

**ASSEMBLY BILL**

**No. 1921**

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**Introduced by Assembly Member Hill**

February 22, 2012

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An act to add and repeal Article 4.4 (commencing with Section 1366.10) of Chapter 2.2 of Division 2 of the Health and Safety Code, and to add and repeal Chapter 8.3 (commencing with Section 10760) of Part 2 of Division 2 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1921, as introduced, Hill. Health insurance: transitional reinsurance program.

Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. A willful violation of provisions governing health care service plans is a crime. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. Existing federal law, the Patient Protection and Affordable Care Act, provides for implementation of certain reforms relative to health care coverage.

This bill, until January 1, 2018, would establish a transitional reinsurance program for health plans, and require participation by health care service plans and health insurers. The bill would require the Insurance Commissioner to select a reinsurance entity, which would collect payments from contributing health plans and pay claims, as specified. The bill would authorize the commissioner and the Director of Managed Health Care to take various actions to implement the program. The bill would require contributing entities to make payments to the reinsurance entity no earlier than October 1, 2013, and would

provide for the reinsurance entity to pay claims to a reinsurance-eligible recipient no earlier than January 1, 2014, with payments and claims to cease on December 31, 2016, except for necessary adjustments. Because a willful violation of the bill’s provisions with respect to health care service plans 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. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

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

1 SECTION 1. Article 4.4 (commencing with Section 1366.10)  
2 is added to Chapter 2.2 of Division 2 of the Health and Safety  
3 Code, to read:

4  
5 Article 4.4. Reinsurance  
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7 1366.10. For purposes of this article, the following terms have  
8 the following meanings:

9 (a) “Applicable reinsurance entity” means a nonprofit entity  
10 that carries out the duties as described in Section 10760.5 of the  
11 Insurance Code.

12 (b) “Attachment point” means the threshold dollar amount of  
13 costs incurred by a contributing entity for payment of essential  
14 health benefits, provided to an enrolled individual, after which  
15 threshold the costs for covered essential health benefits are eligible  
16 for reinsurance payments.

17 (c) “Benefit year” means a calendar year for which a health plan  
18 provides coverage for health benefits.

19 (d) “California-specific reinsurance benefit and payment  
20 parameters” means any notice issued by the director describing  
21 procedures for collecting funds from contributing entities and  
22 making payments to reinsurance-eligible recipients.

23 (e) “Coinsurance rate” means the rate at which the applicable  
24 reinsurance entity will reimburse the reinsurance-eligible recipient

1 for costs incurred to cover essential health benefits, upon reaching  
2 the attachment point and before reaching the reinsurance rate.  
3 Coinsurance rate may be further defined by any federal or  
4 California-specific benefits and payment parameters or regulation.

5 (f) “Contributing entity” means the following: an entity licensed  
6 as a health care service plan by the department; or in the case of  
7 a self-insured group health plan covering residents of California,  
8 the third-party administrator of the group health plan.

9 (g) “Covered individual claim” means a properly documented  
10 claim submitted by a reinsurance-eligible recipient for a reinsurance  
11 payment from the transitional reinsurance program.

12 (h) “Federal reinsurance benefits and payment parameters”  
13 means a notice issued by the Secretary of the United States  
14 Department of Health and Human Services describing procedures  
15 for collecting funds from contributing entities and making  
16 payments to eligible reinsurance recipients.

17 (i) “Grandfathered health plan” shall have the meaning set forth  
18 in Section 1251 of the PPACA.

19 (j) “PPACA” means the federal Patient Protection and  
20 Affordable Care Act (Public Law 111-148), as amended by the  
21 Health Care and Education Reconciliation Act of 2010 (Public  
22 Law 111-152), and any subsequent rules or regulations issued  
23 pursuant to that law.

24 (k) “Reinsurance cap” means the threshold dollar amount for  
25 costs incurred by a reinsurance-eligible recipient for payment of  
26 California essential health benefits for an enrolled individual, after  
27 which threshold the costs for covered essential benefits are no  
28 longer eligible for reinsurance payments. Reinsurance cap may be  
29 further defined by any federal or California-specific benefits and  
30 payment parameters or regulation.

31 (l) “Reinsurance contribution payment” means the required  
32 payment by any contributing entity to the applicable reinsurance  
33 entity, as further defined by regulation.

34 (m) “Reinsurance contribution year” means the 12-month period  
35 for purposes of assessing contribution payments from contributing  
36 entities, as further defined by regulation.

37 (n) “Reinsurance-eligible recipient” means, for purposes of the  
38 transitional reinsurance program, the issuer of any health plan  
39 offered in the California individual market that is not a  
40 grandfathered plan.

1 (o) “State high-risk pool” means health insurance programs for  
2 Californians unable to obtain coverage in the individual health  
3 insurance market because of their preexisting conditions. State  
4 high-risk pool specifically refers to either or both the California  
5 Pre-Existing Condition Insurance Plan (PCIP) and the Managed  
6 Risk Medical Insurance Program (MRMIP) both operated by the  
7 Managed Risk Medical Insurance Board.

8 (p) “Third-party administrator” means the claims-processing  
9 entity for a self-insurer. In the case of a self-insurer that processes  
10 its own claims, the self-insurer itself will be considered the  
11 third-party administrator for the purpose of the transitional  
12 reinsurance program.

13 1366.11. The director and the Insurance Commissioner may  
14 jointly modify the federal reinsurance benefits and payment  
15 parameters by issuing a California-specific notice of benefits and  
16 payment parameters by March 15 of the year prior to the benefit  
17 year.

18 The notice shall contain at least both of the following:

19 (a) The data requirements and data collection frequency for  
20 reinsurance-eligible recipients.

21 (b) The reinsurance attachment point, reinsurance cap, and  
22 coinsurance rate, if different from the corresponding parameters  
23 specified in the federal notice of benefit and payment parameters.

24 The director’s notice shall not be subject to the Administrative  
25 Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
26 Part 1 of Division 3 of Title 2 of the Government Code).

27 1366.12. (a) A contributing entity that is licensed by the  
28 department shall be required to do all of the following:

29 (1) Make payments to the applicable reinsurance entity  
30 according to the procedures established by the PPACA or state  
31 regulations.

32 (2) Comply with all reasonable requests of the applicable  
33 reinsurance entity or the director for appropriate documentation  
34 to establish earned premium for the reinsurance contribution period.

35 (3) Comply with any additional requirements as established by  
36 state or federal regulations.

37 (b) A reinsurance-eligible recipient that is licensed by the  
38 department shall do all of the following:

39 (1) Submit documentation on covered individual claims to the  
40 applicable reinsurance entity in a format as established by any

1 federal benefit or payment parameters or any California-specific  
2 benefit and payments parameters.

3 (2) Remit to the applicable reinsurance entity any payments of  
4 reinsurance benefits deemed to be overpayments following an  
5 audit or reconciliation of collections and payments.

6 (3) Comply with any additional requirements as established by  
7 the PPACA, state regulations or any California-specific reinsurance  
8 benefit and payment parameters.

9 1366.13. The director may issue orders to a contributing entity  
10 licensed by the department whenever the director determines that  
11 it is reasonably necessary to ensure compliance with Section  
12 1366.12. A licensee to which an order pursuant to this section is  
13 issued may, within 15 days of receipt of that order, request a  
14 hearing at which the licensee may challenge the order.

15 1366.14. (a) This article shall be effective on January 1, 2013,  
16 for purposes of selecting an applicable reinsurance entity and  
17 adopting regulations, including emergency regulations to  
18 implement the transitional reinsurance program; however, no  
19 contributing entity shall be required to remit any payment to the  
20 applicable reinsurance entity before October 1, 2013, and no  
21 payment to a reinsurance-eligible recipient shall occur before  
22 January 1, 2014.

23 (b) The applicable reinsurance entity shall cease requiring  
24 collections from contributing entities and making payments to  
25 reinsurance-eligible recipients after December 31, 2016, except  
26 to require adjustments relating to any final reconciliation of  
27 collections and payments. The transitional reinsurance program  
28 shall terminate on January 1, 2018.

29 (c) The director may adopt regulations in accordance with the  
30 Administrative Procedure Act (Chapter 3.5 (commencing with  
31 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
32 Code) to implement this article. The department shall consult with  
33 the Insurance Commissioner in adopting necessary regulations.  
34 For purposes of Chapter 3.5 (commencing with Section 11340) of  
35 Part 1 of Division 3 of Title 2 of the Government Code, including  
36 Section 11349.6 of the Government Code, the adoption or  
37 amendment of the regulations required to be adopted pursuant to  
38 this article is an emergency and shall be considered by the Office  
39 of Administrative Law as necessary for the immediate preservation  
40 of the public peace, health and safety, and general welfare.

1 1366.15. This article shall remain in effect only until January  
2 1, 2018, and as of that date is repealed, unless a later enacted  
3 statute, that is enacted before January 1, 2018, deletes or extends  
4 that date.

5 SEC. 2. Chapter 8.3 (commencing with Section 10760) is added  
6 to Part 2 of Division 2 of the Insurance Code, to read:

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CHAPTER 8.3. REINSURANCE

10 10760. For purposes of this chapter, the following terms have  
11 the following meanings:

12 (a) "Applicable reinsurance entity" means a nonprofit entity  
13 that carries out the duties as described in Section 10760.5.

14 (b) "Attachment point" means the threshold dollar amount of  
15 costs incurred by a contributing entity for payment of essential  
16 health benefits, provided to an enrolled individual, after which  
17 threshold the costs for covered essential health benefits are eligible  
18 for reinsurance payments.

19 (c) "Benefit year" means a calendar year for which a health plan  
20 provides coverage for health benefits.

21 (d) "California-specific reinsurance benefit and payment  
22 parameters" means any notice issued by the commissioner  
23 describing procedures for collecting funds from contributing  
24 entities and making payments to reinsurance-eligible recipients.

25 (e) "Coinsurance rate" means the rate at which the applicable  
26 reinsurance entity will reimburse the reinsurance-eligible recipient  
27 for costs incurred to cover essential health benefits, upon reaching  
28 the attachment point and before reaching the reinsurance rate.  
29 Coinsurance rate may be further defined by any federal or  
30 California-specific benefits and payment parameters or regulation.

31 (f) "Contributing entity" means the following: an entity licensed  
32 as a health care service plan by the commissioner; or in the case  
33 of a self-insured group health plan covering residents of California,  
34 the third-party administrator of the group health plan.

35 (g) "Covered individual claim" means a properly documented  
36 claim submitted by a reinsurance-eligible recipient for a reinsurance  
37 payment from the transitional reinsurance program.

38 (h) "Federal reinsurance benefits and payment parameters"  
39 means a notice issued by the Secretary of the United States  
40 Department of Health and Human Services describing procedures

1 for collecting funds from contributing entities and making  
2 payments to eligible reinsurance recipients.

3 (i) “Grandfathered health plan” shall have the meaning set forth  
4 in Section 1251 of the PPACA.

5 (j) “PPACA” means the federal Patient Protection and  
6 Affordable Care Act (Public Law 111-148), as amended by the  
7 Health Care and Education Reconciliation Act of 2010 (Public  
8 Law 111-152), and any subsequent rules or regulations issued  
9 pursuant to that law.

10 (k) “Reinsurance cap” means the threshold dollar amount for  
11 costs incurred by a reinsurance-eligible recipient for payment of  
12 California essential health benefits for an enrolled individual, after  
13 which threshold the costs for covered essential benefits are no  
14 longer eligible for reinsurance payments. “Reinsurance cap” may  
15 be further defined by any federal or California-specific benefits  
16 and payment parameters or regulation.

17 (l) “Reinsurance contribution payment” means the required  
18 payment by any contributing entity to the applicable reinsurance  
19 entity, as further defined by regulation.

20 (m) “Reinsurance contribution year” means the 12-month period  
21 for purposes of assessing contribution payments from contributing  
22 entities, as further defined by regulation.

23 (n) “Reinsurance-eligible recipient” means, for purposes of the  
24 transitional reinsurance program, the issuer of any health plan  
25 offered in the California individual market that is not a  
26 grandfathered plan.

27 (o) “State high-risk pool” means health insurance programs for  
28 Californians unable to obtain coverage in the individual health  
29 insurance market because of their preexisting conditions. State  
30 high-risk pool specifically refers to either or both the California  
31 Pre-Existing Condition Insurance Plan (PCIP) and the Managed  
32 Risk Medical Insurance Program (MRMIP) both operated by the  
33 Managed Risk Medical Insurance Board.

34 (p) “Third-party administrator” means the claims-processing  
35 entity for a self-insurer. In the case of a self-insurer that processes  
36 its own claims, the self-insurer itself will be considered the  
37 third-party administrator for the purpose of the transitional  
38 reinsurance program.

39 10760.5. There shall be established a California Transitional  
40 Reinsurance Program, in which contributing entities are required

1 to make payments to the applicable reinsurance entity, and  
2 reinsurance-eligible recipients will receive reinsurance payments  
3 for covered individual claims. Based upon a competitive bidding  
4 process, the Insurance Commissioner shall select the applicable  
5 reinsurance entity.

6 10761. The commissioner and the Director of Managed Health  
7 Care may jointly modify the federal reinsurance benefits and  
8 payment parameters by issuing a California-specific notice of  
9 benefits and payment parameters by March 15 of the year prior to  
10 the benefit year.

11 The notice shall contain at least both of the following:

12 (a) The data requirements and data collection frequency for  
13 reinsurance-eligible recipients.

14 (b) The reinsurance attachment point, reinsurance cap, and  
15 coinsurance rate, if different from the corresponding parameters  
16 specified in the federal notice of benefit and payment parameters.

17 The commissioner's notice shall not be subject to the  
18 Administrative Procedure Act (Chapter 3.5 (commencing with  
19 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
20 Code).

21 10761.5. The applicable reinsurance entity selected pursuant  
22 to the procedures in Section 10760.5 shall have all of the following  
23 duties:

24 (a) Collect reinsurance contributions from contributing entities.

25 (b) Remit a portion of payments collected from contributing  
26 entities to the United States Treasury as further defined by the  
27 PPACA.

28 (c) Receive and maintain required claims data on all covered  
29 individual claims submitted by reinsurance-eligible recipients.

30 (d) Accept and validate requests for reinsurance payments from  
31 reinsurance-eligible recipients.

32 (e) Remit reinsurance payments to reinsurance-eligible  
33 recipients.

34 (f) Reconcile and verify reinsurance contributions and payments  
35 and resolve any discrepancy with any contributing entity or  
36 reinsurance-eligible recipient.

37 (g) Report to the commissioner any dispute it is unable to resolve  
38 with a contributing entity or reinsurance-eligible recipient.

39 (h) Maintain a complete accounting of collections from  
40 contributing entities, payments to reinsurance-eligible recipients

1 and its own administrative expenses, and make timely reports of  
2 the accounting to the commissioner and the Director of the  
3 Department of Managed Health Care in a format and on a schedule  
4 to be established by regulation.

5 (i) Coordinate reinsurance program with state high-risk pools  
6 to the extent necessary as may be required by state or federal law.

7 (j) Any other duties as further defined by the PPACA, state  
8 regulations, or any California-specific reinsurance and benefit  
9 payment parameters.

10 10761.7. Records relating to claims data, reinsurance  
11 contributions and payments, remittances to the United States  
12 Treasury, and those pertaining to the administrative expenses of  
13 the applicable reinsurance entity shall be maintained by the  
14 applicable reinsurance entity for a period of 10 years following  
15 the termination of the last applicable benefit year of the transitional  
16 reinsurance program, as further defined by the PPACA or state  
17 regulations. Those records shall be available to the Commissioner  
18 and the Director of the Department of Managed Health Care for  
19 inspection. The applicable reinsurance entity shall adhere at all  
20 times to the confidentiality requirements in the maintenance of  
21 those records as established in the federal Health Insurance  
22 Portability and Accountability Act of 1996 (HIPAA) and the  
23 Confidentiality of Medical Information Act (Part 2.6 (commencing  
24 with Section 56) of Division 1 of the Civil Code).

25 10762. (a) A contributing entity that is licensed by the  
26 commissioner shall be required to do all of the following:

27 (1) Make payments to the applicable reinsurance entity  
28 according to the procedures established by the PPACA or state  
29 regulations.

30 (2) Comply with all reasonable requests of the applicable  
31 reinsurance entity or the commissioner for appropriate  
32 documentation to establish earned premium for the reinsurance  
33 contribution period.

34 (3) Comply with any additional requirements as established by  
35 state or federal regulations.

36 (b) A reinsurance-eligible recipient that is licensed by the  
37 commissioner shall do all of the following:

38 (1) Submit documentation on covered individual claims to the  
39 applicable reinsurance entity in a format as established by any

1 federal benefit or payment parameters or any California-specific  
2 benefit and payments parameters.

3 (2) Remit to the applicable reinsurance entity any payments of  
4 reinsurance benefits deemed to be overpayments following an  
5 audit or reconciliation of collections and payments.

6 (3) Comply with any additional requirements as established by  
7 the PPACA, state regulations, or any California-specific  
8 reinsurance benefit and payment parameters.

9 10763. The commissioner may issue orders to a contributing  
10 entity that is a health insurer regulated by this code whenever the  
11 commissioner determines that it is reasonably necessary to ensure  
12 compliance with Section 10762. A health insurer to which an order  
13 pursuant to this section is issued may, within 15 days of receipt of  
14 that order, request a hearing at which the licensee may challenge  
15 the order.

16 10764. (a) This chapter shall be effective on January 1, 2013,  
17 for purposes of selecting an applicable reinsurance entity and  
18 adopting regulations, including emergency regulations to  
19 implement the transitional reinsurance program; however, no  
20 contributing entity shall be required to remit any payment to the  
21 applicable reinsurance entity before October 1, 2013, and no  
22 payment to a reinsurance-eligible recipient shall occur before  
23 January 1, 2014.

24 (b) The applicable reinsurance entity shall cease requiring  
25 collections from contributing entities and making payments to  
26 reinsurance-eligible recipients after December 31, 2016, except  
27 to require adjustments relating to any final reconciliation of  
28 collections, and payments. The transitional reinsurance program  
29 shall fully terminate on January 1, 2018.

30 (c) The commissioner may adopt regulations in accordance with  
31 the Administrative Procedure Act (Chapter 3.5 (commencing with  
32 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
33 Code) to implement this chapter. The commissioner shall consult  
34 with the Department of Managed Health Care in adopting necessary  
35 regulations. For purposes of Chapter 3.5 (commencing with Section  
36 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
37 including Section 11349.6 of the Government Code, the adoption  
38 or amendment of the regulations required to be adopted pursuant  
39 to this chapter is an emergency and shall be considered by the  
40 Office of Administrative Law as necessary for the immediate

1 preservation of the public peace, health and safety, and general  
2 welfare.

3 10765. This chapter shall remain in effect only until January  
4 1, 2018, and as of that date is repealed, unless a later enacted  
5 statute, that is enacted before January 1, 2018, deletes or extends  
6 that date.

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