SENATE BILL **No. 1063**

Introduced by Senator Cox

February 16, 2010

An act to amend Sections 12693.21 and 12693.615 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1063, as introduced, Cox. Healthy Families Program.

Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health care services to children less than 19 years of age who meet certain criteria, including having a limited gross household income. Existing law requires the board to establish the required copayment levels for specific benefits, as specified, and prohibits the total annual copayments charged to subscribers from exceeding $250 per family. Existing law also prohibits copayments from exceeding the copayment level established for state employees through the Public Employees' Retirement System.

This bill would prohibit the total annual copayments from exceeding $350 per family and would delete the provision prohibiting copayments from exceeding the copayment level established for state employees through the Public Employees' Retirement System. The bill would also require the board to structure copayments for prescription drugs and emergency health care services in a specified manner.

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

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

SECTION 1. Section 12693.21 of the Insurance Code is amended to read:

12693.21. *(a)* The board may do all of the following consistent with the standards in this part:

~~(a)~~

(1) Determine eligibility criteria for the program.

~~(b)~~

(2) Determine the participation requirements of applicants, subscribers, purchasing credit members, and participating health, dental, and vision plans.

~~(c)~~

(3) Determine when subscribers' coverage begins and the extent and scope of coverage.

~~(d)~~

(4) Determine family contribution amount schedules and collect the contributions.

~~(e)~~

(5) Determine who may be a family contribution sponsor and provide a mechanism for sponsorship.

~~(f)~~

(6) Provide or make available subsidized coverage through participating health, dental, and vision plans, in a purchasing pool, which may include the use of a purchasing credit mechanism, through supplemental coverage, or through coordination with other state programs.

~~(g)~~

(7) Provide for the processing of applications, the enrollment of subscribers, and the distribution of purchasing credits.

~~(h)~~

(8) Determine and approve the benefit designs and copayments required by health, dental, or vision plans participating in the purchasing pool component program.

~~(i)~~

(9) Approve those health plans eligible to receive purchasing credits.

~~(j)~~

(10) Enter into contracts.

~~(k)~~

(11) Sue and be sued.

~~(*i*)~~

(12) Employ necessary staff.

~~(m)~~

(13) Authorize expenditures from the fund to pay program expenses that exceed subscriber contributions, and to administer the program as necessary.

~~(n)~~

(14) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the Healthy Families Fund and if sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to limit enrollment.

~~(o)~~

(15) Issue rules and regulations, as necessary. Until January 1, 2000, any rules and regulations issued pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

~~(p)~~

(16) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part.

(b) The board shall do both of the following to the extent consistent with the limitations of Section 2103 of Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397cc):

(1) Structure copayments for prescription drugs so that the copayment for a brand name drug is at least 150 percent of the copayment for the equivalent generic drug, except where no generic equivalent is available or where the use of the brand name drug is medically necessary.

(2) Structure copayments for emergency health care services so that the copayment charged for those services is at least 150 percent of the highest copayment charged for nonpreventive health

care services. The emergency health care services copayment shall be waived if the subscriber is hospitalized.

SEC. 2. Section 12693.615 of the Insurance Code is amended to read:

12693.615. (a) The board shall establish the required subscriber copayment levels for specific benefits consistent with the limitations of Section 2103 of Title XXI of the *federal* Social Security Act *(42 U.S.C. Sec. 1397cc)*. The copayment levels established by the board shall, to the extent possible, reflect the copayment levels established for state employees, effective January 1, 1998, through the Public Employees' Retirement System. ~~Under no circumstances shall copayments exceed the copayment level established for state employees, effective, January 1, 1998, through the Public Employees' Retirement System.~~ Total annual copayments charged to subscribers shall not exceed ~~two hundred fifty dollars ($250)~~ *three hundred fifty dollars ($350)* per family. The board shall instruct participating health plans to work with their provider networks to provide for extended payment plans for subscribers utilizing a significant number of health services for which copayments are charged. The board shall track the number of subscribers who meet the copayment maximum in each year and make adjustments in the amount if a significant number of subscribers reach the copayment maximum.

(b) No deductibles shall be charged to subscribers for health benefits.

(c) Coverage provided to subscribers shall not contain any preexisting condition exclusion requirements.

(d) No participating health, dental, or vision plan shall exclude any subscriber on the basis of any actual or expected health condition or claims experience of that subscriber or a member of that subscriber's family.

(e) There shall be no variations in rates charged to subscribers, including premiums and copayments, on the basis of any actual or expected health condition or claims experience of any subscriber or subscriber's family member. The only variation in rates charged to subscribers, including copayments and premiums, that shall be permitted is that which is expressly authorized by Section 12693.43 *and subdivision (b) of Section 12693.21*.

(f) There shall be no copayments for preventive services as defined in Section 1367.35 of the Health and Safety Code.

(g) There shall be no annual or lifetime benefit maximums in any of the coverage provided under the program.

(h) Plans that receive purchasing credits pursuant to Section 12693.39 shall comply with subdivisions (b), (c), (d), (e), (f), and (g).

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