

AMENDED IN SENATE APRIL 25, 2011

AMENDED IN SENATE APRIL 5, 2011

**SENATE BILL**

**No. 51**

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**Introduced by Senator Alquist**

December 15, 2010

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An act to add Sections 1367.001 and 1367.003 to the Health and Safety Code, and to add Sections 10112.1 and 10112.25 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 51, as amended, Alquist. Health care coverage.

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 prohibits a health care service plan from expending for administrative costs, as defined, an excessive amount of the payments the plan receives for providing health care services to its subscribers and enrollees.

Existing law provides for the regulation of health insurers by the Department of Insurance. The Insurance Commissioner is required to withdraw approval of an individual or mass-marketed health insurance policy if the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged, as specified.

The federal Patient Protection and Affordable Care Act prohibits a health insurance issuer issuing health insurance coverage from establishing lifetime limits or unreasonable annual limits on the dollar value of benefits for any participant or beneficiary, as specified. The act also requires a health insurance issuer issuing health insurance coverage to comply with minimum medical loss ratios and to provide

an annual rebate to each insured if the medical loss ratio of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified.

This bill would require health care service plans and health insurers to comply with the requirements imposed under those federal provisions, as specified. The bill would authorize the Director of the Department of Managed Health Care and the Insurance Commissioner to issue guidance and promulgate regulations to implement requirements relating to medical loss ratios, as specified.

Because a willful violation of those requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

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: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

1 SECTION 1. Section 1367.001 is added to the Health and  
2 Safety Code, to read:

3 1367.001. To the extent required by federal law, every health  
4 care service plan that issues, sells, renews, or offers contracts for  
5 health care coverage in this state shall comply with the  
6 requirements of Section 2711 of the federal Public Health Service  
7 Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued  
8 under that section, in addition to any state laws or regulations that  
9 do not prevent the application of those requirements.

10 SEC. 2. Section 1367.003 is added to the Health and Safety  
11 Code, to read:

12 1367.003. (a) Every health care service plan that issues, sells,  
13 renews, or offers health care service plan contracts for health care  
14 coverage in this state, including a grandfathered health plan, *but*  
15 *not including specialized health care service plan contracts*, shall  
16 provide an annual rebate to each enrollee under such coverage, on  
17 a pro rata basis, if the ratio of the amount of premium revenue  
18 expended by the health care service plan on the costs for

1 reimbursement for clinical services provided to enrollees under  
2 such coverage and for activities that improve health care quality  
3 to the total amount of premium revenue, excluding federal and  
4 state taxes and licensing or regulatory fees and after accounting  
5 for payments or receipts for risk adjustment, risk corridors, and  
6 reinsurance, is less than the following:

7 (1) With respect to a health care service plan offering coverage  
8 in the large group market, 85 percent.

9 (2) With respect to a health care service plan offering coverage  
10 in the small group market or in the individual market, 80 percent.

11 (b) Every health care service plan that issues, sells, renews, or  
12 offers health care service plan contracts for health care coverage  
13 in this state, including a grandfathered health plan, shall comply  
14 with the following minimum medical loss ratios:

15 (1) With respect to a health care service plan offering coverage  
16 in the large group market, 85 percent.

17 (2) With respect to a health care service plan offering coverage  
18 in the small group market or in the individual market, 80 percent.

19 ~~(e) Every health care service plan shall submit its rates to the  
20 director pursuant to the requirements imposed under Section  
21 1385.03 or 1385.04. If the director notifies a health care service  
22 plan that a filed rate does not comply with the requirements of  
23 law, it shall be unlawful for the health care service plan to  
24 implement that rate.~~

25 ~~(d)~~

26 (c) (1) The total amount of an annual rebate required under this  
27 section shall be calculated in an amount equal to the product of  
28 the following:

29 (A) The amount by which the percentage described in paragraph  
30 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph  
31 (1) or (2) of subdivision (a).

32 (B) The total amount of premium revenue, excluding federal  
33 and state taxes and licensing or regulatory fees and after accounting  
34 for payments or receipts for risk adjustment, risk corridors, and  
35 reinsurance.

36 (2) A health care service plan shall provide any rebate owing  
37 to an enrollee no later than August 1 of the year following the year  
38 in which the rate was in effect.

39 (e)

1 (d) (1) On or before July 1, 2013, the director may issue  
2 guidance to health care service plans regarding compliance with  
3 this section. This guidance shall not be subject to the  
4 Administrative Procedure Act (Chapter 3.5 (commencing with  
5 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
6 Code). The director may also promulgate regulations regarding  
7 compliance with this section.

8 (2) The department shall consult with the Department of  
9 Insurance in issuing guidance under paragraph (1), in adopting  
10 necessary regulations, and in taking any other action for the  
11 purpose of implementing this section.

12 SEC. 3. Section 10112.1 is added to the Insurance Code, to  
13 read:

14 10112.1. To the extent required by federal law, every health  
15 insurer that issues, sells, renews, or offers policies for health care  
16 coverage in this state shall comply with the requirements of Section  
17 2711 of the federal Public Health Service Act (42 U.S.C. Sec.  
18 300gg-11) and any rules or regulations issued under that section,  
19 in addition to any state laws or regulations that do not prevent the  
20 application of those requirements.

21 SEC. 4. Section 10112.25 is added to the Insurance Code, to  
22 read:

23 10112.25. (a) Every health insurer that issues, sells, renews,  
24 or offers health insurance policies for health care coverage in this  
25 state, including a grandfathered health plan, *but not including*  
26 *specialized health insurance policies*, shall provide an annual  
27 rebate to each insured under such coverage, on a pro rata basis, if  
28 the ratio of the amount of premium revenue expended by the health  
29 insurer on the costs for reimbursement for clinical services  
30 provided to insureds under such coverage and for activities that  
31 improve health care quality to the total amount of premium  
32 revenue, excluding federal and state taxes and licensing or  
33 regulatory fees and after accounting for payments or receipts for  
34 risk adjustment, risk corridors, and reinsurance, is less than the  
35 following:

36 (1) With respect to a health insurer offering coverage in the  
37 large group market, 85 percent.

38 (2) With respect to a health insurer offering coverage in the  
39 small group market or in the individual market, 80 percent.

1 (b) Every health insurer that issues, sells, renews, or offers health  
2 insurance policies for health care coverage in this state, including  
3 a grandfathered health plan, shall comply with the following  
4 minimum medical loss ratios:

5 (1) With respect to a health insurer offering coverage in the  
6 large group market, 85 percent.

7 (2) With respect to a health insurer offering coverage in the  
8 small group market or in the individual market, 80 percent.

9 ~~(c) Every health insurer shall submit its rates to the  
10 commissioner pursuant to the requirements imposed under Section  
11 10181.3, 10181.4, or 10290. If the commissioner notifies a health  
12 insurer that a filed rate does not comply with the requirements of  
13 law, it shall be unlawful for the health insurer to implement that  
14 rate.~~

15 ~~(d)~~

16 (c) (1) The total amount of an annual rebate required under this  
17 section shall be calculated in an amount equal to the product of  
18 the following:

19 (A) The amount by which the percentage described in paragraph  
20 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph  
21 (1) or (2) of subdivision (a).

22 (B) The total amount of premium revenue, excluding federal  
23 and state taxes and licensing or regulatory fees and after accounting  
24 for payments or receipts for risk adjustment, risk corridors, and  
25 reinsurance.

26 (2) A health insurer shall provide any rebate owing to an insured  
27 no later than August 1 of the year following the year in which the  
28 rate was in effect.

29 ~~(e)~~

30 (d) (1) On or before July 1, 2013, the commissioner may issue  
31 guidance to health insurers regarding compliance with this section.  
32 This guidance shall not be subject to the Administrative Procedure  
33 Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
34 Division 3 of Title 2 of the Government Code). The commissioner  
35 may also promulgate regulations regarding compliance with this  
36 section.

37 (2) The department shall consult with the Department of  
38 Managed Health Care in issuing guidance under paragraph (1), in  
39 adopting necessary regulations, and in taking any other action for  
40 the purpose of implementing this section.

1 SEC. 5. No reimbursement is required by this act pursuant to  
2 Section 6 of Article XIII B of the California Constitution because  
3 the only costs that may be incurred by a local agency or school  
4 district will be incurred because this act creates a new crime or  
5 infraction, eliminates a crime or infraction, or changes the penalty  
6 for a crime or infraction, within the meaning of Section 17556 of  
7 the Government Code, or changes the definition of a crime within  
8 the meaning of Section 6 of Article XIII B of the California  
9 Constitution.

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