AMENDED IN ASSEMBLY MAY 1, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1809

Introduced by Assembly Member Monning

February 21, 2012

An act to amend Section *100520 of the Government Code, to amend Section 1367.003 of the Health and Safety Code, and to amend Sections 10112.25 and* 12923.5 of, and to repeal Sections 12693.925 and 12693.95 of, the Insurance Code, relating to health care coverage, *and making an appropriation therefor*.

LEGISLATIVE COUNSEL'S DIGEST

AB 1809, as amended, Monning. Health care ~~coverage: reports.~~ *coverage.*

~~Existing~~

(1) Existing law requires the Managed Risk Medical Insurance Board to, by January 20, 2004, *report* specified information with regard to the State Children's Health Insurance Program. Existing law also requires the board to provide, by April 15, 1998, a proposal relating to drug and alcohol treatment programs for children.

This bill would delete those obsolete provisions.

~~Existing~~

(2) Existing law requires the Department of Managed Health Care and the Department of Insurance to maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments. Existing law requires the working group to report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care for review and approval and,

commencing January 1, 2004, requires the commissioner and the director to submit the approved report to the Legislature every year for 5 years.

This bill would delete that reporting requirement.

(3) Existing law requires a health care service plan and a health insurer to comply with minimum medical loss ratios and to provide an annual rebate to each enrollee or insured if the medical loss ratio of the amount of the revenue expended by the plan or insurer on costs to the total amount of premium revenue is less than a certain percentage, as specified. Existing federal law authorizes an issuer of health care coverage to provide those premium rebates to its current enrollees by a premium credit, lump-sum check, or, if the enrollee paid the premium using a credit card or debit card, by a lump-sum reimbursement to the account used to pay the premium. Existing federal law requires an issuer of health care coverage to provide the premium rebate to its former enrollees in the form of a lump-sum check or lump-sum reimbursement using the same method that the former enrollee used for payment of the premium.

This bill would make these provisions of federal law applicable to a health care service plan and health insurer with respect to the method by which it provides premium rebates to current and former enrollees or insureds, as specified. The bill would require a health care service plan and health insurer to make a good faith effort to locate its former enrollees or insureds who are entitled to the rebate.

(4) Existing law requires the executive board of the California Health Benefit Exchange to establish a navigator program in accordance with the federal Patient Protection and Affordable Care Act to conduct public education activities and distribute information on qualified health care plans. Existing law also creates the California Health Trust Fund, a continuously appropriated fund, within the State Treasury for purposes of the provisions establishing the exchange.

This bill would create the Health Care Coverage Information, Enrollment, and Eligibility Assistance Account within the California Health Trust Fund. The bill would require a health care service plan and health insurer that is unable to locate its former enrollees or insureds who are entitled to a premium rebate to cause those rebate funds to be deposited in the account to be continuously appropriated for purposes of distributing funding for health care coverage information, enrollment, and eligibility assistance.

Because this bill would cause additional moneys to be deposited into a continuously appropriated fund, the bill would make an appropriation.

(5) Under existing law, a willful violation of the Knox-Keene Health Care Service Plan Act of 1975 is a crime.

Because a willful violation of the bill's requirements with respect to a health care service plan would be a crime, this 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~~ *2/3*. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. Section 100520 of the Government Code is amended to read:

100520. (a) *(1)* The California Health Trust Fund is hereby created in the State Treasury for the purpose of this title. Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this title. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(2) The Health Care Coverage Information, Enrollment, and Eligibility Assistance Account is hereby created within the fund for the purposes of distributing funding for health care coverage information, enrollment, and eligibility assistance. Notwithstanding Section 13340, all moneys in the account shall be continuously appropriated without regard to fiscal year for purposes of this title. Any moneys in the account that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) Notwithstanding any other provision of law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, or a county general fund or any other county fund.

(c) The board of the California Health Benefit Exchange shall establish and maintain a prudent reserve in the fund.

(d) The board or staff of the Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(e) Notwithstanding Section 16305.7, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(f) Effective January 1, 2016, if at the end of any fiscal year, the fund has unencumbered funds in an amount that equals or is more than the board approved operating budget of the Exchange for the next fiscal year, the board shall reduce the charges imposed under subdivision (n) of Section 100503 during the following fiscal year in an amount that will reduce any surplus funds of the Exchange to an amount that is equal to the agency's operating budget for the next fiscal year.

SEC. 2. Section 1367.003 of the Health and Safety Code is amended to read:

1367.003. (a) Every health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, but not including specialized health care service plan contracts, shall provide an annual rebate to each enrollee under ~~such~~ *that* coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health care service plan on the costs for reimbursement for clinical services provided to enrollees under ~~such~~ *that* coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

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

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

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

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

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

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

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

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

(2) A health care service plan shall provide any rebate owing to an enrollee no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(3) (A) A health care service plan that is required to provide a rebate to its current enrollees pursuant to this section may choose to provide that rebate in the form of a premium credit, a lump-sum payment by check, or, if the enrollee paid the premium using a credit card or debit card, by lump-sum through a reimbursement to the enrollee's credit card or debit card.

(B) Any rebate provided in the form of a premium credit shall be provided by applying the full amount due to the first month's premium that is due on or after August 1. If the amount of the rebate exceeds the premium due for August, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited to the enrollee.

(4) When a health care service plan is required to provide a rebate pursuant to this section to its former enrollees, the plan shall do all of the following:

(A) Make a good faith effort to locate each former enrollee entitled to the rebate.

(B) Pay each former enrollee who was enrolled as an individual plan participant, and who the plan is able to locate, the premium rebate to which that former enrollee is entitled in the form of a lump-sum payment by check or through a lump-sum reimbursement to the enrollee's credit card or debit card that the enrollee used

to make the premium payment with respect to which the rebate is required.

(C) Cause the amount of all rebates that former individual enrollees who the plan was unable to locate, following a good faith effort, to be deposited in to the Health Care Coverage Information, Enrollment, and Eligibility Assistance Account created by paragraph (2) of subdivision (a) of Section 100520 of the Government Code.

(5) Nothing in Chapter 7 (commencing with Section 1500) of Title 10 of Part 3 of the Code of Civil Procedure shall be construed to require the rebate funds described in subparagraph (C) of paragraph (4) to be deposited with the Controller as unclaimed tangible personal property.

(d) (1) The director may adopt 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) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The director may also adopt 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) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(e) The department shall consult with the Department of Insurance in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

(f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.

(g) Nothing in this section shall be construed to apply to provisions of this chapter pertaining to financial statements, assets, liabilities, and other accounting items to which subdivision (s) of Section 1345 applies.

(h) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 3. Section 10112.25 of the Insurance Code is amended to read:

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

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

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

(b) Every health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including

a grandfathered health plan, shall comply with the following minimum medical loss ratios:

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

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

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

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

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

(2) A health insurer shall provide any rebate owing to an insured no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(3) (A) A health insurer that is required to provide a rebate to an insured pursuant to this section may choose to provide that rebate in the form of a premium credit, or a lump sum payment by check, or, if the insured paid the premium using a credit card or debit card, by lump-sum through a reimbursement to the insured's credit card or debit card.

(B) Any rebate provided in the form of a premium credit shall be provided by applying the full amount due to the first month's premium that is due on or after August 1. If the amount of the rebate exceeds the premium due for August, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited to the insured.

(4) When a health insurer is required to provide a rebate pursuant to this section to a former insured it shall do all of the following:

(A) Make a good faith effort to locate each former insured entitled to the rebate.

(B) Pay each former insured who held an individual policy, and who the health insurer is able to locate, the premium rebate to which that person is entitled pursuant to this section in the form of a lump-sum payment by check or through a lump-sum

reimbursement to the insured's credit card or debit card that the insured used to make the premium payment with respect to which the rebate is required.

(C) Cause the amount of all rebates to which the former individual insureds were entitled, but who the health insurer was unable to locate following a good faith effort, to be deposited in to the Health Care Coverage Information, Enrollment, and Eligibility Assistance Account created by paragraph (2) of subdivision (a) of Section 100520 of the Government Code.

(5) Nothing in Chapter 7 (commencing with Section 1500) of Title 10 of Part 3 of the Code of Civil Procedure shall be construed to require the rebate funds described in subparagraph (C) of paragraph (4) to be deposited with the Controller as unclaimed tangible personal property.

(d) (1) The commissioner may adopt 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) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The commissioner may also adopt 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) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(e) The department shall consult with the Department of Managed Health Care in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

(f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal

Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections.

(g) Nothing in this section shall be construed to apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Insurance Pool (Part 6.6 (commencing with Section 12739.5)), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

~~SECTION 1.~~

SEC. 4. Section 12693.925 of the Insurance Code is repealed.

~~SEC. 2.~~

SEC. 5. Section 12693.95 of the Insurance Code is repealed.

~~SEC. 3.~~

SEC. 6. Section 12923.5 of the Insurance Code is amended to read:

12923.5. (a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments.

(b) The joint working group shall undertake a review and examination of the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code as they apply to the Department of Managed Health Care and the Department of Insurance to ensure consistency in consumer protection.

(c) The joint working group shall review and examine all of the following processes in each department:

(1) Grievance and consumer complaint processes, including, but not limited to, outreach, standard complaints, including coverage and medical necessity complaints, independent medical review, and information developed for consumer use.

(2) The processes used to ensure enforcement of the law, including, but not limited to, the medical survey and audit process

in the Health and Safety Code and market conduct exams in the Insurance Code.

(3) The processes for regulating the timely payment of claims.

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.

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