AMENDED IN ASSEMBLY JULY 12, 2011

AMENDED IN ASSEMBLY JUNE 28, 2011

AMENDED IN SENATE MAY 31, 2011

AMENDED IN SENATE MARCH 30, 2011

AMENDED IN SENATE MARCH 24, 2011

SENATE BILL No. 703

Introduced by Senator Hernandez

February 18, 2011

An act to add Part 6.25 (commencing with Section 12694.1) to Division 2 of the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 703, as amended, Hernandez. Health care coverage: Basic Health Program.

Existing law, the federal Patient Protection and Affordable Care Act, requires each state to, by January 1, 2014, establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and employers. Existing state law establishes the California Health Benefit Exchange within state government. The federal Patient Protection and Affordable Care Act also authorizes the establishment of a basic health program under which a state may enter into contracts to offer one or more standard health plans providing a minimum level of essential benefits to eligible individuals instead of offering those individuals coverage through an Exchange, if specified criteria are met.

Existing law establishes the Managed Risk Medical Insurance Board (MRMIB) and makes it responsible for administering the California

Major Risk Medical Insurance Program and the Healthy Families Program to provide health care coverage to certain residents of the state who are unable to secure adequate coverage, subject to specified eligibility requirements.

This bill would establish in state government a Basic Health Program, to be administered by MRMIB. The bill would require MRMIB to enter into a contract with the United States Secretary of Health and Human Services to implement the Basic Health Program, and would set forth the powers and the duties of MRMIB relative to determining eligibility for enrollment, setting premiums for coverage, and selecting participating health plans under the Basic Health Program, subject to requirements under federal law. The bill would require the board to permit enrollment in the Basic Health Program on January 1, 2014. The bill would create the Basic Health Program Trust Fund for those purposes and would make moneys in the fund subject to appropriation by the Legislature, except that if the annual Budget Act is not enacted by a certain date, the bill would authorize the board to transfer specified funds from the trust fund to health plans in order to comply with certain requirements, thereby making an appropriation. The bill would require the Basic Health Program to be funded by federal funds, private donations, premiums paid by eligible individuals, and other non-General Fund moneys available for that purpose. Notwithstanding those provisions, the bill would authorize the board to obtain loans from the General Fund for initial start-up expenses, to be repaid by July 1, 2016, and would establish a procedure for continued coverage of individuals under the California Health Benefit Exchange if costs of the Basic Health Program exceed moneys available from specified sources. *The bill would require the board to request an evaluation of the Basic Health Program and to seek funding for the evaluation from an unspecified independent nonprofit private foundation.*

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. Part 6.25 (commencing with Section 12694.1) is added to Division 2 of the Insurance Code, to read:

PART 6.25. BASIC HEALTH PROGRAM

12694.1. It is the intent of the Legislature to establish a Basic Health Program option to implement the option contained in Section 1331 of the federal Patient Protection and Affordable Care Act (PPACA). The Legislature finds and declares that Section 1331 of PPACA creating the Basic Health Program does the following:

(a) Requires eligible individuals and their dependents enrolled in the Basic Health Program be provided a health plan containing the essential health benefits at a monthly premium price that does not exceed the amount of the premium that the eligible individual would have been required to pay if the individual had enrolled in the applicable second lowest cost silver plan offered to the individual through the California Health Benefit Exchange.

(b) (1) Prohibits the cost sharing an eligible individual is required to pay under the Basic Health Program from exceeding the cost sharing required under a platinum plan for individuals with a household income at or below 150 percent of the federal poverty level for the size of the family involved.

(2) Prohibits the cost sharing an eligible individual is required to pay under the Basic Health Program from exceeding the cost sharing required under a gold plan for an individual with a household income above 150 percent of the federal poverty level but at or below 200 percent of the federal poverty level for the size of the family involved.

(c) Requires the medical loss ratio for products in the Basic Health Program to be 85 percent, instead of 80 percent, in the individual and small group market.

12694.15. For purposes of this part, the following definitions shall apply:

(a) "Basic Health Program" means the program authorized by Section 1331 of PPACA.

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

(c) "County organized health system" means a licensed health care service plan established pursuant to Section 14087.51 or 14087.54 of the Welfare and Institutions Code or Chapter 3 (commencing with Section 101675) of Part 4 of Division 101 of the Health and Safety Code.

(d) "Department" means the State Department of Health Care Services.

(e) "Eligible individual" shall have the same meaning as set forth in subdivision (e) of Section 1331 of PPACA.

(f) "Essential health benefits" shall have the same meaning as set forth in Section 1302 of PPACA.

(g) "Fund" means the Basic Health Program Trust Fund established by Section 12694.955.

(h) "Health plan" means a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

(i) "Local initiative" means a licensed health care service plan established pursuant to Section 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, or 14087.96 of the Welfare and Institutions Code.

(j) "Patient Protection and Affordable Care Act" or "PPACA" means Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

12694.2. The Basic Health Program is hereby created and shall be administered by the Managed Risk Medical Insurance Board.

12694.25. The board shall enter into a contract with the United States Secretary of Health and Human Services to implement a Basic Health Program to provide coverage to eligible individuals.

12694.26. The board shall permit enrollment in the Basic Health Program on January 1, 2014.

12694.3. (a) The board shall administer the Basic Health Program in conjunction with the Healthy Families Program, and shall provide an eligibility and enrollment process that allows an individual, or his or her natural or adoptive parent, legal guardian, caretaker relative, foster parent, or stepparent with whom the child resides, to enroll in the Basic Health Program at the same time an individual, or his or her natural or adoptive parent, legal guardian, caretaker relative, foster parent, or stepparent with whom the child resides, applies for enrollment in the Healthy Families Program. An individual may enroll in the same health plan, or a different

health plan, than his or her child or children who are enrolled in the Healthy Families Program.

(b) In implementing the requirements of this section, and consistent with the requirements of Section 1331 of PPACA, the board may do all of the following:

(1) Determine eligibility criteria for the Basic Health Program.

(2) Determine the participation requirements of eligible individuals applying for coverage in the Basic Health Program.

(3) Determine the participation requirements of participating health plans.

(4) Determine when the coverage of eligible individuals begins and the extent and scope of coverage.

(5) Determine, through negotiation with health plans, premium and cost-sharing amounts.

(6) Collect premiums.

(7) Provide or make available subsidized coverage through participating health plans.

(8) Provide for the processing of applications and the enrollment of eligible individuals.

(9) Determine and approve the benefit designs and cost sharing required by health plans participating in the Basic Health Program.

(10) Enter into contracts.

(11) Employ necessary staff.

(12) Authorize expenditures from the fund to pay program expenses that exceed eligible individual premium contributions and to administer the Basic Health Program, as necessary.

(13) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the fund, and, if sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to reduce costs.

(14) Issue rules and regulations, as necessary. Until January 1, 2016, 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.

(15) Make application assistance payments to individuals who have successfully completed the requirements of a Certified Application Assistant in the Healthy Families Program and who successfully enroll eligible individuals in Basic Health Program coverage.

(16) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this part and Section 1331 of PPACA.

12694.35. In implementing this part, eligibility for coverage under, and the benefits, premiums, and cost sharing in, the Basic Health Program, shall meet the requirements of Section 1331 of PPACA. The board may determine the benefits, if any, to offer Basic Health Program participants that are in addition to the essential health benefits package required by Section 1302 of PPACA, including benefits provided through specialized health care service plans, as defined in subdivision (o) of Section 1345 of the Health and Safety Code, and specialized health insurance policies, as defined in Section 106, to the extent that PPACA authorizes the inclusion of such plans or policies in the Basic Health Program. To the extent authorized by federal law, the board shall determine whether benefits provided through specialized health care service plans and specialized health insurance policies are made available through the Basic Health Program as part of a benefit package made available through health plans~~,~~ or as an additional product to be purchased by individuals receiving coverage through the Basic Health Program.

12694.4. The Basic Health Program shall be administered without regard to gender, race, creed, color, sexual orientation, health status, disability, or occupation.

12694.45. (a) The board shall use appropriate and efficient means to notify eligible individuals of the availability of health coverage from the Basic Health Program.

(b) The board, in conjunction with the department, shall conduct a community outreach and education campaign to assist in notifying eligible individuals of the availability of health coverage through the Basic Health Program. The board and the department shall seek federal funding and funding from private entities, including foundation funding, for this purpose. The department

and the California Health Benefit Exchange shall include information on the availability of coverage through the Basic Health Program in all eligibility outreach efforts, and the board shall also include information on the availability of coverage in the Medi-Cal program and the California Health Benefit Exchange.

(c) The board shall use appropriate materials, which may include brochures, pamphlets, fliers, posters, and other promotional items, to notify families of the availability of coverage through the Basic Health Program.

12694.5. (a) The board shall ensure that written enrollment information issued or provided by the Basic Health Program is available to program subscribers and applicants in each of the Medi-Cal threshold languages.

(b) The board shall ensure that telephone services provided to program subscribers and applicants by the Basic Health Program are available in all of the languages identified as Medi-Cal threshold languages.

(c) The board shall ensure that interpreter services are available between eligible individuals and participating health plans in the Medi-Cal threshold languages. The board shall ensure that subscribers are provided information within provider network directories of available linguistically diverse providers.

(d) The board shall ensure that participating health plans, specialized health care service plans, and specialized health insurance policies provide documentation on how they provide linguistically and culturally appropriate services, including marketing materials, to subscribers.

12694.55. No participating health plan, specialized health care service plan, or specialized health insurance policy shall, in an area served by the Basic Health Program, directly, or through an employee, agent, or contractor, provide an applicant with any marketing material relating to benefits or rates provided under the Basic Health Program, unless the material has been reviewed and approved by the board.

12694.57. The board may do the following:

(a) Amend existing Healthy Families Program contracts to allow the parents of children enrolled in the Healthy Families Program to enroll in the same plan as their child or children through the Basic Health Program.

(b) Require, as a condition of participation in the Basic Health Program, health plans to participate in the Healthy Families Program.

12694.6. (a) The board may establish geographic areas, consistent with the geographic areas of the Healthy Families Program, within which participating health plans may offer coverage to subscribers.

(b) Nothing in this section shall restrict a county organized health system, a health plan, or a local initiative from providing services to Basic Health Program subscribers in their licensed geographic service area.

12694.65. (a) Notwithstanding any other provision of law, the board shall not be subject to licensure or regulation by the Department of Insurance or the Department of Managed Health Care.

(b) A participating health plan, specialized health care service plan, or specialized health insurance policy that contracts with the Basic Health Program and is regulated by the Insurance Commissioner or the Department of Managed Health Care shall be licensed and in good standing with its respective licensing agency. In its application to the Basic Health Program, an applicant shall provide assurance of its standing with the appropriate licensing agency.

12694.7. (a) The board shall contract with a broad range of health plans in an area, if available, to ensure that subscribers have a choice of health plans from among a reasonable number and different types of competing health plans. The board shall develop and make available objective criteria for health plan selection and provide adequate notice of the application process to permit all health plans a reasonable and fair opportunity to participate. The criteria and application process shall allow participating health plans to comply with their state and federal licensing and regulatory obligations, except as otherwise provided in this part. Health plan selection shall be based on the criteria developed by the board.

(b) (1) In its selection of participating health plans, the board shall take all reasonable steps to ensure that the range of choices of health plans available to each applicant shall include health plans that include in their provider networks, and have signed contracts with, traditional and public and private safety net providers.

(2) A participating health plan shall annually submit to the board a report summarizing its provider network. The report shall provide, as available, information on the provider network as it relates to all of the following:

(A) Geographic access for the subscribers.

(B) Linguistic services.

(C) The ethnic composition of providers.

(D) The number of subscribers who selected traditional and public and private safety net providers.

(c) (1) The board shall not rely solely on a determination by the Department of Managed Health Care or the Insurance Commissioner of a health plan network's adequacy or geographic access to providers in the awarding of contracts under this part. The board shall collect and review demographic, census, and other data to provide to prospective local initiatives, health plans, or specialized health plans, and identify specific provider contracting target areas with significant numbers of uninsured individuals with incomes that would make them eligible for the Basic Health Program. The board shall give priority to those health plans, on a county-by-county basis, that demonstrate that they have included in their prospective plan networks significant numbers of providers in these geographic areas.

(2) Targeted contracting areas are those ZIP Codes or groups of ZIP Codes or census tracts or groups of census tracts that have a percentage of eligible individuals that is greater than the overall percentage of eligible individuals in that county.

(d) In each geographic area, the board shall designate a community provider plan that is the participating health plan that has the highest percentage of traditional and public and private safety net providers in its network. Subscribers selecting such a health plan shall be given a premium discount in an amount determined by the board.

(e) This section shall also apply to a specialized health care service plan, as defined in subdivision (o) of Section 1345 of the Health and Safety Code, and a specialized health insurance policy, as defined in Section 106, to the extent that the inclusion of that plan or policy in the Basic Health Program is authorized by PPACA.

12694.75. (a) After two consecutive months of nonpayment of premiums by an eligible individual enrolled in the Basic Health

Program, and a reasonable written notice period of not less than 30 days is provided to the eligible individual, the eligible individual may be disenrolled from the Basic Health Program for the failure to pay premiums. The board may conduct or contract for collection actions to collect unpaid family contributions.

(b) Subject to any additional requirements of federal law, disenrollments shall be effective at the end of the second consecutive month of nonpayment.

12694.8. The Basic Health Program may place a lien on compensation or benefits, recovered or recoverable by a subscriber or applicant, or from any party or parties responsible for the compensation or benefits for which benefits have been provided under a plan contract or policy issued under this part.

12694.85. The board shall establish and use a competitive process to select participating health plans and any other contractors under this part. Any contract entered into pursuant to this part shall be exempt from Chapter 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

12694.855. (a) A health care provider that is provided documentation of an individual's enrollment in the Basic Health Program shall not seek reimbursement or attempt to obtain payment for any covered services provided to that individual other than from the participating health plan covering that individual.

(b) Subdivision (a) shall not apply to any cost sharing required for covered services provided to the individual under his or her participating health plan.

(c) For purposes of this section, "health care provider" means any professional person, organization, health facility, or any other person or institution licensed by the state to deliver or furnish health care services.

12694.9. To the extent permitted by federal law, an eligible individual enrolled in the Basic Health Program shall continue to be eligible for the program for a period of 12 months from the month eligibility is established.

12694.95. The board shall do all of the following:

(a) Make use of a simple and easy to understand mail-in and Internet application process.

(b) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including, but not limited to, deductibles, cost sharing, and coinsurance, under the individual's health plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific product or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet Web site and through other means for individuals without access to the Internet.

(c) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance.

(d) Maintain an Internet Web site through which eligible individuals may obtain standardized comparative information on those health plans.

(e) Utilize a standardized format for presenting health benefits plan options offered through the Basic Health Program, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Service Act.

(f) Establish a process to inform individuals who lose eligibility ~~for~~ *under* the Basic Health Program of the availability of coverage through Medi-Cal and the California Health Benefit Exchange, and to transmit their eligibility-related information to those programs electronically to facilitate enrollment.

12694.955. (a) The Basic Health Program Trust Fund is hereby created in the State Treasury for the purpose of this part. All federal funds received pursuant to Section 1331 of PPACA shall be placed in the Basic Health Program Trust Fund. Moneys in the fund shall be used for the purposes of this part, upon appropriation by the Legislature, except that if the annual Budget Act is not enacted by June 30 of any fiscal year preceding the fiscal year to which the budget would apply, the board may transfer federal funds and premium payments from the Basic Health Program Trust Fund to health plans contracting with the board to ensure that individuals receiving coverage through the Basic Health Program are able to comply with the requirement to maintain minimum essential coverage as described in Section 1501 of PPACA. 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.

(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, a county general fund, or any other county fund.

(c) The board shall establish and maintain a prudent reserve in the fund.

(d) Notwithstanding Section 16305.7 of the Government Code, 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.

(e) Subject to approval by the Department of Finance, and upon notification to the committees of each house of the Legislature that consider the budget and the committees of each house that consider appropriations, the board may obtain loans from the General Fund for all necessary and reasonable start-up and initial expenses related to the administration of the fund and the Basic Health Program. The board shall repay principal and interest, using the pooled money investment account rate of interest, to the General Fund no later than July 1, 2016.

12694.957. (a) The board shall ensure that the establishment, operation, and administrative functions of the Basic Health Program do not exceed the combination of federal funds, private donations, premiums paid by eligible individuals, and other non-General Fund moneys available for this purpose. Except for loans authorized pursuant to subdivision (e) of Section 12694.955, no state General Fund money shall be used for any purpose under this part.

(b) The board shall negotiate contracts with health plans to provide or pay for benefits to enrollees under this part. Each contract entered into pursuant to this part shall require the participating health plan to assume full risk for the cost of care for the contract period. The board shall not contract with any participating health plan if such a contract would result in costs exceeding the funds available for purposes of this part, as described in subdivision (a). The requirements of this subdivision shall also apply to contracts with specialized health care service plans, as defined in subdivision (o) of Section 1345 of the Health and Safety Code, and specialized health insurance policies, as defined in Section 106, to the extent that the inclusion of such plans or policies in the Basic Health Program is authorized by PPACA.

(c) In the event that the board reasonably expects that the cost of the Basic Health Program will exceed the available funds specified in subdivision (a), coverage for eligible individuals shall continue until the annual redetermination of each eligible individual, after which time the board shall immediately transfer the eligible individual to coverage in the California Health Benefit Exchange. To the extent permitted by federal law, the board shall contract with the federal government to allow federal funds made available under paragraph (3) of subdivision (d) of Section 1331 of PPACA, relating to 95 percent of the premium tax credits under Section 36B of the Internal Revenue Code of 1986, and the cost-sharing reduction under Section 1402, to be used for the costs of the board in implementing and administering this part.

12694.959. (a) The board shall request an evaluation of the Basic Health Program. The board shall seek funding for the evaluation from an independent nonprofit private foundation.

(b) The purpose of the evaluation is to determine the extent to which the Basic Health Program has achieved objectives to provide low-income Californians with equal or better benefit levels, and less expensive premiums and lower cost sharing than would be available in the California Health Benefit Exchange. In addition, the evaluation is intended to assess the impact of the Basic Health Program on all of the following:

(1) The viability of the California Health Benefit Exchange (Exchange).

(2) Providers, health plans, and insurers that serve the Medi-Cal program and the Healthy Families Program.

(3) Continuity of care and coverage for individuals moving from the Medi-Cal program to the Basic Health Program and from the Basic Health Program to the Exchange.

(c) Components of the evaluation may include, but are not limited to, the following:

(1) A determination of the extent to which individuals served through the Basic Health Program have lower premiums, additional benefits, or lower cost sharing than they would otherwise have received in the Exchange.

(2) A determination of the extent to which individuals served through the Basic Health Program have a choice of quality health coverage options and adequate provider access and networks.

(3) A determination of the extent to which Basic Health Program administrators have been able to coordinate the contracting of health plans and health insurance or the purchasing of other services with the Medi-Cal program, Healthy Families Program, and the Exchange.

(4) A determination of the extent to which the Exchange is attracting competitive health plan participation and offers premium rate structures, and a determination as to the impact the inclusion of the Basic Health Program population would have on the Exchange.

(d) The evaluation shall include, but is not limited to, all of the following:

(1) Enrollment in the Exchange and enrollment in the Basic Health Program, including actual enrollment as compared to the estimated number of individuals eligible for the Exchange and the Basic Health Program, the number of individuals enrolled in the Exchange with family incomes between 300 percent and 400 percent of the federal poverty level, and the number of individuals enrolled in the Exchange with family incomes above 400 percent of the federal poverty level.

(2) The average cost per person of the individuals enrolled in the Exchange as compared to the average cost per person of individuals enrolled in the Basic Health Program.

(3) The impact of the Basic Health Program on the funding available for Exchange administrative costs.

(4) The impact of the Basic Health Program on premiums in the Exchange and the impact of the Exchange on premiums in the Basic Health Program.

(5) The impact of the Basic Health Program on the Exchange's ability to selectively contract with health plans.

(6) The average premium and average cost sharing per person enrolled in the Basic Health Program and the Exchange.

(7) The number of plans participating in the Basic Health Program and the Exchange, including whether and to what extent health plans in the Medi-Cal program participate in the Basic Health Program in counties with Medi-Cal managed care.

(8) The number of individuals enrolling in the Basic Health Program who, in the month immediately preceding Basic Health Program enrollment, were enrolled in the Medi-Cal program.

(9) The number of individuals enrolled in the Medi-Cal program who, in the month immediately preceding Medi-Cal enrollment, were enrolled in the Basic Health Program.

(10) The number of individuals enrolled in the Exchange who, in the month immediately preceding Exchange enrollment, were enrolled in the Basic Health Program.

(11) The number of individuals enrolled in the Basic Health Program who, in the month immediately preceding enrollment in the Basic Health Program, were enrolled in the Exchange.

(12) The average amount of federal funding received by the state per person by year, broken down by federal funding for premiums and federal funds for cost-sharing subsidies, for individuals enrolled in the Basic Health Program.

(13) Whether implementation of the Basic Health Program has resulted in diminished access to health care providers for Medi-Cal beneficiaries or diminished provider participation in the Medi-Cal program.

(e) The Legislature hereby requests the results of the evaluation to be furnished to the appropriate policy and fiscal committees of the Legislature by July 1, 2017.

(f) The California Health Benefit Exchange, the Basic Health Program, the Medi-Cal program, and the Health Families Program shall provide, in a timely manner, the data necessary for the evaluation requested by this section.

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