ASSEMBLY BILL No. 1526

Introduced by Assembly Member Monning

January 19, 2012

An act to amend Sections 12711, 12718, 12725, and 12737 of the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1526, as introduced, Monning. California Major Risk Medical Insurance Program.

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 residents who have been rejected for coverage by at least one private health plan, as specified. Existing law creates the Major Risk Medical Insurance Fund and continuously appropriates the fund to MRMIB for the purposes of MRMIP.

This bill would alternatively require, as a condition of eligibility for MRMIP, that an applicant have documentation from a licensed physician, physician assistant, nurse practitioner, or other health care professional, if designated by MRMIB verifying the applicant's preexisting medical condition. By expanding the eligibility criteria for MRMIP, the bill would make moneys in a continuously appropriated fund available for a new or expanded purpose and would thereby make an appropriation.

Existing law specifies the minimum scope of benefits offered by participating health plans in MRMIP and requires the exclusion of

benefits that exceed $75,000 in a calendar year or $750,000 in a lifetime, as specified.

This bill would eliminate those annual or lifetime limits and would authorize MRMIB to exclude from the subscriber contribution rate that portion of the standard average individual rate attributable to the elimination of those limits.

The bill would also provide that regulations adopted and readopted by MRMIB to implement changes made to MRMIP enacted in 2012 are deemed to be an emergency and would exempt MRMIB from describing facts showing the need for immediate action and from review by the Office of Administrative Law.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 12711 of the Insurance Code is amended to read:

12711. The board shall have the authority:

(a) To determine the eligibility of applicants.

(b) To determine the major risk medical coverage to be provided program subscribers.

(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 assuring the availability of adequate health care services.

(d) To approve subscriber contributions, and plan rates, and establish program contribution amounts.

(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. *The adoption and readoption of regulations to implement the changes made to this part enacted in 2012 shall be deemed to be an emergency and necessary to avoid serious harm to the public*

peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

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

SEC. 2. Section 12718 of the Insurance Code is amended to read:

12718. *(a)* Benefits under this ~~chapter or Chapter 5 (commencing with Section 12720)~~ *part* shall be subject to required subscriber copayments and deductibles as the board may authorize. Any authorized copayments shall not exceed 25 percent and any authorized deductible shall not exceed an annual household deductible amount of five hundred dollars ($500). However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars ($25). 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) Benefits under this part shall have no annual or lifetime limits.

SEC. 3. 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~~ *demonstrate that he or she is unable to secure adequate private health care coverage by providing either of the following:*

(1) Documentation that he or she has 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)~~

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

~~(2)~~

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

~~(3)~~

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

(2) Documentation satisfactory to the board from a licensed physician, physician assistant, or nurse practitioner, or, if designated by the board, other health care professional, verifying the applicant's preexisting medical condition.

(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 *under paragraph (1) of subdivision (b).*

(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 shall by regulation prescribe a period of time during which a resident is ineligible to apply for major risk medical coverage through the program if the resident either voluntarily disenrolls from, or was terminated for nonpayment of the premium from, a private health plan after enrolling in that private health plan

pursuant to either Section 10127.15 or Section 1373.62 of the Health and Safety Code.

(f) For the period commencing September 1, 2003, to December 31, 2007, inclusive, subscribers and their dependents receiving major risk coverage through the program may receive that coverage for no more than 36 consecutive months. Ninety days before a subscriber or dependent's eligibility ceases pursuant to this subdivision, the board shall provide the subscriber and any dependents with written notice of the termination date and written information concerning the right to purchase a standard benefit plan from any health care service plan or health insurer participating in the individual insurance market pursuant to Section 10127.15 or Section 1373.62 of the Health and Safety Code. This subdivision shall become inoperative on December 31, 2007.

SEC. 4. Section 12737 of the Insurance Code is amended to read:

12737. (a) The board shall establish program contribution amounts for each category of risk for each participating health plan. The program contribution amounts shall be based on the average amount of subsidy funds required for the program as a whole. To determine the average amount of subsidy funds required, the board shall calculate a loss ratio, including all medical costs, administration fees, and risk payments, for the program in the prior calendar year. The loss ratio shall be calculated using 125 percent of the standard average individual rates for comparable coverage as the denominator, and all medical costs, administration fees, and risk payments as the numerator. The average amount of subsidy funds required is calculated by subtracting 100 percent from the program loss ratio. For purposes of calculating the program loss ratio, no participating health plan's loss ratio shall be less than 100 percent and participating health plans with fewer than 1,000 program members shall be excluded from the calculation.

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

(1) In all areas of the state, at least one plan shall be available to program participants at an average subscriber contribution of

125 percent of the standard average individual rates for comparable coverage.

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

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

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

(c) For purposes of subdivision (a), the board may exclude from the subscriber contribution that portion of the standard average individual rate attributable to the elimination of annual and lifetime benefit limits pursuant to subdivision (b) of Section 12718.

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