for program
12 coverage.*

13 ~~SEC. 30. Section 12726 is added to the Insurance Code, to
14 read:~~

15 ~~12726. (a) The board shall permit the exclusion of coverage
16 or benefits for charges or expenses incurred by a subscriber during
17 the first six months of enrollment in the program for any condition
18 for which, during the six months immediately preceding enrollment
19 in the program medical advice, diagnosis, care, or treatment was
20 recommended or received as to the condition during that period.~~

21 ~~(b) The exclusion from coverage of this section shall be waived
22 to the extent to which the subscriber was covered under any
23 creditable coverage, as defined in Section 10900, or under the
24 federal Health Insurance Portability and Accountability Act of
25 1996, or under other creditable coverage as defined by the board
26 that was terminated, if the subscriber has applied for enrollment
27 in the program not later than 63 days following termination of the
28 prior coverage, or within 180 days of termination of coverage if
29 the subscriber lost his or her previous creditable coverage because
30 the subscriber's employment ended, the availability of health
31 coverage offered through employment or sponsored by an employer
32 terminated, or an employer's contribution toward health coverage
33 terminated. The exclusion from coverage of this section shall also
34 be waived as to any condition of a subscriber previously receiving
35 coverage under a plan of another state similar to the program
36 established by this part if the subscriber was eligible for benefits
37 under that other state coverage for the condition.~~

38 ~~(c) The board shall allow a participating health plan that does
39 not utilize a preexisting condition provision to impose a waiting
40 or affiliation period, not to exceed 90 days, before the coverage it~~

1 issued shall become effective. During the waiting or affiliation
2 period a subscriber shall not be required to make the contribution
3 for program coverage.

4 (d) This section shall become operative on January 1, 2009.

5 SEC. 31. Section 12737 of the Insurance Code is amended to
6 read:

7 12737. (a) The board shall establish program contribution
8 amounts for coverage provided by each participating health plan.

9 (b) For the period January 1, 2008, to December 31, 2008,
10 inclusive, subscriber contributions shall be established at not more
11 than 125 percent of the standard average individual rate for
12 comparable coverage, as determined by the board. On and after
13 January 1, 2009, subscriber contributions shall be established at
14 120 percent of the standard average individual rates for comparable
15 coverage, as determined by the board, for a subscriber with a family
16 income above 300 percent of the federal poverty level and at 110
17 percent of the standard average individual rates for comparable
18 coverage, as determined by the board, for a subscriber with a family
19 income at or below 300 percent of the federal poverty level. The
20 board shall not include the portion of the standard average
21 individual rate attributable to the difference between coverage with
22 a seventy-five thousand dollar (\$75,000) annual benefit maximum
23 and coverage with no annual maximum benefit in its determination
24 of the standard average individual rates for comparable coverage.

25 SEC. 18. Section 12737 of the Insurance Code is repealed.

26 12737. (a) The board shall establish program contribution
27 amounts for each category of risk for each participating health
28 plan. The program contribution amounts shall be based on the
29 average amount of subsidy funds required for the program as a
30 whole. To determine the average amount of subsidy funds required,
31 the board shall calculate a loss ratio, including all medical costs,
32 administration fees, and risk payments, for the program in the prior
33 calendar year. The loss ratio shall be calculated using 125 percent
34 of the standard average individual rates for comparable coverage
35 as the denominator, and all medical costs, administration fees, and
36 risk payments as the numerator. The average amount of subsidy
37 funds required is calculated by subtracting 100 percent from the
38 program loss ratio. For purposes of calculating the program loss
39 ratio, no participating health plan's loss ratio shall be less than 100

1 percent and participating health plans with fewer than 1,000
2 program members shall be excluded from the calculation.

3 ~~Subscriber contributions shall be established to encourage~~
4 ~~members to select those health plans requiring subsidy funds at or~~
5 ~~below the program average subsidy. Subscriber contribution~~
6 ~~amounts shall be established so that no subscriber receives a~~
7 ~~subsidy greater than the program average subsidy, except that:~~

8 (1) ~~In all areas of the state, at least one plan shall be available~~
9 ~~to program participants at an average subscriber contribution of~~
10 ~~125 percent of the standard average individual rates for comparable~~
11 ~~coverage.~~

12 (2) ~~No subscriber contribution shall be increased by more than~~
13 ~~10 percent above 125 percent of the standard average individual~~
14 ~~rates for comparable coverage.~~

15 (3) ~~Subscriber contributions for participating health plans joining~~
16 ~~the program after January 1, 1997, shall be established at 125~~
17 ~~percent of the standard average individual rates for comparable~~
18 ~~coverage for the first two benefit years the plan participates in the~~
19 ~~program.~~

20 (b) ~~The program shall pay program contribution amounts to~~
21 ~~participating health plans from the Major Risk Medical Insurance~~
22 ~~Fund.~~

23 *SEC. 19. Section 12737 is added to the Insurance Code, to*
24 *read:*

25 *12737. (a) The board shall establish program contribution*
26 *amounts for coverage provided by each participating health plan.*
27 *Subscriber contributions shall be established to encourage*
28 *members to select those participating health plans with the lowest*
29 *costs and that require subsidy at or below the program average*
30 *subsidy.*

31 *(b) Subscriber contributions shall be established at no more*
32 *than 125 percent of the standard average individual rate for*
33 *comparable coverage, as determined by the board. The board may*
34 *establish lower contributions for subscribers at or below 300*
35 *percent of the federal poverty level, but in no case shall the*
36 *subscriber contribution be lower than 110 percent of the standard*
37 *average individual rate for comparable individual coverage. In*
38 *implementing subdivision (b) of Section 12718, the board may*
39 *exclude from the subscriber contribution that portion of the*

1 *standard average individual rate attributable to the elimination*
2 *of an annual or lifetime benefit maximum.*

3 ~~SEC. 32.~~

4 *SEC. 20.* Section 12738 is added to the Insurance Code, to
5 read:

6 12738. (a) On or before July 1, 2011, the board shall report
7 to the Legislature on the implementation of this chapter, including
8 the number and type of persons enrolled in the program, program
9 costs and revenues, average per capita costs for program
10 subscribers, and annual increases in the costs of coverage provided
11 to program subscribers as a reflection of rate changes in the
12 individual market.

13 (b) The board shall also include in the report an implementation
14 and transition plan for an alternative approach to ensuring quality
15 coverage for high risk, potentially high cost individuals, other than
16 a segregated high risk pool, that may include a reinsurance
17 mechanism or a risk adjustment mechanism, or both. The transition
18 plan shall outline the steps the board will need to take in order to
19 replace the program with an alternative mechanism by January 1,
20 2012. ~~The report shall include anticipated costs and expected per~~
21 ~~covered life fees for health plans and insurers who have elected~~
22 ~~to pay the fee pursuant to Section 1376.63 of the Health and Safety~~
23 ~~Code or Section 10127.19 of this code to support the costs of the~~
24 ~~alternative mechanism. 2013, and shall take into account changes~~
25 ~~in costs and coverage in the individual market. The plan developed~~
26 ~~by the board shall also take into account any subsequent state or~~
27 ~~federal program that provides broad-based or universal coverage~~
28 ~~and that includes guaranteed coverage for high-risk or medically~~
29 ~~uninsurable persons.~~

30 ~~SEC. 33.~~ Section 12739 of the Insurance Code is amended to
31 read:

32 ~~12739.~~ (a) ~~There is hereby created in the State Treasury a~~
33 ~~special fund known as the Major Risk Medical Insurance Fund~~
34 ~~that is, notwithstanding Section 13340 of the Government Code,~~
35 ~~continuously appropriated to the board for the purposes specified~~
36 ~~in Sections 10127.15 and 12739.1 and Chapter 9 (commencing~~
37 ~~with Section 12739.5) and Section 1373.62 of the Health and Safety~~
38 ~~Code.~~

39 (b) ~~After January 1, 2008, the following amounts shall be~~
40 ~~deposited annually in the Major Risk Medical Insurance Fund:~~

1 ~~(1) Twenty-four million three hundred ninety-three thousand~~
2 ~~dollars (\$24,393,000) from the Hospital Services Account in the~~
3 ~~Cigarette and Tobacco Products Surtax Fund.~~

4 ~~(2) Fourteen million six hundred seven thousand dollars~~
5 ~~(\$14,607,000) from the Physician Services Account in the Cigarette~~
6 ~~and Tobacco Products Surtax Fund.~~

7 ~~(3) One million dollars (\$1,000,000) from the Unallocated~~
8 ~~Account in the Cigarette and Tobacco Products Surtax Fund.~~

9 ~~(4) Funds received as a result of the collection of the fees~~
10 ~~imposed pursuant to Chapter 9 (commencing with Section~~
11 ~~12739.5).~~

12 ~~(e) Notwithstanding any other provision of law, any money in~~
13 ~~the fund that is attributable to monetary penalties imposed pursuant~~
14 ~~to this part shall not be continuously appropriated and shall be~~
15 ~~available for expenditure as provided in this chapter only upon~~
16 ~~appropriation by the Legislature.~~

17 *SEC. 21. Section 12739 of the Insurance Code is amended to*
18 *read:*

19 12739. (a) There is hereby created in the State Treasury a
20 special fund known as the Major Risk Medical Insurance Fund
21 that is, notwithstanding Section 13340 of the Government Code,
22 continuously appropriated to the board for the purposes specified
23 in Sections 10127.15 and 12739.1 and *Chapter 9 (commencing*
24 *with Section 12739.5) and* Section 1373.62 of the Health and Safety
25 Code.

26 ~~(b) After June 30, 1991, the~~ *The* following amounts shall be
27 deposited annually in the Major Risk Medical Insurance Fund:

28 ~~(1) Eighteen-Twenty-four million three hundred ninety-three~~
29 ~~thousand dollars (\$18,000,000) (\$24,393,000) from the Hospital~~
30 ~~Services Account in the Cigarette and Tobacco Products Surtax~~
31 ~~Fund.~~

32 ~~(2) (A) Eleven-Fourteen million six hundred seven thousand~~
33 ~~dollars (\$11,000,000) (\$14,607,000) from the Physician Services~~
34 ~~Account in the Cigarette and Tobacco Products Surtax Fund.~~

35 ~~(B) Notwithstanding subparagraph (A), for the 2007-08 fiscal~~
36 ~~year only, the Controller shall reduce the amount deposited into~~
37 ~~the Major Risk Medical Insurance Fund from the Physician~~
38 ~~Services Account in the Cigarette and Tobacco Products Surtax~~
39 ~~Fund to one million dollars (\$1,000,000).~~

1 (3) One million dollars (\$1,000,000) from the Unallocated
2 Account in the Cigarette and Tobacco Products Surtax Fund.

3 (4) *Funds received as a result of the collection of the fees*
4 *imposed pursuant to Chapter 9 (commencing with Section*
5 *12739.5).*

6 (c) *Notwithstanding any other provision of law, any money in*
7 *the fund that is attributable to monetary penalties imposed pursuant*
8 *to this part shall not be continuously appropriated and shall be*
9 *available for expenditure as provided in this chapter only upon*
10 *appropriation by the Legislature.*

11 ~~SEC. 34.~~

12 SEC. 22. Chapter 9 (commencing with Section 12739.5) is
13 added to Part 6.5 of Division 2 of the Insurance Code, to read:

14
15 CHAPTER 9. CONTRIBUTION REQUIREMENTS

16
17 12739.5. No later than February 1 of each year, commencing
18 February 1, ~~2008~~ 2009, each health care service plan subject to
19 Section 1373.63 of the Health and Safety Code and each health
20 insurer subject to Section 10127.19 shall notify the board of its
21 election either to guarantee issuance and renewal to all individual
22 applicants regardless of health status and in strict compliance with
23 the rating requirements and limitations of Section 1373.63 of the
24 Health and Safety Code or Section 10127.19, as applicable, or to
25 be a payer. The board shall notify the Director of Managed Health
26 Care and the commissioner of the entities that have elected to be
27 a payer and the amount of the fee each entity is required to pay.

28 12739.6. (a) The board shall establish the anticipated program
29 costs and the level of fees to be paid by health plans and health
30 insurers who have elected to be payers pursuant to Section 1373.63
31 of the Health and Safety Code and Section 10127.19 on a per
32 covered life per month basis. ~~Effective January 1, 2009, each health~~
33 ~~plan and health insurer shall pay the fee determined by the board~~
34 ~~based on their relative number of covered lives.~~

35 (b) ~~The board shall complete the following actions pursuant to~~
36 ~~subdivision (a):~~

37 (1) ~~Estimate the anticipated cost of operating the program during~~
38 ~~the next state fiscal year, including, but not limited to, the cost of~~
39 ~~providing all covered benefits to all prospective eligible~~
40 ~~subscribers; administrative costs, including the board's staff and~~

1 overhead for the program; and a reasonable sum to establish and
 2 maintain a prudent reserve.

3 ~~(2) Estimate the total revenue anticipated to be available for~~
 4 ~~program operation during the next state fiscal year. The estimate~~
 5 ~~shall include anticipated state appropriations, subscriber~~
 6 ~~contributions, and revenue from all other sources, but shall exclude~~
 7 ~~revenue anticipated to be received from payers pursuant to this~~
 8 ~~chapter.~~

9 ~~(3) Subtract the estimate described in paragraph (2) from the~~
 10 ~~estimate described in paragraph (1). The difference between the~~
 11 ~~two estimates shall be the total aggregate amount of program costs~~
 12 ~~to be contributed by payers covered life per month bases.~~
 13 *Commencing in 2009, each health plan and each health insurer*
 14 *shall annually pay the fee determined by the board based on the*
 15 *plan's or insurer's relative number of covered lives.*

16 *(b) For calendar year 2009, the board may establish the fee at*
 17 *no more than fifty cents (\$.50) per covered life per month as the*
 18 *board determines, in consultation with the advisory committee*
 19 *established pursuant to Section 12714.1, is necessary to cover*
 20 *program costs and to reduce or eliminate any waiting list or*
 21 *anticipated demand for the program.*

22 *(c) For calendar year 2010, the board may establish the fee at*
 23 *no more than seventy-five cents (\$0.75) per covered life per month*
 24 *as the board determines, in consultation with the advisory*
 25 *committee established pursuant to Section 12714.1, is necessary*
 26 *to cover program costs and to reduce or eliminate any waiting list*
 27 *or anticipated demand for the program.*

28 *(d) For calendar year 2011, the board may establish the fee at*
 29 *no more than one dollar (\$1) per covered life per month as the*
 30 *board determines, in consultation with the advisory committee*
 31 *established pursuant to Section 12714.1, is necessary to cover*
 32 *program costs and to reduce or eliminate any waiting list or*
 33 *anticipated demand for the program.*

34 .

35 12739.7. (a) On or before March 1 of each year, beginning in
 36 ~~2008~~ 2009, each health care service plan subject to Section 1373.63
 37 of the Health and Safety Code and each health insurer subject to
 38 Section 10127.19 shall report to the board the following
 39 information:

1 (1) The total number of covered lives as of the preceding
2 December 31, as determined by the board.

3 (A) For purposes of this chapter, “covered lives” include
4 individuals who receive health care coverage provided,
5 indemnified, or administered by a health care service plan or health
6 insurer subject to this chapter and individuals who receive health
7 care services pursuant to an agreement by which the health care
8 service plan or health insurer rents or leases a contracted network
9 of providers. Each named enrollee, insured, or covered person,
10 including primary subscribers or policyholders, covered spouses,
11 domestic partners, and each covered dependent shall count
12 separately as a covered life. Covered lives shall not include persons
13 covered under the Medi-Cal program, Medicare, the Healthy
14 Families Program (Part 6.2 (commencing with Section 12693)),
15 this program, the Access for Infants and Mothers Program (Part
16 6.3 (commencing with Section 12695)), the California Cooperative
17 Health Insurance Purchasing Program, the California Children and
18 Families Act of 1998 (Division 108 (commencing with Section
19 130100) of the Health and Safety Code), the Public Employees’
20 Medical and Hospital Care Act (Part 5 (commencing with Section
21 22750) of Division 5 of Title 2 of the Government Code),
22 accident-only, specified disease, long-term care, CHAMPUS
23 supplement, hospital indemnity, Medicare supplement, dental-only,
24 or vision-only insurance policies or specified disease insurance
25 that does not pay benefits on a fixed benefit, cash payment only
26 basis or short-term limited duration health insurance, or by a local,
27 nonprofit program or county serving children whose annual
28 household income is below 400 percent of the federal poverty level
29 who are under the age of 18 years and who are not eligible for the
30 Medi-Cal program, the Access for Infants and Mothers Program,
31 or the Healthy Families Program.

32 (B) For purposes of this chapter, covered lives shall include
33 individual coverage, conversion coverage, guaranteed issue
34 coverage pursuant to the federal Health Insurance Portability and
35 Accountability Act of 1996, small group coverage, other group
36 coverage, government employee coverage, other government
37 coverage, association coverage, services provided by an
38 administrator of health benefits coverage, and other coverage. For
39 purposes of this section, “administrator of health benefits coverage”
40 means a licensed health insurer or health care service plan, or any

1 person or entity affiliated with, or a subsidiary of, a health insurer
2 or health care service plan, that collects any charge or premium
3 from, or who adjusts or settles claims on behalf of, residents of
4 the state or who leases contracted provider networks to purchasers.

5 (2) Other related information as the board, in consultation with
6 the advisory panel established by Section 12714.1, may require to
7 implement and administer this chapter. The board may specify
8 form, format, and other requirements for this report, in consultation
9 with the advisory panel established pursuant to Section 12714.1.
10 The absence of these specifications by the board does not relieve
11 a health care service plan or health insurer from reporting the
12 information in a timely fashion.

13 (b) The board may determine, at its discretion, an amount of
14 program costs to be covered by a health care service plan or health
15 insurer subject to this section that fails to report to the board by
16 March 1 of any year, the number of covered lives as required by
17 this section.

18 ~~12739.8.—(a) The board shall calculate the share of program~~
19 ~~costs to be covered each year, beginning in 2008, for the year 2009,~~
20 ~~by a health care service plan and a health insurer subject to this~~
21 ~~chapter on a per covered life basis, based on its share of the health~~
22 ~~care coverage market, but in no event shall a health care service~~
23 ~~plan or a health insurer cover program costs in excess of one dollar~~
24 ~~and fifty cents (\$1.50) per covered life per month, unless a higher~~
25 ~~amount is approved by the Legislature.~~

26 ~~(b) The board shall calculate the share of program costs required~~
27 ~~by each health care service plan and health insurer by multiplying~~
28 ~~the estimate, described in paragraph (3) of subdivision (b) of~~
29 ~~Section 12739.6 by a fraction, the numerator of which shall be the~~
30 ~~number of covered lives reported by March 1 of that year by the~~
31 ~~plan or insurer and the denominator of which shall be the total~~
32 ~~number of covered lives reported by March 1 of that year by all~~
33 ~~plans and insurers. The product shall be the market share for the~~
34 ~~plan or insurer.~~

35 ~~(c) By June 1 of each year, the board shall produce a schedule~~
36 ~~showing the share of the total program costs for each plan and~~
37 ~~insurer based on its market share as determined under subdivision~~
38 ~~(b). Each plan and insurer shall have the affirmative duty of~~
39 ~~obtaining that schedule from the board no later than June 10 of~~
40 ~~each year, beginning in 2008.~~

1 12739.8. *No later than June 1 of each year, the board shall*
2 *produce a schedule showing the total fee due and payable for each*
3 *plan and insurer based on the fee level set by the board and the*
4 *number of covered lives reported by the health plan or health*
5 *insurer to the board. Each health plan and health insurer shall*
6 *have the affirmative duty to obtain that schedule from the board.*

7 12739.9. (a) A health care service plan and a health insurer
8 shall either offer all of the plan's or insurer's health coverage
9 products to all individuals at standard average rates as required in
10 Section 1373.63 of the Health and Safety Code or Section 10127.19
11 or be a payer, as elected pursuant to Section 12739.5.

12 (b) A health care service plan that is a payer and a health insurer
13 that is a payer shall pay its share of program costs ~~calculated under~~
14 ~~Section 12739.8~~ prior to January 1 of each year, beginning in 2009,
15 *as determined by the board within 90 days from the date that the*
16 *board produces the schedule described in Section 12739.8 showing*
17 *each plan's and insurer's fee level. A health care service plan shall*
18 *make its payment to the Director of the Department of Managed*
19 *Health Care, and a health insurer shall make its payment to the*
20 *commissioner.*

21 ~~12739.11. If the board determines that the costs for the~~
22 ~~operation of the program exceed or are likely to exceed the estimate~~
23 ~~it made pursuant to Section 12739.6, the board, in consultation~~
24 ~~with the advisory panel established by Section 12714.1, may adjust~~
25 ~~the amount of program costs required from a payer by multiplying~~
26 ~~the amount of the insufficiency by the fraction described in Section~~
27 ~~12739.8. The numerator and denominator of the fraction shall be~~
28 ~~based on information submitted by the plan or insurer pursuant to~~
29 ~~Section 12739.7 for the preceding March 1.~~

30 12739.12. Each payer's share of any fee imposed by the board
31 pursuant to this section shall constitute a fee payable in accordance
32 with Section 1356.2 of the Health and Safety Code, for payers
33 licensed by the Department of Managed Health Care, or Section
34 1827.86, for payers having a certificate of authority or license
35 issued by the commissioner.

36 12739.13. If revenues collected pursuant to this chapter exceed
37 the amount actually required for the operation of the program for
38 any fiscal year, the excess shall be retained in the fund and shall
39 be used by the board to reduce the share of program costs paid by

1 health care service plans and health insurers in the subsequent
2 fiscal year.

3 ~~SEC. 35.~~

4 *SEC. 23.* Until January 1, ~~2010~~ *2011*, the adoption and
5 readoption of any rules and regulations issued by the Managed
6 Risk Medical Insurance Board, the Department of Managed Health
7 Care, or the Department of Insurance to implement this act shall
8 be deemed to be an emergency and necessary for the immediate
9 preservation of the public peace, health and safety, or general
10 welfare for purposes of Sections 11346.1 and 11349.6 of the
11 Government Code, and the Managed Risk Medical Insurance
12 Board, the Department of Managed Health Care, and the
13 Department of Insurance are hereby exempted from the
14 requirements to describe specific facts showing the need for
15 immediate action and from review by the Office of Administrative
16 Law.

17 ~~SEC. 36.~~

18 *SEC. 24.* No reimbursement is required by this act pursuant to
19 Section 6 of Article XIII B of the California Constitution because
20 the only costs that may be incurred by a local agency or school
21 district will be incurred because this act creates a new crime or
22 infraction, eliminates a crime or infraction, or changes the penalty
23 for a crime or infraction, within the meaning of Section 17556 of
24 the Government Code, or changes the definition of a crime within
25 the meaning of Section 6 of Article XIII B of the California
26 Constitution.