AMENDED IN SENATE AUGUST 24, 2012

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AMENDED IN ASSEMBLY MARCH 20, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1526

Introduced by Assembly Member Monning

January 19, 2012

An act to amend ~~Sections 12705, 12718, 12725, and~~ *Section* 12737 of~~, and to add Chapter 9 (commencing with Section 12739.45) to Part 6.5 of Division 2 of,~~ the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1526, as amended, Monning. California Major Risk Medical Insurance Program.

Existing law establishes the California Major Risk Medical Insurance Program (MRMIP) that is administered by the Managed Risk Medical Insurance Board (MRMIB) to provide major risk medical coverage to residents who have been rejected for coverage by at least one private health plan, as specified. Existing law creates the Major Risk Medical Insurance Fund and continuously appropriates the fund to MRMIB for the purposes of MRMIP.

~~This bill would alternatively require, as a condition of eligibility for MRMIP, that an applicant have documentation from a licensed physician, physician assistant, nurse practitioner, or, if designated by MRMIB, other health care professional, verifying the applicant's~~

~~preexisting medical condition. By expanding the eligibility criteria for MRMIP, the bill would make moneys in a continuously appropriated fund available for a new or expanded purpose and would thereby make an appropriation.~~

~~Existing law specifies the minimum scope of benefits offered by participating health plans in MRMIP and requires the exclusion of benefits that exceed $75,000 in a calendar year or $750,000 in a lifetime, as specified.~~

~~This bill would authorize MRMIB to eliminate those annual or lifetime limits and would require MRMIB to exclude from the subscriber contribution rate that portion of the standard average individual rate attributable to the elimination of those limits.~~

~~The bill would also create the Major Risk Medical Insurance Reconciliation Fund in the State Treasury and would require that remittances received by MRMIP on or after January 1, 2013, from health plans participating in MRMIP as a result of reconciliation based on the actual claim costs of subscribers for prior fiscal years be deposited in the fund. The bill would require that moneys in the fund be available for any authorized purpose upon appropriation by the Legislature.~~

Existing law requires MRMIB to establish program contribution amounts for each category of risk for each participating health plan and requires that these amounts be based on the average amount of subsidy funds required for the program as a whole, to be determined in a specified manner. Existing law authorizes participating health plans to charge subscriber contributions that do not exceed the difference between its plan rate and the program contribution amounts for a category of risk. Existing law requires the program to pay program contribution amounts to participating health plans from the Major Risk Medical Insurance Fund.

This bill would, for the period commencing January 1, 2013, to December 31, 2013, inclusive, additionally authorize the program to further subsidize subscriber contributions based on a specified percentage of the standard average individual risk rate for comparable coverage, as specified. The bill would prohibit the amount of any subsidy provided to subscribers from affecting the calculation of premiums for certain products. Because the bill removes a restriction limiting the expenditure of money available under an existing appropriation from a continuously appropriated fund, the bill would make an appropriation.

The bill would also provide that *if* regulations *are* adopted and readopted, *those regulations* by MRMIB to implement the changes

made to MRMIP enacted by this bill are deemed to be an emergency and *the bill* would exempt MRMIB from describing facts showing the need for immediate action and from review by the Office of Administrative Law.

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

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

~~SECTION 1. Section 12705 of the Insurance Code is amended to read:~~

~~12705. For the purposes of this part, the following terms have the following meanings:~~

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

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

~~(c) Except as provided in Chapter 9 (commencing with Section 12739.45), "fund" means the Major Risk Medical Insurance Fund, from which the program may authorize expenditures to pay for medically necessary services which exceed subscribers' contributions, and for administration of the program.~~

~~(d) "Major risk medical coverage" means the payment for medically necessary services provided by institutional and professional providers.~~

~~(e) "Participating health plan" means a private insurer (1) holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code), or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service agreements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and (2) which contracts with the program to administer major risk medical coverage to program subscribers.~~

~~(f) "Plan rates" means the total monthly amount charged by a participating health plan for a category of risk.~~

~~(g) "Program" means the California Major Risk Medical Insurance Program.~~

~~(h) "Subscriber" means an individual who is eligible for and receives major risk medical coverage through the program, and includes a member of a federally recognized California Indian tribe.~~

~~(i) "Subscriber contribution" means the portion of participating health plan rates paid by the subscriber, or 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 plan options available in the county where the member resides.~~

~~SEC. 2. Section 12718 of the Insurance Code is amended to read:~~

~~12718. (a) Benefits under this part shall be subject to required subscriber copayments and deductibles as the board may authorize. Any authorized copayments shall not exceed 25 percent and any authorized deductible shall not exceed an annual household deductible amount of five hundred dollars ($500). However, health plans not utilizing a deductible may be authorized to charge an office visit copayment of up to twenty-five dollars ($25). If the board contracts with participating health plans pursuant to Chapter 5 (commencing with Section 12720), copayments or deductibles shall be authorized in a manner consistent with the basic method of operation of the participating health plans. The aggregate amount of deductible and copayments payable annually under this section shall not exceed two thousand five hundred dollars ($2,500) for an individual and four thousand dollars ($4,000) for a family.~~

~~(b) The board may remove annual and lifetime limits on benefits under this part. The board shall exclude the cost attributable to the removal of those limits from the subscriber contribution as described in subdivision (c) of Section 12737.~~

~~SEC. 3. Section 12725 of the Insurance Code is amended to read:~~

~~12725. (a) Each resident of the state meeting the eligibility criteria of this section is eligible to apply for major risk medical coverage through the program. For these purposes, "resident"~~

~~includes a member of a federally recognized California Indian tribe.~~

~~(b) To be eligible for enrollment in the program, an applicant shall demonstrate that he or she is unable to secure adequate private health care coverage by providing either of the following:~~

~~(1) Documentation that he or she has been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:~~

~~(A) Impose substantial waivers that the program determines would leave a subscriber without adequate coverage for medically necessary services.~~

~~(B) Afford limited coverage that the program determines would leave the subscriber without adequate coverage for medically necessary services.~~

~~(C) Afford coverage only at an excessive price, which the board determines is significantly above standard average individual coverage rates.~~

~~(2) Documentation satisfactory to the board from a licensed physician, physician assistant, or nurse practitioner, or, if designated by the board, other health care professional, verifying the applicant's preexisting medical condition.~~

~~(c) Rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described in Section 10198.61, shall not be deemed to be rejection for the purposes of eligibility for enrollment under paragraph (1) of subdivision (b).~~

~~(d) The board may permit dependents of eligible subscribers to enroll in major risk medical coverage through the program if the board determines the enrollment can be carried out in an actuarially and administratively sound manner.~~

~~(e) Notwithstanding the provisions of this section, the board shall by regulation prescribe a period of time during which a resident is ineligible to apply for major risk medical coverage through the program if the resident either voluntarily disenrolls from, or was terminated for nonpayment of the premium from, a private health plan after enrolling in that private health plan pursuant to either Section 10127.15 or Section 1373.62 of the Health and Safety Code.~~

~~(f) For the period commencing September 1, 2003, to December 31, 2007, inclusive, subscribers and their dependents receiving major risk coverage through the program may receive that coverage for no more than 36 consecutive months. Ninety days before a subscriber or dependent's eligibility ceases pursuant to this subdivision, the board shall provide the subscriber and any dependents with written notice of the termination date and written information concerning the right to purchase a standard benefit plan from any health care service plan or health insurer participating in the individual insurance market pursuant to Section 10127.15 or Section 1373.62 of the Health and Safety Code. This subdivision shall become inoperative on December 31, 2007.~~

~~SEC. 4.~~

SECTION 1. Section 12737 of the Insurance Code is amended to read:

12737. (a) The board shall establish program contribution amounts for each category of risk for each participating health plan. The program contribution amounts shall be based on the average amount of subsidy funds required for the program as a whole. To determine the average amount of subsidy funds required, the board shall calculate a loss ratio, including all medical costs, administration fees, and risk payments, for the program in the prior calendar year. The loss ratio shall be calculated using 125 percent of the standard average individual rates for comparable coverage as the denominator, and all medical costs, administration fees, and risk payments as the numerator. The average amount of subsidy funds required is calculated by subtracting 100 percent from the program loss ratio. For purposes of calculating the program loss ratio, no participating health plan's loss ratio shall be less than 100 percent and participating health plans with fewer than 1,000 program members shall be excluded from the calculation.

Subscriber contributions shall be established to encourage members to select those health plans requiring subsidy funds at or below the program average subsidy. Subscriber contribution amounts shall be established so that no subscriber receives a subsidy greater than the program average subsidy, except that:

(1) In all areas of the state, at least one plan shall be available to program participants at an average subscriber contribution of 125 percent of the standard average individual rates for comparable coverage.

(2) No subscriber contribution shall be increased by more than 10 percent above 125 percent of the standard average individual rates for comparable coverage.

(3) Subscriber contributions for participating health plans joining the program after January 1, 1997, shall be established at 125 percent of the standard average individual rates for comparable coverage for the first two benefit years the plan participates in the program.

(b) The program shall pay program contribution amounts to participating health plans from the Major Risk Medical Insurance Fund.

~~(c) For purposes of subdivision (a), the board shall exclude from the subscriber contribution that portion of the standard average individual rate attributable to the elimination of annual and lifetime benefit limits pursuant to subdivision (b) of Section 12718.~~

(c) For the period commencing January 1, 2013, to December 31, 2013, inclusive, in addition to the amount of subsidy funds required pursuant to subdivision (a), the program may further subsidize subscriber contributions so that the amount paid by each subscriber is below 125 percent of the standard average individual risk rate for comparable coverage but no less than 100 percent of the standard average individual risk rate for comparable coverage. For purposes of calculating premiums for the following products, any reference to, or use of, subscriber contributions, premiums, average premiums, or amounts paid by subscribers in the program shall be construed to mean subscriber contributions as described in subdivision (a) without application of the additional subsidies permitted by this subdivision:

(1) Standard benefit plans pursuant to Section 10127.16 and Section 1373.622 of the Health and Safety Code.

(2) Health benefit plans and health care service plan contracts for federally eligible defined individuals pursuant to Sections 10901.3 and 10901.9 and Sections 1399.805 and 1399.811 of the Health and Safety Code.

(3) Conversion coverage pursuant to Section 12682.1 and Section 1373.6 of the Health and Safety Code.

~~SEC. 5. Chapter 9 (commencing with Section 12739.45) is added to Part 6.5 of Division 2 of the Insurance Code, to read:~~

~~CHAPTER 9. MAJOR RISK MEDICAL INSURANCE RECONCILIATION FUND~~

~~12739.45. (a) There is hereby created in the State Treasury the Major Risk Medical Insurance Reconciliation Fund. As used in this chapter, "fund" means the Major Risk Medical Insurance Reconciliation Fund.~~

~~(b) Remittances received by the program on or after January 1, 2013, from participating health plans as a result of reconciliation based on the actual claim costs of subscribers for prior fiscal years shall be deposited in the fund.~~

~~(c) Moneys in the fund shall be available for any authorized purpose upon appropriation by the Legislature.~~

~~SEC. 6. The~~

SEC. 2. Nothing in this act shall be construed to require the Managed Risk Medical Insurance Board to adopt and readopt regulations to implement the changes made by this act. However, if the Managed Risk Medical Insurance Board adopts and readopts regulations, the adoption and readoption of regulations by the Managed Risk Medical Insurance Board to implement the changes made by this act to Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code shall be deemed to be an emergency and necessary 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 it describe facts showing the need for immediate action and from review by the Office of Administrative Law.

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