ASSEMBLY BILL No. 1921

Introduced by Assembly Member Hill

February 22, 2012

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:

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

Article 4.4. Reinsurance

1366.10. For purposes of this article, the following terms have the following meanings:

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

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

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

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

(e) "Coinsurance rate" means the rate at which the applicable reinsurance entity will reimburse the reinsurance-eligible recipient

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

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

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

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

(i) "Grandfathered health plan" shall have the meaning set forth in Section 1251 of the PPACA.

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

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

(*l*) "Reinsurance contribution payment" means the required payment by any contributing entity to the applicable reinsurance entity, as further defined by regulation.

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

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

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

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

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

The notice shall contain at least both of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) 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) to implement this article. The department shall consult with the Insurance Commissioner in adopting necessary regulations. For purposes of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, including Section 11349.6 of the Government Code, the adoption or amendment of the regulations required to be adopted pursuant to this article is an emergency and shall be considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, and general welfare.

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

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

Chapter 8.3. Reinsurance

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

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

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

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

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

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

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

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

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

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

(i) "Grandfathered health plan" shall have the meaning set forth in Section 1251 of the PPACA.

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

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

(*l*) "Reinsurance contribution payment" means the required payment by any contributing entity to the applicable reinsurance entity, as further defined by regulation.

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

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

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

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

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

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

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

The notice shall contain at least both of the following:

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

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

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

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

(a) Collect reinsurance contributions from contributing entities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) 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) to implement this chapter. The commissioner shall consult with the Department of Managed Health Care in adopting necessary regulations. For purposes of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, including Section 11349.6 of the Government Code, the adoption or amendment of the regulations required to be adopted pursuant to this chapter is an emergency and shall be considered by the Office of Administrative Law as necessary for the immediate

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

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

SEC. 3. 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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