AMENDED IN SENATE APRIL 13, 2009

SENATE BILL No. 227

Introduced by Senator Alquist

February 23, 2009

An act to add Sections 1356.2, 1373.623, 1373.63, and 1399.807 to the Health and Safety Code, and to amend Sections 12700, 12705, 12711, 12712, 12718, 12725, 12726, and 12739 of, to add Sections 1827.86, 10127.165, 10127.19, 10903, 12711.3, 12714.1, 12714.5, and 12738.5 to, to add Chapter 9 (commencing with Section 12739.5) to Part 6.5 of Division 2 of, and to repeal and add Sections 12723 and 12737 of, the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 227, as amended, Alquist. 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. Existing law requires a health care service plan and a health insurer to 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 to those individuals.

This bill would require a health care service plan and a health insurer to elect ~~to~~ either *to* accept for coverage at rates set by MRMIB and under specified conditions persons eligible for MRMIP that have been assigned to the plan or insurer by MRMIB regardless of health status or previous health care claims experience, or ~~to~~ alternatively *to* pay a fee set by MRMIB based on its market share ~~and medical loss ratio~~, as specified. 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 MRMIB, 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 establish a voluntary reenrollment program for persons enrolled in the former pilot program, would implement benefit changes for MRMIP, and would establish limits on MRMIP subscriber contribution amounts, as specified. The bill would require MRMIB to appoint a panel to advise it on MRMIP, would authorize MRMIB to apply for federal funding and take other actions, as specified, and would require MRMIB to report to the Legislature on or before July 1, 2012, as specified. The bill would require MRMIB to report and make recommendations to the Legislature by September 1, 2010, regarding the status of benefits and premiums provided to federally eligible defined individuals, based on data provided by plans and insurers, as specified. The bill would enact other related provisions. By imposing new requirements on health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.

(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 also specify that any money in the fund attributable to monetary penalties imposed under MRMIP shall not be continuously appropriated.

The bill would, until January 1, 2012, exempt MRMIB, the Department of Managed Health Care, and the Department of Insurance from certain procedural requirements necessary to adopt rules and regulations.

(3) 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:

SECTION 1. Section 1356.2 is added to the Health and Safety Code, to read:

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

(b) A health care service plan that has elected not to pay the fee under Chapter 9 (commencing with Section 12739.5) of Part 6.5 of Division 2 of the Insurance Code shall demonstrate to the satisfaction of the director that it is in compliance with subdivision (a) of Section 1373.63.

(c) The fees paid pursuant to this section and Section 12739.7 of the Insurance Code shall not be considered administrative costs for the purposes of Section 1300.78 of Title 28 of the California Code of Regulations or for purposes of calculating any medical loss ratio imposed on health plans by statute or regulation.

SEC. 2. Section 1373.623 is added to the Health and Safety Code, to read:

1373.623. (a) Commencing January 1, 2010, at least annually thereafter, and at such other times as the Managed Risk Medical Insurance Board shall request, health care service plans providing continuation coverage pursuant to Section 1373.622 shall report to the Managed Risk Medical Insurance Board the number of covered lives remaining in the continuation coverage and such related information as the board may require to implement subdivision (f) of Section 12725 of the Insurance Code.

(b) Health care service plans providing continuation coverage shall provide to enrollees in continuation coverage the notice developed by the Managed Risk Medical Insurance Board pursuant to subdivision (f) of Section 12725 of the Insurance Code.

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

1373.63. (a) On and after January 1, 2010, except as provided in subdivision (e), every health care service plan, except for a specialized health care service plan or a Medicare-only or Medicare-supplement-only health care service plan, licensed in California, that provides individual or group coverage, shall accept for coverage persons eligible pursuant to Section 12725 of the Insurance Code for the Major Risk Medical Insurance Program, according to the assignment of eligible persons by the Managed Risk Medical Insurance Board pursuant to Section 12712 of the Insurance Code, regardless of the individual's health status or previous health care claims experience. As used in this section, "board" means the Managed Risk Medical Insurance Board.

(b) Health care service plans subject to this section shall provide coverage to persons assigned by the board with the same level of benefits as the Major Risk Medical Insurance Program, as determined by the board, and shall charge those persons premium rates determined by the board.

(c) For persons assigned for coverage to the health care service plan, the health care service plan may impose only those coverage exclusions or waiting periods as provided by the board in regulation and pursuant to Section 12726 of the Insurance Code.

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

(e) A health care service plan shall not be subject to the requirements of this section if it instead elects to pay the fee under

Chapter 9 (commencing with Section 12739.5) of Part 6.5 of Division 2 of the Insurance Code.

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

SEC. 4. Section 1399.807 is added to the Health and Safety Code, to read:

1399.807. On or before March 1, 2010, health care service plans that offer, issue, or renew individual coverage pursuant to this article shall provide to the department such data and information as the department determines, in consultation with the Managed Risk Medical Insurance Board and the Insurance Commissioner, are necessary to be provided to the Managed Risk Medical Insurance Board for purposes of the study required under Section 12714.5 of the Insurance Code.

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

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

(b) A health insurer that has elected not to pay the fee under Chapter 9 (commencing with Section 12739.5) of Part 6.5~~,~~ shall demonstrate to the satisfaction of the commissioner that it is in compliance with subdivision (a) of Section 10127.19.

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

(d) The fees paid pursuant to this section and Section 12739.7 shall not be considered administrative costs for the purposes of Section 1300.78 of Title 28 of the California Code of Regulations or for purposes of calculating any medical loss ratio imposed on health insurers by statute or regulation.

SEC. 6. Section 10127.165 is added to the Insurance Code, to read:

10127.165. (a) Commencing January 1, 2010, at least annually thereafter, and at such other times as the Managed Risk Medical Insurance Board shall request, health insurers providing continuation coverage pursuant to Section 10127.16 shall report to the Managed Risk Medical Insurance Board the number of covered lives remaining in the continuation coverage and such related information as the board may require to implement subdivision (f) of Section 12725.

(b) Health insurers providing continuation coverage shall provide to insureds in continuation coverage the notice developed by the Managed Risk Medical Insurance Board pursuant to subdivision (f) of Section 12725.

SEC. 7. Section 10127.19 is added to the Insurance Code, to read:

10127.19. (a) On and after January 1, 2010, except as provided in subdivision (e), every health insurer that provides individual or group health insurance, as defined in Section 106, to residents of this state shall accept for coverage persons eligible pursuant to Section 12725 for the Major Risk Medical Insurance Program, according to the assignment of eligible persons by the Managed Risk Medical Insurance Board, pursuant to Section 12712, regardless of the individual's health status or previous health care claims experience. As used in this section, "board" means the Managed Risk Medical Insurance Board.

(b) Health insurers subject to this section shall provide coverage to persons assigned by the board with the same level of benefits as the Major Risk Medical Insurance Program, as determined by

the board, and shall charge those persons premium rates determined by the board.

(c) For persons assigned for coverage to the insurer, the insurer may impose only those coverage exclusions or waiting periods as provided by the board in regulation and pursuant to Section 12726.

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

(e) A health insurer shall not be subject to the requirements of this section if it instead elects to pay the fee under Chapter 9 (commencing with Section 12739.5) of Part 6.5.

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

(g) The requirements of this section shall not apply to Medicare supplement, specialized health, or CHAMPUS supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis, or to short-term limited duration health insurance.

SEC. 8. Section 10903 is added to the Insurance Code, to read:

10903. On or before March 1, 2010, health insurers that offer, issue, or renew individual coverage pursuant to this chapter shall provide to the commissioner such data and information as the commissioner determines, in consultation with the Managed Risk Medical Insurance Board and the Department of Managed Health Care, are necessary to be provided to the Managed Risk Medical Insurance Board for purposes of the study required under Section 12714.5.

SEC. 9. Section 12700 of the Insurance Code is amended to read:

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

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

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

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

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

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

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

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

(h) That on and after January 1, 2010, sufficient funding from a combination of public and private sources shall be available so that the program can provide health care coverage to eligible persons willing to pay premiums and without the need for waiting lists.

SEC. 10. Section 12705 of the Insurance Code is amended to read:

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

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

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

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

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

(e) "Participating health plan" means a health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, that contracts with the board to administer major risk medical coverage to program subscribers and, pursuant to the terms of its contract with the board, provides, arranges, pays for, or reimburses the costs of health care services.

(f) "Payer" means an entity described in Section 1373.63 of the Health and Safety Code or Section 10127.19 that elects to pay the fee, as described in Chapter 9 (commencing with Section 12739.5).

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

(h) "Program" means the California Major Risk Medical Insurance Program.

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

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

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

SEC. 11. Section 12711 of the Insurance Code is amended to read:

12711. The board shall have the following authority:

(a) To determine the eligibility of applicants.

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

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

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

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

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

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

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

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

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

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

(*l*) To establish reasonable participation requirements for subscribers.

(m) To assign persons eligible for the program pursuant to Section 12725 among health plans subject to Section 1373.63 of the Health and Safety Code and health insurers subject to Section 10127.19, except for plans and insurers that have elected instead to pay the fee pursuant to those sections.

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

SEC. 12. Section 12711.3 is added to the Insurance Code, to read:

12711.3. The board, subject to the approval of the Department of Finance, may obtain loans from the General Fund for all necessary and reasonable expenses related to the administration of the fund. The board shall repay principal and interest, using the pooled money investment account rate of interest, to the General Fund no later than January 1, 2017.

SEC. 13. Section 12712 of the Insurance Code is amended to read:

12712. The board shall perform the following functions:

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

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

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

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

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

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

(g) Implement strategies to ensure program integrity and to ensure that the program serves the target population of uninsurable individuals. Strategies may include, but are not limited to, ensuring that applicants have provided adequate evidence of their inability to obtain health care coverage and requiring subscribers to attest that they do not have health care coverage that meets their medical needs at a lower cost than coverage available in the program.

(h) Administer the program in a manner to maximize the program's eligibility for any federal funds available for high-risk health insurance pools consistent with the purposes of this part. The board shall apply for or otherwise seek any available federal funds consistent with the purposes of this part.

(i) In order to reduce or eliminate any waiting list for coverage in the program, and to ensure the availability of a coverage option for persons who have been denied private individual health coverage, develop a process for and implement assignment of persons eligible for the program to obtain their health coverage from health care service plans subject to Section 1373.63 of the Health and Safety Code and health insurers subject to Section 10127.19. The board shall determine the benefit design that shall be provided by health care service plans and health insurers to eligible persons assigned to them by the board, consistent with the benefits provided to subscribers. In developing the assignment process, the board shall take into account the geographic service area of health plans and health insurers who are available for assignment and the geographic area where potential enrollees and insureds reside. To the greatest extent possible, the board shall provide eligible persons with a choice of health plan or health insurer. The board shall not assign any eligible persons to health plans or health insurers that have elected instead to pay the fee pursuant to Section 1373.63 of the Health and Safety Code or

Section 10127.19. The board shall determine how many eligible persons it shall assign to each health care service plan subject to Section 1373.63 of the Health and Safety Code and each health insurer subject to Section 10127.19, consistent with the purposes of this part, taking into consideration the costs of providing coverage in the program and the fees paid by health care service plans and health insurers who elect to pay the fee pursuant to Section 1373.63 of the Health and Safety Code or Section 10127.19.

SEC. 14. Section 12714.1 is added to the Insurance Code, to read:

12714.1. (a) The board shall appoint an 11-member panel to advise the board on the program. Appointments to the panel shall be completed, and the panel shall be prepared to perform its duties, prior to February 1, 2010.

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

(1) Four representatives of health care service plans and health insurers that provide health coverage in the individual health insurance market, at least three of which shall be health plans participating in the program.

(2) Two program subscribers.

(3) Two health care providers with expertise in the care and treatment of chronic diseases, at least one of which shall be a physician and surgeon.

(4) Three representatives of organizations representing the interests of health care consumers and medically uninsurable persons.

(c) The Director of the Department of Managed Health Care, or his or her designee, and the commissioner, or his or her designee, shall participate in the panel as nonvoting members.

(d) The panel members shall have demonstrated expertise in the provision of health-related services to medically uninsurable individuals.

(e) The initial term of the panel members shall be staggered, with six members being appointed for a two-year term and five members being appointed for a four-year term. Upon the expiration of the initial term, all panel members shall be appointed for a four-year term.

(f) The panel shall elect, from among its members, its chair who shall regularly report to the board, during the board's public meetings, on behalf of the panel.

(g) The panel shall do all of the following:

(1) Make recommendations to improve the quality of health care provided to subscribers in the program.

(2) Advise the board on policies and program operations.

(3) Make recommendations to ensure the affordability of coverage for subscribers, especially low-income subscribers.

(4) Make recommendations to ensure the cost-effectiveness of health care provided to subscribers in the program.

(5) Meet at least quarterly, unless deemed unnecessary by the chair.

(h) The board shall consider all written recommendations of the panel and respond to the panel in writing when the board rejects a written recommendation made by the panel.

(i) All members of the advisory panel shall serve without compensation. Members of the panel shall be reimbursed for all necessary travel expenses associated with the activities of the panel. Consumer representatives on the panel may receive per diem compensation if they are otherwise economically unable to attend and participate in panel activities.

SEC. 15. Section 12714.5 is added to the Insurance Code, to read:

12714.5. (a) On or before September 1, 2010, the board shall report and make recommendations to the appropriate fiscal and policy committees of the Legislature regarding the status of benefits and premiums provided to federally eligible defined individuals under Article 11.5 (commencing with Section 1399.801) of Chapter 2.2 of Division 2 of the Health and Safety Code, and Chapter 9.5 (commencing with Section 10900) of Part 2 of this division. The board shall consult with the advisory panel established pursuant to Section 12714.1, the Department of Managed Health Care, and the Department of Insurance in the preparation of this report.

(b) The board shall assess the products provided to federally eligible defined individuals, and the premiums charged, in comparison to coverage and subscriber contributions within the program, and shall analyze the impact that any changes to benefits and subscriber contributions in the program have had on coverage and premiums for federally eligible defined individuals. The board

shall obtain an actuarial analysis and comparison between benefits and premiums in the program and those in the individual market for federally eligible defined individuals. The board shall make recommendations as to the need for policy changes related to the premiums that health plans and health insurers are required to charge for coverage to federally eligible defined individuals, in relationship to the contributions of subscribers in the program, and shall discuss the impact of any changes in the program on premium rates and coverage for federally eligible defined individuals.

SEC. 16. Section 12718 of the Insurance Code is amended to read:

12718. (a) Benefits under this chapter or Chapter 5 (commencing with Section 12720) shall be subject to required subscriber copayments and deductibles as the board may authorize. Benefits in the program shall provide comprehensive coverage, including, effective January 1, 2011, lower subscriber cost sharing for primary and preventive health care services and the medications necessary and appropriate for the treatment and management of chronic health conditions. Benefits, subscriber cost sharing, and out-of-pocket costs shall be appropriate for a program serving high-risk and medically uninsurable persons. To the greatest extent possible, the board shall establish benefits that are compatible with comprehensive coverage products available in the individual health insurance market, but in no event shall the benefits for the program be less than the minimum benefits required to be offered by health plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) plus coverage for prescription drugs. The board may offer more than one benefit design option with different subscriber cost sharing in the form of copayments, deductibles, and annual out-of-pocket costs. If the board contracts with participating health plans pursuant to Chapter 5 (commencing with Section 12720), copayments or deductibles shall be authorized in a manner consistent with the basic method of operation of the participating health plans. The aggregate amount of deductible and copayments payable annually under this section shall not exceed two thousand five hundred dollars ($2,500) for an individual and four thousand dollars ($4,000) for a family.

(b) Major risk medical coverage in the program shall have no annual limits on total coverage or benefits and shall not have a

limit on covered benefits over the lifetime of each subscriber of less than one million dollars ($1,000,000).

SEC. 17. Section 12723 of the Insurance Code is repealed.

SEC. 18. Section 12723 is added to the Insurance Code, to read:

12723. If the board contracts with participating health plans or insurers to provide or administer major risk coverage, the board shall contract with either health insurers holding valid, outstanding certificates of authority from the commissioner, or health care service plans licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

SEC. 19. Section 12725 of the Insurance Code is amended to read:

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

(b) To be eligible for enrollment in the program, an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:

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

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

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

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

(d) The board may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the

board determines the enrollment can be carried out in an actuarially and administratively sound manner.

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

(f) Notwithstanding the provisions of this section, the board shall by regulation establish a process of eligibility and voluntary reenrollment in the program for persons enrolled in guaranteed coverage under the guaranteed issue pilot project established by Chapter 794 of the Statutes of 2002. Individuals shall be voluntarily enrolled in the program providing all of the following conditions are met:

(1) There are currently no individuals on a waiting list for the program because of insufficient funds available for the program.

(2) Persons are made eligible by the board under this subdivision as funds allow, based on the date they were disenrolled from the program pursuant to the pilot project, with those disenrolled first made eligible first, and on a first-come-first-served basis.

(3) The program determines the maximum number of individuals who may voluntarily reenroll from each health plan providing pilot project coverage consistent with the proportion of pilot project enrollees enrolled in each health plan as reported by the health plans and health insurers pursuant to Section 1373.623 of the Health and Safety Code and Section 10127.165 of this code.

(4) The board develops a notice that carriers participating in the pilot project must provide to persons enrolled in the guaranteed issue pilot program notifying the individuals of potential eligibility for the program and option to be reenrolled.

SEC. 20. Section 12726 of the Insurance Code is amended to read:

12726. The board may permit the exclusion of coverage or benefits for charges or expenses incurred by a subscriber during the first six months of enrollment in the program for any condition for which, during the six months immediately preceding enrollment

in the program medical advice, diagnosis, care, or treatment was recommended or received as to the condition during that period.

However, the exclusion from coverage of this section shall be waived to the extent to which the subscriber was covered under any creditable coverage, as defined in Section 10900, that was terminated, provided the subscriber has applied for enrollment in the program not later than 63 days following termination of the prior coverage, or within 180 days of termination of coverage if the subscriber lost his or her previous creditable coverage because the subscriber's employment ended, the availability of health coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward health coverage terminated. The exclusion from coverage of this section shall also be waived as to any condition of a subscriber previously receiving coverage under a plan of another state similar to the program established by this part if the subscriber was eligible for benefits under that other-state coverage for the condition. The board may allow a participating health plan that does not utilize a preexisting condition provision to impose a waiting or affiliation period, not to exceed 90 days, before the coverage issued becomes effective. During the waiting or affiliation period a subscriber shall not be required to make the contribution for program coverage.

SEC. 21. Section 12737 of the Insurance Code is repealed.

SEC. 22. Section 12737 is added to the Insurance Code, to read:

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

(b) Subscriber contributions shall be established at no more than ~~200~~ *150* percent of the standard average individual rate for comparable coverage, as determined by the board. The board shall establish a sliding scale with lower contribution requirements for subscribers at or below 300 percent of the federal poverty level, but in no case shall the subscriber contribution be lower than 110 percent of the standard average individual rate for comparable individual coverage, unless federal funds are received, pursuant to subdivision (j) of Section 12711. ~~Upon receipt of federal funds, the board shall~~

(c) Upon receipt of federal funds, and contingent upon the allowable use and purpose of those funds, the board shall offer enrollment to individuals who are on the waiting list for the

program. If no individuals are on the waiting list for the program, the board shall use federal funds, contingent upon the allowable use and purpose of those funds, to lower subscriber contributions for subscribers at or below 300 percent of the federal poverty ~~level to six percent of income, and~~ *level. In no case shall the board lower subscriber contributions for subscribers at or below 300 percent of the federal poverty level to less than 6 percent of income. The board* may additionally lower subscriber contributions for subscribers over 300 but less than ~~500~~ *400* percent of the federal poverty level *to no less than 6 percent of income* with any remaining federal funds. *Any further available federal funds shall be used to recalculate the fee described in Section 12739.6 for the following year.*

(d) In implementing subdivision (b) of Section 12718, the board may exclude from the subscriber contribution that portion of the standard average individual rate attributable to the elimination of the annual benefit maximum and the increase in the lifetime benefit maximum.

SEC. 23. Section 12738.5 is added to the Insurance Code, to read:

12738.5. (a) On or before July 1, 2012, the board shall report to the Legislature on the implementation of this chapter, including the number and type of persons enrolled in the program, program costs and revenues, average per capita costs for program subscribers, and annual increases in the costs of coverage provided to program subscribers as a reflection of rate changes in the individual market.

(b) The board shall also include in the report an implementation and transition plan for an alternative approach to ensuring quality coverage for high risk, potentially high cost individuals, other than a segregated high risk pool, that may include a reinsurance mechanism or a risk adjustment mechanism, or both. The transition plan shall outline the steps the board will need to take in order to replace the program with an alternative mechanism by January 1, 2014, and shall take into account changes in costs and coverage in the individual market. The plan developed by the board shall also take into account any subsequent state or federal program that provides broad-based or universal coverage and that includes guaranteed coverage for high-risk or medically uninsurable persons.

SEC. 24. Section 12739 of the Insurance Code is amended to read:

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

(b) The following amounts shall be deposited annually in the Major Risk Medical Insurance Fund:

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

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

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

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

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

SEC. 25. Chapter 9 (commencing with Section 12739.5) is added to Part 6.5 of Division 2 of the Insurance Code, to read:

Chapter 9. Contribution Requirements

12739.5. No later than February 1 of each year, commencing February 1, 2010, each health care service plan subject to Section 1373.63 of the Health and Safety Code and each health insurer subject to Section 10127.19 shall notify the board of its election to either accept for coverage all eligible persons assigned to the health plan or health insurer by the board in compliance with the limitations of Section 1373.63 of the Health and Safety Code or Section 10127.19, as applicable, or to be a payer. The board shall

notify the Director of the Department of Managed Health Care and the commissioner of the entities that have elected to be a payer and, no later than May 1 of each year, the amount of the fee each entity is required to pay.

~~12739.6. The board shall establish a quartile ranking of all health plans and health insurers, based on their reported medical loss ratio, for the purposes of applying a graduated fee schedule to health plans and health insurers that elect to be payers pursuant to Section 1373.63 of the Health and Safety Code and Section 10127.19.~~

12739.6. The board shall establish fees to be paid by health plans and health insurers who have elected to be payers on a per covered life per month basis~~, adjusted by the ranking of the plan's or insurer's reported medical loss ratio~~. Each health plan and each health insurer shall annually pay the fee determined by the board based on the plan's or insurer's relative number of covered lives ~~and the ranking of the plan's or insurer's reported medical loss ratio~~. The fee charged by the board shall not exceed one dollar ($1) per covered life per month ~~for plans and insurers in the bottom quartile of the reported medical loss ratio.~~.

12739.7. (a) On or before March 1 of each year, beginning in 2010, each health care service plan subject to Section 1373.63 of the Health and Safety Code and each health insurer subject to Section 10127.19 shall report to the board the following information:

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

~~For purposes of this chapter, "covered lives" shall mean individuals who receive health care coverage provided or indemnified through an individual or group health care service plan contract or individual or group health insurance policy. Each named enrollee, insured, or covered person, including primary subscribers or policyholders, covered spouses, domestic partners, and each covered dependent shall count separately as a covered life. Covered lives shall not include persons~~

(A) For purposes of this chapter, "covered lives" include individuals who receive health care coverage provided, indemnified, or administered by a health care service plan or health insurer subject to this chapter, and individuals who receive health care services pursuant to an agreement by which a health

care service plan or health insurer subject to this chapter rents or leases a contracted network of providers. Each named enrollee, insured, or covered individual, including primary subscribers or policyholders, covered spouses, domestic partners, and dependents, shall count separately as a covered life, except in the following instances:

(i) A health care service plan or health insurer providing, indemnifying, or administering group health care coverage shall count every 10 named enrollees, insureds, or covered individuals in a group as one covered life.

(ii) In a group purchasing arrangement where more than 25 percent of the enrollees or insureds are retirees and more than 25 percent of the enrollees or insureds who are nonretirees can be considered high-risk individuals, as defined by the health care service plan or health insurer, the health care service plan or health insurer providing, indemnifying, or administering health care coverage shall exclude all of the covered lives in the group for the purposes of reporting the total number of covered lives to the board.

(B) For purposes of this chapter, covered lives shall include individuals described in subparagraph (A) covered by individual coverage, conversion coverage, guaranteed issue coverage pursuant to the federal Health Insurance Portability and Accountability Act of 1996, small group coverage, other group coverage, government employee coverage, other government coverage, association coverage, services provided by an administrator of health benefits coverage, and other coverage. For purposes of this subparagraph, "administrator of health benefits coverage" means a licensed health care service plan or a health insurer holding a valid, outstanding certificate of authority from the Insurance Commissioner, or any person or entity affiliated with, or a subsidiary of, a licensed health care service plan or a health insurer holding a valid, outstanding certificate of authority from the Insurance Commissioner, that collects any charge or premium from, or that adjusts or settles claims on behalf of, residents of the state or that leases contracted provider networks to purchasers.

(C) For purposes of this chapter, notwithstanding subparagraph (A) or (B), covered lives shall not include individuals covered under the Medi-Cal program, Medicare, the Healthy Families

Program (Part 6.2 (commencing with Section 12693)), this program, continuation coverage related to the pilot program established by Chapter 794 of the Statutes of 2002 that sunsetted on December 31, 2007, the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Children and Families Act of 1998 (Division 108 (commencing with Section 130100) of the Health and Safety Code), accident-only, specified disease, long-term care, CHAMPUS supplement, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis or short-term limited duration health insurance, or by a local, nonprofit program or county serving children whose annual household income is below 400 percent of the federal poverty level who are under the age of 18 years and who are not eligible for the Medi-Cal program, the Access for Infants and Mothers Program, or the Healthy Families Program.

~~(2) The medical loss ratio of the plan or insurer, which reflects the amount spent on health care benefits compared to the aggregate dues, fees, premiums, and other periodic payments received by the plan or insurer.~~

~~(A) For purposes of this paragraph, "health care benefits" shall include, but shall not be limited to, all of the following:~~

~~(i) Health care services that are either provided or reimbursed by the plan or insurer or its contracted providers as covered benefits to its enrollees and subscribers or insureds and policy holders.~~

~~(ii) The costs of programs or activities, including training and the provision of informational materials that are determined, as part of the regulations under subdivision (e), to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine.~~

~~(iii) Disease management expenses using cost-effective evidence-based guidelines.~~

~~(iv) Payments to providers as risk pool payments of pay-for-performance initiatives.~~

~~(v) Plan medical advice by telephone.~~

~~(vi) Prescription drug management programs.~~

~~(B) For purposes of this paragraph, a health care service plan may, in its medical loss ratio reporting, average its total costs across both of the following:~~

~~(i) All health care service plan contracts issued, amended, or renewed by the plan, or by its affiliated plans, in California, except Medicare supplement plan contracts, administrative services-only contracts, or other similar administrative arrangements, or coverage offered by specialized health care service plans, including, but not limited to, ambulance, dental, vision, behavioral health, chiropractic, and naturopathic coverage.~~

~~(ii) All health insurance policies issued, amended, or renewed in California by the plan's affiliated health insurers with a valid California certificate of authority, except those policies listed in clause (i) of subparagraph (C).~~

~~(C) For purposes of this paragraph, a health insurer may, in its medical loss ratio reporting, average its total costs across both of the following:~~

~~(i) All health insurance policies issued, amended, or renewed by the insurer in California, except Medicare supplement policies, administrative services-only policies, or other similar administrative arrangements, short-term limited duration health insurance policies, vision-only, dental-only, behavioral health-only, or pharmacy-only policies, CHAMPUS-supplement or TRICARE-supplement insurance policies, or hospital indemnity, hospital only, accident only, or specified disease insurance policies that do not pay benefits on a fixed benefit, cash payment only basis.~~

~~(ii) All health care service plan contracts issued, amended, or renewed in California by the insurer's affiliated health care service plans licensed to operate in California, except those contracts described in clause (i) of subparagraph (B).~~

~~(3)~~

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

(b) The board may determine, at its discretion, an amount of program costs to be covered by a health care service plan or health insurer subject to this section that fails to report to the board by

March 1 of any year, the number of covered lives as required by this section.

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

12739.9. (a) A health care service plan and a health insurer shall either accept for coverage all persons eligible for the program and assigned to the health plan or health insurer by the board as required in Section 1373.63 of the Health and Safety Code or Section 10127.19 or be a payer, as elected pursuant to Section 12739.5.

(b) A health care service plan that is a payer and a health insurer that is a payer shall pay the fee no later than June 1 of each year. A health care service plan shall make its payment to the Director of the Department of Managed Health Care, and a health insurer shall make its payment to the commissioner.

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

12739.13. If revenues collected pursuant to this chapter exceed the amount actually required for the operation of the program for any fiscal year, the excess shall be retained in the fund and shall be used by the board to reduce the fee paid by health care service plans and health insurers in the subsequent fiscal year.

SEC. 26. Until January 1, 2012, the adoption and readoption of any rules and regulations issued by the Managed Risk Medical Insurance Board, the Department of Managed Health Care, or the Department of Insurance to implement this act shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the Managed Risk Medical Insurance Board, the Department of Managed Health Care, and the Department of Insurance are hereby exempted from the requirements to describe specific facts showing

the need for immediate action and from review by the Office of Administrative Law.

SEC. 27. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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