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CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 718

Introduced by Assembly Member Emmerson
(Coauthor: Senator Negrete McLeod)

February 26, 2009

~~An act to add and repeal Section 14087.521 of the Welfare and Institutions Code, relating to healing arts.~~ *An act to amend Sections 1399.805, 1399.811, 1399.813, and 1399.815 of the Health and Safety Code, and to amend Sections 10901.3, 10901.9, 10902.1, and 10902.3 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 718, as amended, Emmerson. ~~Inland Empire Health Plan E-Prescribing Pilot Program.~~ *Health care coverage: federally eligible defined individuals: preferred provider products: premium rates.*

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 or a health insurer offering individual plan contracts or individual health insurance policies to fairly and affirmatively offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. For those contracts and policies that offer services through a preferred provider arrangement, existing law requires that the premium not exceed the average premium paid by a similar subscriber of the Major Risk Medical Insurance Program (MRMIP), as specified.

This bill would define the "average premium paid" for purposes of this provision as an amount calculated on an annual basis by the Managed Risk Medical Insurance Board using a weighted average based on each plan's or insurer's enrollment in MRMIP, as specified. The bill would require plans and insurers to include a statement regarding those maximum premium rates in certain solicitation and sales materials.

Existing law requires plans and insurers to file a specified notice with the Department of Managed Health Care or the Department of Insurance prior to renewing or amending a contract or policy issued to a federally eligible defined individual and prior to changing the premium rates applicable to that contract or policy. Existing law requires the notice or amendment to include a certification of compliance with specified premium requirements.

This bill would specify that this certification binds the plan or insurer to the representation of compliance and subjects the plan or insurer to all remedies available to the Director of the Department of Managed Health Care or the Insurance Commissioner, as specified.

Because a willful violation of the bill's 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.

~~Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. Existing law authorizes the California Medical Assistance Commission to negotiate exclusive contracts with any county that seeks to provide, or arrange for the provision of health care services provided under the Medi-Cal program. Existing law authorizes the Board of Supervisors of San Bernardino County to, by ordinance, establish a commission to negotiate the above-described exclusive contract and to arrange for the supervision of certain health care services.~~

~~The Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous devices and dangerous drugs, which include controlled substances. Existing law authorizes the electronic transmission of prescriptions under specified circumstances.~~

~~This bill would, until January 1, 2013, create the Inland Empire Health Plan E-Prescribing Pilot Program and would require the program to promote health care quality and the exchange of health care information and to include specified components, including electronic prescribing, as defined. The bill would require the Inland Empire Health Plan, a joint powers agency, to select, through a competitive bid process, an entity whose product has specified certification to administer the program and would require this entity to submit a report to the Legislature, by January 1, 2012, regarding the goals and results of the program and whether the program should be extended, as specified. The bill would provide that a physician who contracts with the Inland Empire Health Plan shall not be required to participate in the pilot program. The bill would provide that the above-described provisions shall be funded by funds made available by the federal American Recovery and Reinvestment Act of 2009. By imposing a new requirement on a joint powers agency, 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.~~

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

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

SECTION 1. It is the intent of the Legislature, to the extent funding and resources are available, that the Managed Risk Medical Insurance Board shall develop and deliver the average premiums paid to the Department of Managed Health Care and the Department of Insurance for the 2010 calendar year and that the health care service plans and health insurers subject to the provisions of this act shall comply with all of the provisions of this act for all health care service plan contracts and all health insurance polices issued and sold during the 2010 calendar year.

SEC. 2. Section 1399.805 of the Health and Safety Code is amended to read:

1399.805. (a) (1) After the federally eligible defined individual submits a completed application form for a plan contract, the plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan contract, unless the plan has provided notice of the premium charge prior to the application being filed. In no case shall the premium charged for any health care service plan contract identified in subdivision (d) of Section 1366.35 exceed the following amounts:

(A) For health care service plan contracts that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program *(MRMIP)* who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to

an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A plan may adjust the premium based on family size, not to exceed the following amounts:

(A) For health care service plans that offer services through a preferred provider arrangement, the average of the ~~Major Risk Medical Insurance Program~~ *MRMIP* rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.

(B) For health care service plans identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(c) During the first 30 days after the effective date of the plan contract, the individual shall have the option of changing coverage to a different plan contract offered by the same health care service plan. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new plan contract shall become effective no later than the first day of the following month. If an enrolled individual notified the plan of the change after the 15th day of a month, coverage under the new plan contract shall become effective no later than the first day of the second month following notification.

(d) (1) For purposes of subparagraph (A) of paragraph (1) of subdivision (a), the "average premium paid" shall be determined by calculating a weighted average that is based upon each health care service plan's and each health insurer's aggregate enrollment in MRMIP within each designated geographic region, as follows:

(A) Each health care service plan and each health insurer shall have a single weight factor for each geographic region. This weight factor shall be a ratio of each health care service plan's or each health insurer's total MRMIP subscribers in the designated geographic region, divided by the total MRMIP subscribers in that geographic region for all health care service plans and health insurers, for a period of six months.

(B) The weight factor for each health care service plan and each health insurer, as calculated under subparagraph (A), shall be multiplied by the premium rate for that health care service plan or health insurer for each age and dependent category. The result of that multiplication shall be added to the corresponding results for all other health care service plans and health insurers. The total sum shall be the average premium paid for the corresponding age and dependent category.

(2) The "average premium paid," as defined in paragraph (1), shall be calculated on an annual basis by the Managed Risk Medical Insurance Board, which shall consider six months of enrollment in MRMIP, for the six-month period of January 1 to June 30 immediately preceding the calendar year for which the premiums will be effective. The Managed Risk Medical Insurance Board shall, under its letterhead, provide the average premiums paid to the department and the Department of Insurance no later than October 15 of each year prior to the calendar year for which the premiums will be effective, or 20 working days after the MRMIP premiums are finalized for the upcoming calendar year, whichever is later. At the time it provides the average premiums paid, the Managed Risk Medical Insurance Board shall also provide the department and the Department of Insurance the MRMIP premiums and geographical enrollment data that served as the basis for the calculation of the average premiums paid.

SEC. 3. Section 1399.811 of the Health and Safety Code is amended to read:

1399.811. Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, ~~2001,~~ *2010,* shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a

preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program *(MRMIP)* who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium

charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(3) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

(d) (1) For purposes of paragraph (1) of subdivision (a) and paragraph (1) of subdivision (b), the "average premium paid" shall be determined by calculating a weighted average that is based upon each health care service plan's and each health insurer's aggregate enrollment in MRMIP within each designated geographic region, as follows:

(A) Each health care service plan and each health insurer shall have a single weight factor for each geographic region. This weight factor shall be a ratio of each health care service plan's or each health insurer's total MRMIP subscribers in the designated geographic region, divided by the total MRMIP subscribers in that geographic region for all health care service plans and health insurers, for a period of six months.

(B) The weight factor for each health care service plan and each health insurer, as calculated under subparagraph (A), shall

be multiplied by the premium rate for that health care service plan or health insurer for each age and dependent category. The result of that multiplication shall be added to the corresponding results for all other health care service plans and health insurers. The total sum shall be the average premium paid for the corresponding age and dependent category.

(2) The "average premium paid," as defined in paragraph (1), shall be calculated on an annual basis by the Managed Risk Medical Insurance Board, which shall consider six months of enrollment in MRMIP, for the six-month period of January 1 to June 30 immediately preceding the calendar year for which the premiums will be effective. The Managed Risk Medical Insurance Board shall, under its letterhead, provide the average premiums paid to the department and the Department of Insurance no later than October 15 of each year prior to the calendar year for which the premiums will be effective, or 20 working days after the MRMIP premiums are finalized for the upcoming calendar year, whichever is later. At the time it provides the average premiums paid, the Managed Risk Medical Insurance Board shall also provide the department and the Department of Insurance the MRMIP premiums and geographical enrollment data that served as the basis for the calculation of the average premiums paid.

SEC. 4. Section 1399.813 of the Health and Safety Code is amended to read:

1399.813. *(a)* In connection with the offering for sale of ~~any~~ *a* plan contract to an individual, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of all individual contracts.

(b) For plan contracts that offer services through a preferred provider arrangement and that are offered or sold to federally eligible defined individuals, the disclosure described in subdivision (a) shall also include the following statement, which, if the disclosure is made in writing, shall be in at least 12-point boldface type:

"The maximum premium rate for this preferred provider product is available on the Internet Web sites of the Department of Managed Health Care, at www.dmhc.ca.gov, and the Department of Insurance, at www.insurance.ca.gov. By visiting either of these Internet Web sites, you can compare the rates that were disclosed

to you for this product and ensure that they are less than, or equal to, the maximum rate allowed by law."

SEC. 5. Section 1399.815 of the Health and Safety Code is amended to read:

1399.815. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article, or at least 20 business days prior to the initial offering of a plan contract subject to this article, a plan shall file a notice of an amendment with the director in accordance with the provisions of Section 1352. The notice of an amendment shall include a statement certifying that the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons the plan contract does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the plan shall file an amendment in accordance with the provisions of Section 1352, and shall include a statement certifying the plan is in compliance with subdivision (a) of Section 1399.805 and with Section 1399.811. All other changes to a plan contract previously filed with the director pursuant to subdivision (a) shall be filed as an amendment in accordance with the provisions of Section 1352, unless the change otherwise would require the filing of a material modification.

(c) An amendment or notice of an amendment filed pursuant to this section shall not be deemed accepted or approved unless the required statement of certification is concurrently filed with the amendment or notice. The certification required by this section, whether provided by the health care service plan or an independent agent or consultant, binds the plan to the representation of compliance and subjects the plan to all remedies available to the director to the extent the filing or certification is determined to be a misrepresentation, whether or not willful, or a falsification of the information contained therein, or otherwise violates the requirements of this chapter or any of the rules promulgated under this chapter.

SEC. 6. Section 10901.3 of the Insurance Code is amended to read:

10901.3. (a) (1) After the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program *(MRMIP)* who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the ~~Major Risk Medical Insurance Program~~ *MRMIP* who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.

(2) A carrier may adjust the premium based on family size, not to exceed the following amounts:

(A) For health benefit plans that offer services through a preferred provider arrangement, the average of ~~the Major Risk Medical Insurance Program~~ *MRMIP* rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.

(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged

to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.

(b) When a federally eligible defined individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered or postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(c) During the first 30 days after the effective date of the health benefit plan, the individual shall have the option of changing coverage to a different health benefit plan design offered by the same carrier. If the individual notified the plan of the change within the first 15 days of a month, coverage under the new health benefit plan shall become effective no later than the first day of the following month. If an enrolled individual notified the carrier of the change after the 15th day of a month, coverage under the health benefit plan shall become effective no later than the first day of the second month following notification.

(d) (1) For purposes of subparagraph (A) of paragraph (1) of subdivision (a), the "average premium paid" shall be determined by calculating a weighted average that is based upon each carrier's and each health care service plan's aggregate enrollment in MRMIP within each designated geographic region, as follows:

(A) Each carrier and each health care service plan shall have a single weight factor for each geographic region. This weight factor shall be a ratio of each carrier's or each health care service plan's total MRMIP subscribers in the designated geographic region, divided by the total MRMIP subscribers in that geographic region for all carriers and health care service plans, for a period of six months.

(B) The weight factor for each carrier and each health care service plan, as calculated under subparagraph (A), shall be multiplied by the premium rate for that carrier or plan for each age and dependent category. The result of that multiplication shall be added to the corresponding results for all other carriers and health care service plans. The total sum shall be the average premium paid for the corresponding age and dependent category.

(2) The "average premium paid," as defined in paragraph (1), shall be calculated on an annual basis by the Managed Risk Medical Insurance Board, which shall consider six months of enrollment in MRMIP, for the six-month period of January 1 to June 30 immediately preceding the calendar year for which the premiums will be effective. The Managed Risk Medical Insurance Board shall, under its letterhead, provide the average premiums paid to the department and the Department of Managed Health Care no later than October 15 of each year prior to the calendar year for which the premiums will be effective, or 20 working days after the MRMIP premiums are finalized for the upcoming calendar year, whichever is later. At the time it provides the average premiums paid, the Managed Risk Medical Insurance Board shall also provide the department and the Department of Managed Health Care the MRMIP premiums and geographical enrollment data that served as the basis for the calculation of the average premiums paid.

SEC. 7. Section 10901.9 of the Insurance Code is amended to read:

10901.9. Commencing January 1, ~~2001,~~ *2010,* premiums for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program *(MRMIP)* who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual.

However, for federally qualified individuals who are between the ages of 60 to 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of ~~the Major Risk Medical Insurance Program~~ *MRMIP* who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred

provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

~~(2)~~

(3) For a contract that a carrier has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

(d) (1) For purposes of paragraph (1) of subdivision (a) and paragraph (1) of subdivision (b), the "average premium paid" shall be determined by calculating a weighted average that is based upon each carrier's and each health care service plan's aggregate enrollment in MRMIP within each designated geographic region, as follows:

(A) Each carrier and each health care service plan shall have a single weight factor for each geographic region. This weight factor shall be a ratio of each carrier's or each health care service plan's total MRMIP subscribers in the designated geographic region, divided by the total MRMIP subscribers in that geographic region for all carriers and health care service plans, for a period of six months.

(B) The weight factor for each carrier and each health care service plan, as calculated under subparagraph (A), shall be multiplied by the premium rate for that carrier or plan for each age and dependent category. The result of that multiplication shall be added to the corresponding results for all other carriers and health care service plans. The total sum shall be the average premium paid for the corresponding age and dependent category.

(2) The "average premium paid," as defined in paragraph (1), shall be calculated on an annual basis by the Managed Risk Medical Insurance Board, which shall consider six months of enrollment in the MRMIP, for the six-month period of January 1st to June 30th immediately preceding the calendar year for which the premiums will be effective. The Managed Risk Medical Insurance Board shall, under its letterhead, provide the average premiums paid to the department and the Department of Managed Health Care no later than October 15 of each year prior to the

calendar year for which the premiums will be effective, or 20 working days after the MRMIP premiums are finalized for the upcoming calendar year, whichever is later. At the time it provides the average premiums paid, the Managed Risk Medical Insurance Board shall provide the department and the Department of Managed Health Care the MRMIP premiums and geographical enrollment data that served as the basis for the calculation of the average premiums paid.

SEC. 8. Section 10902.1 of the Insurance Code is amended to read:

10902.1. *(a)* In connection with the offering for sale of any health benefit plan designed to an individual, each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all individual contracts.

(b) For health benefit plans that offer services through a preferred provider arrangement and that are offered or sold to federally eligible defined individuals, the disclosure described in subdivision (a) shall also include the following statement, which, if the disclosure is made in writing, shall be in at least 12-point boldface type:

"The maximum premium rate for this preferred provider product is available on the Internet Web sites of the Department of Insurance, at www.dmhc.ca.gov, and the Department of Managed Health Care, at www.mrmib.ca.gov. By visiting either of these Internet Web sites, you can compare the rates that were disclosed to you for this product and ensure that they are less than, or equal to, the maximum rate allowed by law."

SEC. 9. Section 10902.3 of the Insurance Code is amended to read:

10902.3. (a) At least 20 business days prior to renewing or amending a health benefit plan contract subject to this chapter, or at least 20 business days prior to the initial offering of a health benefit plan subject to this chapter, a carrier shall file a statement with the commissioner in the same manner as required for small employers as outlined in Section 10717. The statement shall include a statement certifying that the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. Any action by the commissioner, as permitted under Section 10717, to disapprove, suspend, or postpone the plan's use of a carrier's health benefit plan design shall be in writing, specifying the reasons the

health benefit plan does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the carrier shall file an amendment in the same manner as required for small employers as outlined in Section 10717, and shall include a statement certifying the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. All other changes to a health benefit plan previously filed with the commissioner pursuant to subdivision (a) shall be filed as an amendment in the same manner as required for small employers as outlined in Section 10717.

(c) A statement or amendment filed pursuant to this section shall not be deemed accepted or approved unless the required statement of certification is concurrently filed with the statement or amendment. The certification required by this section, whether provided by the carrier or an independent agent or consultant, binds the carrier to the representation of compliance and subjects the carrier to all remedies available to the commissioner to the extent the filing or certification is determined to be a misrepresentation, whether or not willful, or a falsification of the information contained therein, or otherwise violates the requirements of this code or any of the rules promulgated under this code.

SEC. 10. 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.

~~SECTION 1. Section 14087.521 is added to the Welfare and Institutions Code, to read:~~

~~14087.521. (a) The Inland Empire Health Plan E-Prescribing Pilot Program is hereby created. For purposes of this section, "program" means the Inland Empire Health Plan E-Prescribing Pilot Program.~~

~~(b) The program shall be administered by an entity whose product has been certified by the Certification Commission for~~

~~Health Information Technology or another certifying entity authorized by the federal Department of Health and Human Services, either as a stand-alone electronic prescribing product or service or as part of an electronic health record product or service. This entity shall be selected by the Inland Empire Health Plan through a competitive bid process.~~

~~(c) The program shall promote health care quality and the exchange of health care information consistent with applicable law, including, but not limited to, applicable state and federal confidentiality and data security requirements and applicable state record retention and reporting requirements. The program shall include all of the following components:~~

~~(1) Integrated clinical decision support alerts for allergies, drug-drug interactions, duplications in therapy, and elderly alerts.~~

~~(2) Current payer formulary information.~~

~~(3) Appropriate alternatives, when needed, to support cost-effective prescribing at the point of care, except that nothing in this section shall be construed to authorize the program to establish a drug formulary.~~

~~(4) Drug compendia approved by the federal Centers for Medicare and Medicaid Services.~~

~~(5) Electronic prescribing consistent with applicable state and federal law.~~

~~(6) Patient drug history.~~

~~(d) (1) Electronic prescribing pursuant to the program shall not interfere with a patient's existing freedom to choose a pharmacy and shall not interfere with the prescribing decision at the point of care.~~

~~(2) A physician who contracts with the Inland Empire Health Plan shall not be required to participate in the pilot program.~~

~~(e) The entity administering the program shall, on or before January 1, 2012, submit a report to the Legislature on the goals and results of the program and whether the program should be extended. This report shall include quantifiable data on all of the following:~~

~~(1) The number of prescribers enrolled in the program who use electronic prescribing.~~

~~(2) The number of pharmacies participating in the program.~~

~~(3) The number and percentage of prescriptions sent electronically as a percentage of the overall number of prescriptions reimbursed by the plan.~~

~~(4) Expenditures on the program.~~

~~(5) Data on whether and to what extent the program achieved the following goals:~~

~~(A) Reduced medication errors.~~

~~(B) Reduced prescription fraud.~~

~~(C) Reduced health care costs, including, but not limited to, inpatient hospitalization, by reducing medication errors, increasing patient medication compliance, and identifying medication contraindications.~~

~~(f) For purposes of this section, "electronic prescribing" shall have the same meaning as "electronic data transmission prescription" as defined in subdivision (c) of Section 4040 of the Business and Professions Code.~~

~~(g) This section shall be funded by funds made available by the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5).~~

~~(h) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.~~

~~SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.~~

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