## Senate Bill No. 227

CHAPTER 31

An act to amend Sections 1389.25 and 1389.4 of the Health and Safety Code, and to amend Sections 10113.9 and 10113.95 of, to add Section 12739.755 to, and to add and repeal Part 6.6 (commencing with Section 12739.5) of Division 2 of, the Insurance Code, relating to health care coverage, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor June 29, 2010. Filed with Secretary of State June 29, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 227, Alquist. Health care coverage: temporary high risk pool.

Existing law, the federal Patient Protection and Affordable Care Act, requires the United States Secretary of Health and Human Services to establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals until January 1, 2014. Existing law authorizes the secretary to implement this program directly or through contracts with eligible entities, including the states, and requires that federal money made available pursuant to these provisions be used to establish a qualified high risk pool that meets certain requirements.

Existing law establishes the California Major Risk Medical Insurance Program, which is administered by the Managed Risk Medical Insurance Board (MRMIB), to provide major risk medical coverage to persons who, among other things, have been rejected for coverage by at least one private health plan.

This bill would require MRMIB to enter into an agreement with the federal Department of Health and Human Services to administer a temporary high risk pool to provide health coverage, until January 1, 2014, to specified individuals who have preexisting conditions, consistent with the federal Patient Protection and Affordable Care Act. The bill would repeal these provisions on January 1, 2020. The bill would also appropriate $761,000,000 from the Federal Trust Fund to MRMIB for the purposes of these provisions.

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 that rejects an applicant for individual coverage or offers individual coverage at a rate higher than the standard rate to inform the applicant about the California Major Risk Medical Insurance Program.

This bill would also require the plan or insurer to inform the applicant about the temporary high risk pool established pursuant to the bill and would require that information to be provided in accordance with standards developed by the Department of Managed Health Care or the Department of Insurance, as specified. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would also require the Department of Managed Health Care and the Department of Insurance to post information on their Internet Web sites about the temporary high risk pool established pursuant to the bill.

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.

This bill would provide that it shall become operative only if AB 1887 of the 2009–10 Regular Session is also enacted and becomes operative.

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

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

SECTION 1. Section 1389.25 of the Health and Safety Code is amended to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) A health care service plan that declines to offer coverage or denies enrollment for an individual or his or her dependents applying for individual coverage or that offers individual coverage at a rate that is higher than the standard rate, shall provide the individual applicant with the specific reason

or reasons for the decision in writing at the time of the denial or offer of coverage.

(2) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has delivered a written notice of the change at least 30 days prior to the effective date of the contract renewal or the date on which the rate or coverage changes. A notice of an increase in the premium rate shall include the reasons for the rate increase.

(3) The written notice required pursuant to paragraph (2) shall be delivered to the individual contractholder at his or her last address known to the plan, at least 30 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium rate increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change to the plan design or benefits.

(4) If a plan rejects an applicant or the dependents of an applicant for coverage or offers individual coverage at a rate that is higher than the standard rate, the plan shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (MRMIP) (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code. The information provided to the applicant by the plan shall be in accordance with standards developed by the department, in consultation with the Managed Risk Medical Insurance Board, and shall specifically include the toll-free telephone number and Internet Web site address for MRMIP and the federal temporary high risk pool. The requirement to notify applicants of the availability of MRMIP and the federal temporary high risk pool shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

(c) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the plan shall give the individual applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

SEC. 2. Section 1389.4 of the Health and Safety Code is amended to read:

1389.4. (a) A full service health care service plan that issues, renews, or amends individual health plan contracts shall be subject to this section.

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating

and underwriting criteria comply with Sections 1365.5 and 1389.1 and all other applicable provisions of state and federal law.

(c) On or before June 1, 2006, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual health plan contracts, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

(d) Commencing January 1, 2011, the director shall post on the department's Internet Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code) and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code. The director shall develop the information for the Internet Web site in consultation with the Department of Insurance to enhance the consistency of information provided to consumers. Information about individual health coverage shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company specific rating and underwriting criteria and practices submitted to the director.

(f) This section shall not apply to a closed block of business, as defined in Section 1367.15.

SEC. 3. Section 10113.9 of the Insurance Code is amended to read:

10113.9. (a) This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, 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.

(b) No change in the premium rate or coverage for an individual health insurance policy shall become effective unless the insurer has delivered a written notice of the change at least 30 days prior to the effective date of the policy renewal or the date on which the rate or coverage changes. A

notice of an increase in the premium rate shall include the reasons for the rate increase.

(c) The written notice required pursuant to subdivision (b) shall be delivered to the individual policyholder at his or her last address known to the insurer, at least 30 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(d) If an insurer rejects an applicant or the dependents of an applicant for coverage or offers individual coverage at a rate that is higher than the standard rate, the insurer shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (MRMIP) (Part 6.5 (commencing with Section 12700)), and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5). The information provided to the applicant by the insurer shall be in accordance with standards developed by the department, in consultation with the Managed Risk Medical Insurance Board, and shall specifically include the toll-free telephone number and Internet Web site address for MRMIP and the federal temporary high risk pool. The requirement to notify applicants of the availability of MRMIP and the federal temporary high risk pool shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

SEC. 4. Section 10113.95 of the Insurance Code is amended to read:

10113.95. (a) A health insurer that issues, renews, or amends individual health insurance policies shall be subject to this section.

(b) An insurer subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 10140 and 10291.5 and all other applicable provisions.

(c) On or before June 1, 2006, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which they would be eligible. An insurer may comply with this section by submitting to the department underwriting materials or resource guides provided to agents

and brokers, provided that those materials include the information required to be submitted by this section.

(d) Commencing January 1, 2011, the commissioner shall post on the department's Internet Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2. The commissioner shall develop the information for the Internet Web site in consultation with the Department of Managed Health Care to enhance the consistency of information provided to consumers. Information about individual health insurance shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company-specific rating and underwriting criteria and practices submitted to the commissioner.

(f) This section shall not apply to a closed block of business, as defined in Section 10176.10.

SEC. 5. Part 6.6 (commencing with Section 12739.5) is added to Division 2 of the Insurance Code, to read:

## PART 6.6. QUALIFIED HIGH RISK POOLS

12739.5. It is the intent of the Legislature to implement Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) in California to establish a temporary high risk pool so that access to health coverage for individuals with preexisting medical conditions can be effectively and promptly provided by the Managed Risk Medical Insurance Board.

12739.50. For the purposes of this part, the following terms have the following meanings:

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

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

(c) "Federal temporary high risk pool" is the temporary high risk health insurance pool program established pursuant to Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(d) "Fund" means the Federal Temporary High Risk Health Insurance Fund, established in Section 12739.71, from which the board may authorize expenditures to pay for all of the following:

(1) Covered, medically necessary services that exceed subscribers' contributions.

(2) Administration of the program.

(3) Marketing and outreach.

(e) "High risk medical coverage" or "coverage" means payment for medically necessary services provided by institutional and professional providers through the program.

(f) "Participating health plan" means a private 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 program to provide or administer high risk medical coverage to program subscribers.

(g) "Plan rates" means the total monthly amount charged by a participating health plan to provide or administer high risk medical coverage.

(h) "Program" means the Federal Temporary High Risk Pool through which the board operates the federal temporary high risk pool in California.

(i) "Subscriber" means an eligible individual, as defined in subsection (d) of Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), who is enrolled in the program, and includes a member of a federally recognized California Indian tribe.

(j) "Subscriber contribution" means the premium for high risk medical coverage paid by the subscriber or, if authorized by the federal government, 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 coverage options, including participating health plans, available in the county where the member resides.

12739.51. The Federal Temporary High Risk Pool is hereby created in the California Health and Human Services Agency. The program shall be managed by the board.

12739.52. The board shall have the authority to do all of the following, consistent with Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148):

(a) Enter into an agreement with the federal Department of Health and Human Services to administer the federal temporary high risk pool as provided in Section 12739.53.

(b) Determine eligibility criteria and enrollment and disenrollment criteria and processes, including processes for waiting lists, enrollment limits, disenrollments, and any other limits on enrollment needed to maintain program expenditures within available federal funds.

(c) Determine the participation requirements of applicants, subscribers, and participating health plans, third-party administrators, and other contractors.

(d) Determine when subscribers' coverage begins and ends.

(e) Provide for the processing of applications and the enrollment of subscribers.

(f) Determine the high risk medical coverage to be provided to subscribers, including the scope of benefits and subscriber cost sharing.

(g) Establish subscriber contributions and plan rates.

(h) (1) Provide high risk medical coverage for subscribers through contracts with participating health plans or third-party administrators to provide or administer the coverage. A contract between the board and a participating health plan may provide that the contracting health plan assumes full or partial risk for the cost of covered health services or that the contracting health plan undertakes to provide only administrative services for the state's self-insured high risk medical coverage. A contract between the board and a third-party administrator may provide that the third-party administrator undertakes to provide only administrative services for the state's self-insured high risk medical coverage. The board may provide or purchase stop-loss coverage under which the program and participating health plans or stop-loss insurers share the risk for health plan expenses that exceed plan rates.

(2) Nothing in paragraph (1) shall be construed to alter the rights of a participating health plan under existing law if the board is unable to continue payment to the plan in accordance with the terms of the plan's contract with the board.

(i) Authorize expenditures from the fund to pay program expenses that exceed subscriber contributions.

(j) Contract for administration of the program or any portion of the program with any public agency, including any agency of state government, or with any private entity.

(k) If, and to the extent, permitted by federal law and by the federal Department of Health and Human Services, align program administration with the administration of the Major Risk Medical Insurance Program established pursuant to Part 6.5 (commencing with Section 12700) to ensure coordination and administrative efficiency.

(*l*) Sue and be sued.

(m) Employ necessary staff.

(n) Refer potential violations of state and federal law by participating health plans and other entities and persons to the appropriate regulatory agencies.

(o) Subject to the approval of the Department of Finance, obtain loans from the General Fund for all necessary and reasonable expenses related to the administration of the fund and the program. The board shall repay principal and interest, using the pooled money investment account rate of interest, to the General Fund no later than July 1, 2014.

(p) (1) Issue rules and regulations to carry out the purposes of this part. The adoption and readoption of regulations to implement this part shall be deemed to be an emergency that calls for immediate action 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 the board describe facts showing

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

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the board shall, without taking any regulatory action, initially implement this section pursuant to the agreement with the federal Department of Health and Human Services described in subdivision (a) of Section 12739.53. Thereafter, the board shall adopt any necessary regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and with paragraph (1) of this subdivision.

(q) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed upon the board under this part, including the powers and responsibilities necessary to enter into an agreement with, and comply with the requirements of, the federal Department of Health and Human Services as described in subdivision (a) of Section 12739.53.

12739.53. (a) The board shall, consistent with Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and State and federal law and contingent on the agreement of the federal Department of Health and Human Services and receipt of sufficient federal funding, enter into an agreement with the federal Department of Health and Human Services to administer the federal temporary high risk pool in California.

(b) If the federal Department of Health and Human Services and the state enter into an agreement to administer the federal temporary high risk pool, the board shall do all of the following:

(1) Administer the program pursuant to that agreement.

(2) Begin providing coverage in the program on the date established pursuant to the agreement with the federal Department of Health and Human Services.

(3) Establish the scope and content of high risk medical coverage.

(4) Determine reasonable minimum standards for participating health plans, third-party administrators, and other contractors.

(5) Determine the time, manner, method, and procedures for withdrawing program approval from a plan, third-party administrator, or other contractor, or limiting enrollment of subscribers in a plan.

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

(7) Administer the program to ensure the following:

(A) That the program subsidy amount does not exceed amounts transferred to the fund pursuant to this part.

(B) That the aggregate amount spent for high risk medical coverage and program administration does not exceed the federal funds available to the state for this purpose and that no state funds are spent for the purposes of this part.

(8) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the fund and that no state funds are spent for purposes of this part. If sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to limit enrollment.

(9) In adopting benefit and eligibility standards, be guided by the needs and welfare of persons unable to secure adequate health coverage for themselves and their dependents and by prevailing practices among private health plans.

(10) As required by the federal Department of Health and Human Services, implement procedures to provide for the transition of subscribers into qualified health plans offered through an exchange or exchanges to be established pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(11) Post on the board's Internet Web site the monthly progress reports submitted to the federal Department of Health and Human Services. In addition, the board shall provide notice of any anticipated waiting lists or disenrollments due to insufficient funding to the public, by making that notice available as part of its board meetings, and concurrently to the Legislature.

(12) Develop and implement a plan for marketing and outreach.

(c) There shall not be any liability in a private capacity on the part of the board or any member of the board, or any officer or employee of the board for or on account of any act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this part or affairs related to this part.

12739.54. (a) Plan rates for high risk medical benefits approved for the program shall not be excessive, inadequate, or unfairly discriminatory, but shall be adequate to pay anticipated costs of claims or services and administration.

(b) As a condition of reimbursement, participating health plans or third-party administrators shall submit claims to the board within 18 months following the date of service. The board may vary the time limit established in this subdivision if necessary to administer the reimbursement or reconciliation processes established by the board or to meet the requirements of the state's agreement with the federal Department of Health and Human Services described in subdivision (a) of Section 12739.53.

12739.55. The program may place a lien on compensation or benefits recovered or recoverable by a subscriber from any party or parties responsible for the compensation or benefits for which benefits have been provided pursuant to this part.

12739.56. Except as provided in Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, benefits received under this part are in excess of, and secondary to, any other form of health benefits coverage.

12739.57. The board shall provide coverage pursuant to this part through participating health plans or through provider networks using a third-party administrator and may contract for the processing of applications, the enrollment of subscribers, and all activities necessary to administer the program. Any contract entered into pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed revenue available for the program.

12739.58. A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by regulations of the program.

12739.59. (a) Program decisions concerning an applicant's or subscriber's eligibility or eligibility date may be appealed to the board, according to procedures to be established by the board.

(b) Coverage determinations may be appealed to the board, according to procedures established by the board. If permitted by the federal Department of Health and Human Services, the board shall not be required to provide an appeal concerning a coverage determination if the subject of the appeal is within the jurisdiction of the Department of Managed Health Care pursuant to 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) and its implementing regulations or within the jurisdiction of the Department of Insurance pursuant to the Insurance Code and its implementing regulations.

(c) Hearings shall be conducted according to the requirements of the federal Department of Health and Human Services and, insofar as practicable and not inconsistent with those requirements, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

12739.60. Upon enrollment as a subscriber in the program, the subscriber shall be responsible for payment of the subscriber contribution.

12739.61. The board shall cease to provide coverage through the program on January 1, 2014, and at that time shall cease to operate the program except as required to complete payments to, or payment reconciliations with, participating health plans or other contractors, process appeals, or conduct other necessary transition activities, including, but not limited to, transition of subscribers into an exchange or exchanges established pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148).

12739.62. This part shall remain in effect only until January 1, 2020, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2020, deletes or extends that date.

SEC. 6. Section 12739.755 is added to the Insurance Code, to read:

12739.755. The sum of seven hundred sixty-one million dollars ($761,000,000) is hereby appropriated without regard to fiscal years from the Federal Trust Fund to the board, from funds received from the federal government under Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), for transfer to the fund for the purposes specified in Section 12739.71.

SEC. 7. 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.

SEC. 8. This act shall become operative only if Assembly Bill 1887 of the 2009–10 Regular Session is also enacted and becomes operative.

SEC. 9. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to allow the state to apply for federal funding made available by Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) at the earliest possible time, it is necessary that this act take effect immediately.

O