SENATE BILL No. 27

Introduced by Senator Aanestad

August 4, 2008

An act to amend Sections 1367.01, 1367.03, 1368, 1368.04, 1374.9, 1374.34, and 1393.6 of, to add Section 1341.45 to, and to add and repeal Section 1357.55 of, the Health and Safety Code, and to amend Sections 12725, 12727, and 12739 of, to add Sections 12715.5, 12715.6, 12721.5, and 12739.5 to, to add and repeal Sections 10198.11, 12719, 12724, and 12737.5 of, and to add and repeal Chapter 7.5 (commencing with Section 12738.1) of Part 6.5 of Division 2 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 27, as introduced, Aanestad. California Major Risk Medical Insurance Program: health care service plans: individual health care coverage.

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, as defined, who, among other matters, have been rejected for coverage by at least one private health plan. Existing law authorizes MRMIB to provide that coverage through participating health plans, including health insurers and health care service plans, and authorizes MRMIB to provide or purchase stop-loss coverage under which MRMIP and participating health plans share the risk for health plan expenses that exceed plan rates.

This bill would require that a person either be rejected for coverage by at least 3 different health plans or have a qualified medically

uninsurable condition, as specified, in order to be eligible for MRMIP and would also revise the definition of the term "resident" for purposes of MRMIP eligibility, as specified. The bill would require MRMIB to offer at least 4 different options for major risk medical coverage, including at least one health savings account-compatible option, and would state the intent of the Legislature to enact legislation allowing a related tax deduction and authorizing the state to subsidize the health savings account option, as specified. The bill would state the intent of the Legislature to enact legislation allowing MRMIB to, until a specified date, participate in deductible and out-of-pocket maximum reinsurance using specified products. The bill would also state the intent of the Legislature to enact legislation placing an assessment on health care service plans and health insurers in order to supplement available MRMIP funding and allowing offsetting tax deductions until a specified date.

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. Existing law requires MRMIB to establish program contribution amounts for each category of risk for each participating health plan. Under existing law, the risk categories are based on age and geographic region.

This bill would, until January 1, 2014, require the exclusion of benefits that exceed $150,000 in a calendar year or $1,000,000 in a lifetime. The bill would authorize MRMIB to, by regulation, develop additional risk categories based on morbid obesity and tobacco use, as specified, and would also require MRMIB to adopt regulations that allow participating health plans to incorporate wellness programs, case management services, and disease management services, and offer enrollee rewards based on health risk reduction. The bill would require that those regulations remain in effect until January 1, 2014.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and for the regulation of health insurers by the Department of Insurance. Existing law prohibits health care service plan contracts and health insurance policies from excluding coverage on the basis of a preexisting condition provision for more than a specified period of time.

This bill would authorize MRMIB to create a rider pool consisting of MRMIP applicants with no more than 2 health conditions that made them uninsurable in the private market, as specified. The bill would

authorize an individual health care service plan contract or individual health insurance policy issued to one of the rider pool members to temporarily or permanently exclude coverage for those conditions. The bill would provide for the repeal of these provisions on January 1, 2014.

Existing law creates the Major Risk Medical Insurance Fund and continuously appropriates the fund to MRMIB for purposes of MRMIP. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the act), subjects health care service plans to various fines and administrative penalties for failing to comply with specified provisions of the act and requires that certain administrative penalties be deposited in the Managed Care Fund. Existing law also requires health care service plans to pay specified assessments each fiscal year as a reimbursement of their share of the costs and expenses reasonably incurred in the administration of the act. Existing law requires the adjustment of those assessments and other charges set forth in the act if the director of the department determines that they are in excess of the amount necessary, or are insufficient, to meet the expenses of the act.

This bill would prohibit using the fines and administrative penalties authorized by the act to reduce those assessments. The bill would also require that the fines and administrative penalties authorized pursuant to the act be paid to the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature, for the purposes of MRMIP. The bill would specify that those funds are not continuously appropriated.

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

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

1 SECTION 1. The Legislature hereby finds and declares all of
2 the following:
3 (a) Since 1991, California has provided a mechanism for
4 individuals who are not otherwise eligible for publicly sponsored
5 health care coverage to purchase subsidized health care coverage
6 if they have been denied coverage or offered only high-cost
7 individual coverage. The Major Risk Medical Insurance Program
8 (MRMIP), administered by the Managed Risk Medical Insurance
9 Board (MRMIB), offers coverage to medically uninsurable persons
10 through willing private health plans participating in the program
11 on a voluntary basis.

1 (b) MRMIP offers comprehensive coverage for uninsurable
2 individuals at premium rates significantly higher than standard
3 market rates and subsidizes the costs of coverage not paid by
4 subscriber premiums through an allocation of state funds. Despite
5 the high cost of participation in MRMIP, the benefits provided are
6 limited and choices regarding coverage are absent.
7 (c) As of May 31, 2008, MRMIP provided coverage to 7,305
8 residents. Although waiting lists are generally rare in other state
9 high-risk insurance pools, the waiting list for MRMIP, as of June
10 2008, exceeded 800 individuals. In May 2008, MRMIB reduced
11 the enrollment cap for MRMIP from 8,100 individuals to 7,100
12 individuals, and will only allow enrollment from the waiting list
13 when enrollment declines to below 7,100.
14 (d) The uninsurable population in California is poorly defined
15 and difficult to measure. Estimates of the size of that population
16 range from 165,000 to 396,000 individuals.
17 (e) It is the intent of the Legislature to enact legislation directed
18 toward a segment of the uninsured population with little or no
19 access to the private insurance market, and to provide sustainable
20 funding, improved benefits, and cost-effective plan designs that
21 increase patient access to MRMIP and the individual insurance
22 market while preserving choice.
23 SEC. 2. Section 1341.45 is added to the Health and Safety
24 Code, to read:
25 1341.45. The fines and administrative penalties authorized
26 pursuant to this chapter shall be paid to the Major Risk Medical
27 Insurance Fund created by Section 12739 of the Insurance Code
28 and shall, upon appropriation by the Legislature, be used for the
29 purposes of the Major Risk Medical Insurance Program, as
30 specified in Part 6.5 (commencing with Section 12700) of Division
31 2 of the Insurance Code. Notwithstanding Section 1356.1, these
32 fines and penalties shall not be used to reduce the assessments
33 imposed on health care service plans pursuant to Section 1356.
34 SEC. 3. Section 1357.55 is added to the Health and Safety
35 Code, to read:
36 1357.55. (a) Notwithstanding Section 1357.51, an individual
37 health care service plan contract issued to a member of the rider
38 pool created pursuant to Section 12738.1 of the Insurance Code
39 may permanently or temporarily exclude coverage for the
40 member's qualifying condition or conditions, as identified in the

1 documentation described in subdivision (b) of Section 12738.1 of
2 the Insurance Code.
3 (b) This section shall remain in effect only until January 1, 2014,
4 and as of that date is repealed, unless a later enacted statute, that
5 is enacted before January 1, 2014, deletes or extends that date.
6 SEC. 4. Section 1367.01 of the Health and Safety Code is
7 amended to read:
8 1367.01. (a) A health care service plan and any entity with
9 which it contracts for services that include utilization review or
10 utilization management functions, that prospectively,
11 retrospectively, or concurrently reviews and approves, modifies,
12 delays, or denies, based in whole or in part on medical necessity,
13 requests by providers prior to, retrospectively, or concurrent with
14 the provision of health care services to enrollees, or that delegates
15 these functions to medical groups or independent practice
16 associations or to other contracting providers, shall comply with
17 this section.
18 (b) A health care service plan that is subject to this section shall
19 have written policies and procedures establishing the process by
20 which the plan prospectively, retrospectively, or concurrently
21 reviews and approves, modifies, delays, or denies, based in whole
22 or in part on medical necessity, requests by providers of health
23 care services for plan enrollees. These policies and procedures
24 shall ensure that decisions based on the medical necessity of
25 proposed health care services are consistent with criteria or
26 guidelines that are supported by clinical principles and processes.
27 These criteria and guidelines shall be developed pursuant to Section
28 1363.5. These policies and procedures, and a description of the
29 process by which the plan reviews and approves, modifies, delays,
30 or denies requests by providers prior to, retrospectively, or
31 concurrent with the provision of health care services to enrollees,
32 shall be filed with the director for review and approval, and shall
33 be disclosed by the plan to providers and enrollees upon request,
34 and by the plan to the public upon request.
35 (c) A health care service plan subject to this section, except a
36 plan that meets the requirements of Section 1351.2, shall employ
37 or designate a medical director who holds an unrestricted license
38 to practice medicine in this state issued pursuant to Section 2050
39 of the Business and Professions Code or pursuant to the
40 Osteopathic Act, or, if the plan is a specialized health care service

plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the

1 enrollee's condition, not to exceed five business days from the
2 plan's receipt of the information reasonably necessary and
3 requested by the plan to make the determination. In cases where
4 the review is retrospective, the decision shall be communicated to
5 the individual who received services, or to the individual's
6 designee, within 30 days of the receipt of information that is
7 reasonably necessary to make this determination, and shall be
8 communicated to the provider in a manner that is consistent with
9 current law. For purposes of this section, retrospective reviews
10 shall be for care rendered on or after January 1, 2000.
11 (2) When the enrollee's condition is such that the enrollee faces
12 an imminent and serious threat to his or her health including, but
13 not limited to, the potential loss of life, limb, or other major bodily
14 function, or the normal timeframe for the decisionmaking process,
15 as described in paragraph (1), would be detrimental to the enrollee's
16 life or health or could jeopardize the enrollee's ability to regain
17 maximum function, decisions to approve, modify, or deny requests
18 by providers prior to, or concurrent with, the provision of health
19 care services to enrollees, shall be made in a timely fashion
20 appropriate for the nature of the enrollee's condition, not to exceed
21 72 hours after the plan's receipt of the information reasonably
22 necessary and requested by the plan to make the determination.
23 Nothing in this section shall be construed to alter the requirements
24 of subdivision (b) of Section 1371.4. Notwithstanding Section
25 1371.4, the requirements of this division shall be applicable to all
26 health plans and other entities conducting utilization review or
27 utilization management.
28 (3) Decisions to approve, modify, or deny requests by providers
29 for authorization prior to, or concurrent with, the provision of
30 health care services to enrollees shall be communicated to the
31 requesting provider within 24 hours of the decision. Except for
32 concurrent review decisions pertaining to care that is underway,
33 which shall be communicated to the enrollee's treating provider
34 within 24 hours, decisions resulting in denial, delay, or
35 modification of all or part of the requested health care service shall
36 be communicated to the enrollee in writing within two business
37 days of the decision. In the case of concurrent review, care shall
38 not be discontinued until the enrollee's treating provider has been
39 notified of the plan's decision and a care plan has been agreed

upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the

request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. ~~These penalties shall be paid to the State Managed Care Fund.~~

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

1 (*l*) This section shall not apply to decisions made for the care
2 or treatment of the sick who depend upon prayer or spiritual means
3 for healing in the practice of religion as set forth in subdivision
4 (a) of Section 1270.
5 (m) Nothing in this section shall cause a health care service plan
6 to be defined as a health care provider for purposes of any provision
7 of law, including, but not limited to, Section 6146 of the Business
8 and Professions Code, Sections 3333.1 and 3333.2 of the Civil
9 Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the
10 Code of Civil Procedure.
11 SEC. 5. Section 1367.03 of the Health and Safety Code is
12 amended to read:
13 1367.03. (a) Not later than January 1, 2004, the department
14 shall develop and adopt regulations to ensure that enrollees have
15 access to needed health care services in a timely manner. In
16 developing these regulations, the department shall develop
17 indicators of timeliness of access to care and, in so doing, shall
18 consider the following as indicators of timeliness of access to care:
19 (1) Waiting times for appointments with physicians, including
20 primary care and specialty physicians.
21 (2) Timeliness of care in an episode of illness, including the
22 timeliness of referrals and obtaining other services, if needed.
23 (3) Waiting time to speak to a physician, registered nurse, or
24 other qualified health professional acting within his or her scope
25 of practice who is trained to screen or triage an enrollee who may
26 need care.
27 (b) In developing these standards for timeliness of access, the
28 department shall consider the following:
29 (1) Clinical appropriateness.
30 (2) The nature of the specialty.
31 (3) The urgency of care.
32 (4) The requirements of other provisions of law, including
33 Section 1367.01 governing utilization review, that may affect
34 timeliness of access.
35 (c) The department may adopt standards other than the time
36 elapsed between the time an enrollee seeks health care and obtains
37 care. If the department chooses a standard other than the time
38 elapsed between the time an enrollee first seeks health care and
39 obtains it, the department shall demonstrate why that standard is

1 more appropriate. In developing these standards, the department
2 shall consider the nature of the plan network.
3 (d) The department shall review and adopt standards, as needed,
4 concerning the availability of primary care physicians, specialty
5 physicians, hospital care, and other health care, so that consumers
6 have timely access to care. In so doing, the department shall
7 consider the nature of physician practices, including individual
8 and group practices as well as the nature of the plan network. The
9 department shall also consider various circumstances affecting the
10 delivery of care, including urgent care, care provided on the same
11 day, and requests for specific providers. If the department finds
12 that health care service plans and health care providers have
13 difficulty meeting these standards, the department may make
14 recommendations to the Assembly Committee on Health and the
15 Senate Committee on Insurance of the Legislature pursuant to
16 subdivision (i).
17 (e) In developing standards under subdivision (a), the department
18 shall consider requirements under federal law, requirements under
19 other state programs, standards adopted by other states, nationally
20 recognized accrediting organizations, and professional associations.
21 The department shall further consider the needs of rural areas,
22 specifically those in which health facilities are more than 30 miles
23 apart and any requirements imposed by the State Department of
24 Health *Care* Services on health care service plans that contract
25 with the State Department of Health *Care* Services to provide
26 Medi-Cal managed care.
27 (f) (1) Contracts between health care service plans and health
28 care providers shall assure compliance with the standards
29 developed under this section. These contracts shall require
30 reporting by health care providers to health care service plans and
31 by health care service plans to the department to ensure compliance
32 with the standards.
33 (2) Health care service plans shall report annually to the
34 department on compliance with the standards in a manner specified
35 by the department. The reported information shall allow consumers
36 to compare the performance of plans and their contracting providers
37 in complying with the standards, as well as changes in the
38 compliance of plans with these standards.

(g) (1) When evaluating compliance with the standards, the department shall focus more upon patterns of noncompliance rather than isolated episodes of noncompliance.

(2) The director may investigate and take enforcement action against plans regarding noncompliance with the requirements of this section. Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director may, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing in accordance with Section 1397. The plan may provide to the director, and the director may consider, information regarding the plan's overall compliance with the requirements of this section. The administrative penalties shall not be deemed an exclusive remedy available to the director. ~~These penalties shall be paid to the State Managed Care Fund.~~ The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(3) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(A) Repeated failure to act promptly and reasonably to assure timely access to care consistent with this chapter.

(B) Repeated failure to act promptly and reasonably to require contracting providers to assure timely access that the plan is required to perform under this chapter and that have been delegated by the plan to the contracting provider when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(C) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

~~(4) The administrative penalties authorized pursuant to this section shall be paid to the State Managed Care Fund.~~

(h) The department shall work with the patient advocate to assure that the quality of care report card incorporates information provided pursuant to subdivision (f) regarding the degree to which

1 health care service plans and health care providers comply with
2 the requirements for timely access to care.
3 (i) The department shall report to the Assembly Committee on
4 Health and the Senate Committee on Insurance of the Legislature
5 on March 1, 2003, and on March 1, 2004, regarding the progress
6 toward the implementation of this section.
7 (j) Every three years, the department shall review information
8 regarding compliance with the standards developed under this
9 section and shall make recommendations for changes that further
10 protect enrollees.
11 SEC. 6. Section 1368 of the Health and Safety Code is amended
12 to read:
13 1368. (a) Every plan shall do all of the following:
14 (1) Establish and maintain a grievance system approved by the
15 department under which enrollees may submit their grievances to
16 the plan. Each system shall provide reasonable procedures in
17 accordance with department regulations that shall ensure adequate
18 consideration of enrollee grievances and rectification when
19 appropriate.
20 (2) Inform its subscribers and enrollees upon enrollment in the
21 plan and annually thereafter of the procedure for processing and
22 resolving grievances. The information shall include the location
23 and telephone number where grievances may be submitted.
24 (3) Provide forms for grievances to be given to subscribers and
25 enrollees who wish to register written grievances. The forms used
26 by plans licensed pursuant to Section 1353 shall be approved by
27 the director in advance as to format.
28 (4) (A) Provide for a written acknowledgment within five
29 calendar days of the receipt of a grievance, except as noted in
30 subparagraph (B). The acknowledgment shall advise the
31 complainant of the following:
32 (i) That the grievance has been received.
33 (ii) The date of receipt.
34 (iii) The name of the plan representative and the telephone
35 number and address of the plan representative who may be
36 contacted about the grievance.
37 (B) Grievances received by telephone, by facsimile, by e-mail,
38 or online through the plan's Web site pursuant to Section 1368.015,
39 that are not coverage disputes, disputed health care services
40 involving medical necessity, or experimental or investigational

1 treatment and that are resolved by the next business day following
2 receipt are exempt from the requirements of subparagraph (A) and
3 paragraph (5). The plan shall maintain a log of all these grievances.
4 The log shall be periodically reviewed by the plan and shall include
5 the following information for each complaint:
6 (i) The date of the call.
7 (ii) The name of the complainant.
8 (iii) The complainant's member identification number.
9 (iv) The nature of the grievance.
10 (v) The nature of the resolution.
11 (vi) The name of the plan representative who took the call and
12 resolved the grievance.
13 (5) Provide subscribers and enrollees with written responses to
14 grievances, with a clear and concise explanation of the reasons for
15 the plan's response. For grievances involving the delay, denial, or
16 modification of health care services, the plan response shall
17 describe the criteria used and the clinical reasons for its decision,
18 including all criteria and clinical reasons related to medical
19 necessity. If a plan, or one of its contracting providers, issues a
20 decision delaying, denying, or modifying health care services based
21 in whole or in part on a finding that the proposed health care
22 services are not a covered benefit under the contract that applies
23 to the enrollee, the decision shall clearly specify the provisions in
24 the contract that exclude that coverage.
25 (6) Keep in its files all copies of grievances, and the responses
26 thereto, for a period of five years.
27 (b) (1) (A) After either completing the grievance process
28 described in subdivision (a), or participating in the process for at
29 least 30 days, a subscriber or enrollee may submit the grievance
30 to the department for review. In any case determined by the
31 department to be a case involving an imminent and serious threat
32 to the health of the patient, including, but not limited to, severe
33 pain, the potential loss of life, limb, or major bodily function, or
34 in any other case where the department determines that an earlier
35 review is warranted, a subscriber or enrollee shall not be required
36 to complete the grievance process or to participate in the process
37 for at least 30 days before submitting a grievance to the department
38 for review.
39 (B) A grievance may be submitted to the department for review
40 and resolution prior to any arbitration.

1 (C) Notwithstanding subparagraphs (A) and (B), the department
2 may refer any grievance that does not pertain to compliance with
3 this chapter to the State Department of Health Services, the
4 California Department of Aging, the federal Health Care Financing
5 Administration, or any other appropriate governmental entity for
6 investigation and resolution.
7 (2) If the subscriber or enrollee is a minor, or is incompetent or
8 incapacitated, the parent, guardian, conservator, relative, or other
9 designee of the subscriber or enrollee, as appropriate, may submit
10 the grievance to the department as the agent of the subscriber or
11 enrollee. Further, a provider may join with, or otherwise assist, a
12 subscriber or enrollee, or the agent, to submit the grievance to the
13 department. In addition, following submission of the grievance to
14 the department, the subscriber or enrollee, or the agent, may
15 authorize the provider to assist, including advocating on behalf of
16 the subscriber or enrollee. For purposes of this section, a "relative"
17 includes the parent, stepparent, spouse, adult son or daughter,
18 grandparent, brother, sister, uncle, or aunt of the subscriber or
19 enrollee.
20 (3) The department shall review the written documents submitted
21 with the subscriber's or the enrollee's request for review, or
22 submitted by the agent on behalf of the subscriber or enrollee. The
23 department may ask for additional information, and may hold an
24 informal meeting with the involved parties, including providers
25 who have joined in submitting the grievance or who are otherwise
26 assisting or advocating on behalf of the subscriber or enrollee. If
27 after reviewing the record, the department concludes that the
28 grievance, in whole or in part, is eligible for review under the
29 independent medical review system established pursuant to Article
30 5.55 (commencing with Section 1374.30), the department shall
31 immediately notify the subscriber or enrollee, or agent, of that
32 option and shall, if requested orally or in writing, assist the
33 subscriber or enrollee in participating in the independent medical
34 review system.
35 (4) If after reviewing the record of a grievance, the department
36 concludes that a health care service eligible for coverage and
37 payment under a health care service plan contract has been delayed,
38 denied, or modified by a plan, or by one of its contracting
39 providers, in whole or in part due to a determination that the service
40 is not medically necessary, and that determination was not

communicated to the enrollee in writing along with a notice of the enrollee's potential right to participate in the independent medical review system, as required by this chapter, the director shall, by order, assess administrative penalties. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. ~~These penalties shall be paid to the State Managed Care Fund.~~

(5) The department shall send a written notice of the final disposition of the grievance, and the reasons therefor, to the subscriber or enrollee, the agent, to any provider that has joined with or is otherwise assisting the subscriber or enrollee, and to the plan, within 30 calendar days of receipt of the request for review unless the director, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. In any case not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), the department's written notice shall include, at a minimum, the following:

(A) A summary of its findings and the reasons why the department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director.

(B) A discussion of the department's contact with any medical provider, or any other independent expert relied on by the department, along with a summary of the views and qualifications of that provider or expert.

(C) If the enrollee's grievance is sustained in whole or part, information about any corrective action taken.

(6) In any department review of a grievance involving a disputed health care service, as defined in subdivision (b) of Section 1374.30, that is not eligible for the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30), in which the department finds that the plan has delayed, denied, or modified health care services that are medically necessary, based on the specific medical circumstances of the enrollee, and those services are a covered benefit under the terms and conditions of the health care service plan contract, the department's written notice shall do either of the following:

1 (A) Order the plan to promptly offer and provide those health
2 care services to the enrollee.
3 (B) Order the plan to promptly reimburse the enrollee for any
4 reasonable costs associated with urgent care or emergency services,
5 or other extraordinary and compelling health care services, when
6 the department finds that the enrollee's decision to secure those
7 services outside of the plan network was reasonable under the
8 circumstances.
9 The department's order shall be binding on the plan.
10 (7) Distribution of the written notice shall not be deemed a
11 waiver of any exemption or privilege under existing law, including,
12 but not limited to, Section 6254.5 of the Government Code, for
13 any information in connection with and including the written
14 notice, nor shall any person employed or in any way retained by
15 the department be required to testify as to that information or
16 notice.
17 (8) The director shall establish and maintain a system of aging
18 of grievances that are pending and unresolved for 30 days or more
19 that shall include a brief explanation of the reasons each grievance
20 is pending and unresolved for 30 days or more.
21 (9) A subscriber or enrollee, or the agent acting on behalf of a
22 subscriber or enrollee, may also request voluntary mediation with
23 the plan prior to exercising the right to submit a grievance to the
24 department. The use of mediation services shall not preclude the
25 right to submit a grievance to the department upon completion of
26 mediation. In order to initiate mediation, the subscriber or enrollee,
27 or the agent acting on behalf of the subscriber or enrollee, and the
28 plan shall voluntarily agree to mediation. Expenses for mediation
29 shall be borne equally by both sides. The department shall have
30 no administrative or enforcement responsibilities in connection
31 with the voluntary mediation process authorized by this paragraph.
32 (c) The plan's grievance system shall include a system of aging
33 of grievances that are pending and unresolved for 30 days or more.
34 The plan shall provide a quarterly report to the director of
35 grievances pending and unresolved for 30 or more days with
36 separate categories of grievances for Medicare enrollees and
37 Medi-Cal enrollees. The plan shall include with the report a brief
38 explanation of the reasons each grievance is pending and
39 unresolved for 30 days or more. The plan may include the

following statement in the quarterly report that is made available to the public by the director:

"Under Medicare and Medi-Cal law, Medicare enrollees and Medi-Cal enrollees each have separate avenues of appeal that are not available to other enrollees. Therefore, grievances pending and unresolved may reflect enrollees pursuing their Medicare or Medi-Cal appeal rights."

If requested by a plan, the director shall include this statement in a written report made available to the public and prepared by the director that describes or compares grievances that are pending and unresolved with the plan for 30 days or more. Additionally, the director shall, if requested by a plan, append to that written report a brief explanation, provided in writing by the plan, of the reasons why grievances described in that written report are pending and unresolved for 30 days or more. The director shall not be required to include a statement or append a brief explanation to a written report that the director is required to prepare under this chapter, including Sections 1380 and 1397.5.

(d) Subject to subparagraph (C) of paragraph (1) of subdivision (b), the grievance or resolution procedures authorized by this section shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law.

(e) Nothing in this section shall be construed to allow the submission to the department of any provider grievance under this section. However, as part of a provider's duty to advocate for medically appropriate health care for his or her patients pursuant to Sections 510 and 2056 of the Business and Professions Code, nothing in this subdivision shall be construed to prohibit a provider from contacting and informing the department about any concerns he or she has regarding compliance with or enforcement of this chapter.

SEC. 7. Section 1368.04 of the Health and Safety Code is amended to read:

1368.04. (a) The director shall investigate and take enforcement action against plans regarding grievances reviewed and found by the department to involve noncompliance with the

requirements of this chapter, including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30). Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director shall, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The administrative penalties shall not be deemed an exclusive remedy available to the director. ~~These penalties shall be paid to the State Managed Care Fund.~~ The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

(b) The director may, after appropriate notice and opportunity for hearing in accordance with Section 1397, by order, assess administrative penalties if the director determines that a health care service plan has knowingly committed, or has performed with a frequency that indicates a general business practice, either of the following:

(1) Repeated failure to act promptly and reasonably to investigate and resolve grievances in accordance with Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the director to enforce this chapter.

~~(d) The administrative penalties authorized pursuant to this section shall be paid to the State Managed Care Fund.~~

SEC. 8. Section 1374.9 of the Health and Safety Code is amended to read:

1374.9. For violations of Section 1374.7, the director may, after appropriate notice and opportunity for hearing, by order, levy administrative penalties as follows:

(a) Any health care service plan that violates Section 1374.7, or that violates any rule or order adopted or issued pursuant to this section, is liable for administrative penalties of not less than two thousand five hundred dollars ($2,500) for each first violation, and

of not less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000) for each second violation, and of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each subsequent violation.

~~(b) The administrative penalties shall be paid to the Managed Health Care Fund.~~

~~(c)~~

(b) The administrative penalties available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed advisable by the director to enforce the provisions of this chapter.

SEC. 9. Section 1374.34 of the Health and Safety Code is amended to read:

1374.34. (a) Upon receiving the decision adopted by the director pursuant to Section 1374.33 that a disputed health care service is medically necessary, the plan shall promptly implement the decision. In the case of reimbursement for services already rendered, the plan shall reimburse the provider or enrollee, whichever applies, within five working days. In the case of services not yet rendered, the plan shall authorize the services within five working days of receipt of the written decision from the director, or sooner if appropriate for the nature of the enrollee's medical condition, and shall inform the enrollee and provider of the authorization in accordance with the requirements of paragraph (3) of subdivision (h) of Section 1367.01.

(b) A plan shall not engage in any conduct that has the effect of prolonging the independent review process. The engaging in that conduct or the failure of the plan to promptly implement the decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars ($5,000) for each day that the decision is not implemented. ~~Administrative penalties shall be deposited in the State Managed Care Fund.~~

(c) The director shall require the plan to promptly reimburse the enrollee for any reasonable costs associated with those services when the director finds that the disputed health care services were a covered benefit under the terms and conditions of the health care service plan contract, and the services are found by the independent

1 medical review organization to have been medically necessary
2 pursuant to Section 1374.33, and either the enrollee's decision to
3 secure the services outside of the plan provider network was
4 reasonable under the emergency or urgent medical circumstances,
5 or the health care service plan contract does not require or provide
6 prior authorization before the health care services are provided to
7 the enrollee.
8 (d) In addition to requiring plan compliance regarding
9 subdivisions (a), (b), and (c) the director shall review individual
10 cases submitted for independent medical review to determine
11 whether any enforcement actions, including penalties, may be
12 appropriate. In particular, where substantial harm, as defined in
13 Section 3428 of the Civil Code, to an enrollee has already occurred
14 because of the decision of a plan, or one of its contracting
15 providers, to delay, deny, or modify covered health care services
16 that an independent medical review determines to be medically
17 necessary pursuant to Section 1374.33, the director shall impose
18 penalties.
19 (e) Pursuant to Section 1368.04, the director shall perform an
20 annual audit of independent medical review cases for the dual
21 purposes of education and the opportunity to determine if any
22 investigative or enforcement actions should be undertaken by the
23 department, particularly if a plan repeatedly fails to act promptly
24 and reasonably to resolve grievances associated with a delay,
25 denial, or modification of medically necessary health care services
26 when the obligation of the plan to provide those health care services
27 to enrollees or subscribers is reasonably clear.
28 SEC. 10. Section 1393.6 of the Health and Safety Code is
29 amended to read:
30 1393.6. For violations of Article 3.1 (commencing with Section
31 1357) and Article 3.15 (commencing with Section 1357.50), the
32 director may, after appropriate notice and opportunity for hearing,
33 by order levy administrative penalties as follows:
34 (a) Any person, solicitor, or solicitor firm, other than a health
35 care service plan, who willfully violates any provision of this
36 chapter, or who willfully violates any rule or order adopted or
37 issued pursuant to this chapter, is liable for administrative penalties
38 of not less than two hundred fifty dollars ($250) for each first
39 violation, and of not less than one thousand dollars ($1,000) and

1 not more than two thousand five hundred dollars ($2,500) for each
2 subsequent violation.
3 (b) Any health care service plan that willfully violates any
4 provision of this chapter, or that willfully violates any rule or order
5 adopted or issued pursuant to this chapter, is liable for
6 administrative penalties of not less than two thousand five hundred
7 dollars ($2,500) for each first violation, and of not less than five
8 thousand dollars ($5,000) nor more than ten thousand dollars
9 ($10,000) for each second violation, and of not less than fifteen
10 thousand dollars ($15,000) and not more than one hundred
11 thousand dollars ($100,000) for each subsequent violation.
12 ~~(c) The administrative penalties shall be paid to the Managed~~
13 ~~Health Care Fund.~~
14 ~~(d)~~
15 *(c)* The administrative penalties available to the director pursuant
16 to this section are not exclusive, and may be sought and employed
17 in any combination with civil, criminal, and other administrative
18 remedies deemed advisable by the director to enforce the provisions
19 of this chapter.
20 SEC. 11. Section 10198.11 is added to the Insurance Code, to
21 read:
22 10198.11. (a) Notwithstanding Section 10198.7, an individual
23 health insurance policy issued to a member of the rider pool created
24 pursuant to Section 12738.1 may permanently or temporarily
25 exclude coverage for the member's qualifying condition or
26 conditions, as identified in the documentation described in
27 subdivision (b) of Section 12738.1.
28 (b) This section shall remain in effect only until January 1, 2014,
29 and as of that date is repealed, unless a later enacted statute, that
30 is enacted before January 1, 2014, deletes or extends that date.
31 SEC. 12. Section 12715.5 is added to the Insurance Code, to
32 read:
33 12715.5. The board shall offer at least four different options
34 for major risk medical coverage pursuant to this part, including at
35 least one health savings account-compatible option. These options
36 shall provide for both of the following:
37 (a) Varying deductibles ranging from five hundred dollars ($500)
38 to two thousand five hundred dollars ($2,500) per person and one
39 thousand dollars ($1,000) to four thousand dollars ($4,000) per
40 family.

1 (b) Varying out-of-pocket maximums ranging from two
2 thousand five hundred dollars ($2,500) to five thousand dollars
3 ($5,000) per person and four thousand dollars ($4,000) to seven
4 thousand five hundred dollars ($7,500) per family.
5 SEC. 13. Section 12715.6 is added to the Insurance Code, to
6 read:
7 12715.6. It is the intent of the Legislature to enact legislation
8 allowing a deduction in connection with any health savings
9 account-compatible option provided pursuant to Section 12715.5
10 in conformity with federal law. It is further the intent of the
11 Legislature to enact legislation allowing the state to subsidize the
12 health savings account option using a sliding scale based on
13 income.
14 SEC. 14. Section 12719 is added to the Insurance Code, to
15 read:
16 12719. (a) Benefits that exceed one hundred fifty thousand
17 dollars ($150,000) in a calendar year under the program for a
18 subscriber, a subscriber's enrolled dependent, or a dependent
19 subscriber shall be excluded.
20 (b) Benefits that exceed one million dollars ($1,000,000) in a
21 lifetime under the program for a subscriber, a subscriber's enrolled
22 dependent, or dependent subscriber shall be excluded.
23 (c) This section shall remain in effect only until January 1, 2014,
24 and as of that date is repealed, unless a later enacted statute, that
25 is enacted before January 1, 2014, deletes or extends that date.
26 SEC. 15. Section 12721.5 is added to the Insurance Code, to
27 read:
28 12721.5. It is the intent of the Legislature to enact legislation
29 allowing the board to, until January 1, 2014, participate on a sliding
30 scale based on income in deductible and out-of-pocket maximum
31 reinsurance using products including, but not limited to, health
32 reimbursement arrangements, critical insurance policies, and
33 accident insurance policies.
34 SEC. 16. Section 12724 is added to the Insurance Code, to
35 read:
36 12724. (a) The board shall adopt regulations that allow
37 participating health plans to incorporate wellness programs, case
38 management services, and disease management services, and offer
39 enrollee rewards based on health risk reduction. The regulations

1 adopted by the board pursuant to this section shall remain in effect
2 only until January 1, 2014.
3 (b) This section shall remain in effect only until January 1, 2014,
4 and as of that date is repealed, unless a later enacted statute, that
5 is enacted before January 1, 2014, deletes or extends that date.
6 SEC. 17. Section 12725 of the Insurance Code is amended to
7 read:
8 12725. (a) Each resident of the state meeting the eligibility
9 criteria of this section and who is unable to secure adequate private
10 health coverage is eligible to apply for major risk medical coverage
11 through the program. ~~For these purposes, “resident” includes a~~
12 ~~member of a federally recognized California Indian tribe.~~
13 (b) To be eligible for enrollment in the program, an applicant
14 shall have been rejected for health care coverage by at least ~~one~~
15 *three different* private health ~~plan~~ *plans or shall provide proof that*
16 *he or she has a qualified medically uninsurable condition, as*
17 *documented by a physician and surgeon. The board shall*
18 *determine, by regulation, which conditions are qualified for*
19 *purposes of this section*. An applicant shall be deemed to have
20 been rejected if the only private health coverage that the applicant
21 could secure would do one of the following:
22 (1) Impose substantial waivers that the program determines
23 would leave a subscriber without adequate coverage for medically
24 necessary services.
25 (2) Afford limited coverage that the program determines would
26 leave the subscriber without adequate coverage for medically
27 necessary services.
28 (3) Afford coverage only at an excessive price, which the board
29 determines is significantly above standard average individual
30 coverage rates.
31 (c) Rejection for policies or certificates of specified disease or
32 policies or certificates of hospital confinement indemnity, as
33 described in Section 10198.61, shall not be deemed to be rejection
34 for the purposes of eligibility for enrollment.
35 (d) The board may permit dependents of eligible subscribers to
36 enroll in major risk medical coverage through the program if the
37 board determines the enrollment can be carried out in an actuarially
38 and administratively sound manner.
39 (e) Notwithstanding the provisions of this section, the board
40 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.

(g) (1) For purposes of this section, "resident" means a person who meets one of the following requirements:

(A) Has resided continuously in the State of California for at least six months immediately prior to applying to the program.

(B) Is present in the State of California and provides documentation of recent participation in a high-risk health insurance program in another state.

(2) "Resident" includes a member of a federally recognized California Indian tribe who meets the requirements of subparagraph (A) or (B) of paragraph (1).

SEC. 18. Section 12727 of the Insurance Code is amended to read:

12727. ~~Where more than one participating health plan is offered, the~~ *The* program shall make available to applicants eligible to enroll in the program sufficient information to make an informed choice among th~~e various types of participating health plans~~ *options provided pursuant to Section 12715.5*. Each applicant shall be issued an appropriate document setting forth or summarizing the services to which an enrollee is entitled, procedures for obtaining major risk medical coverage, a list of contracting health plans and providers, and a summary of grievance procedures.

1 SEC. 19. Section 12737.5 is added to the Insurance Code, to
2 read:
3 12737.5. (a) In addition to the risk categories described in
4 Section 2698.400 of Title 10 of the California Code of Regulations,
5 the board may, by regulation, develop risk categories based on
6 morbid obesity and tobacco use. The risk categories developed
7 pursuant to this section shall set objectives for the reduction of
8 morbid obesity and tobacco use and shall allow for rate reductions
9 if those objectives are achieved.
10 (b) The regulations adopted by the board pursuant to this section
11 shall remain in effect only until January 1, 2014.
12 (c) This section shall remain in effect only until January 1, 2014,
13 and as of that date is repealed, unless a later enacted statute, that
14 is enacted before January 1, 2014, deletes or extends that date.
15 SEC. 20. Chapter 7.5 (commencing with Section 12738.1) is
16 added to Part 6.5 of Division 2 of the Insurance Code, to read:
17
18 CHAPTER 7.5. RIDER POOL
19
20 12738.1. (a) The board may create a rider pool consisting of
21 applicants with no more than two qualifying conditions.
22 (b) The board shall issue documentation of membership to each
23 member of the rider pool. This documentation shall identify the
24 member's qualifying condition or conditions.
25 (c) For purposes of this section, "qualifying condition" means
26 a health condition that made the individual uninsurable in the
27 private market, as determined by the board, and that the board
28 determines, by regulation, is eligible for purposes of this section.
29 "Qualifying condition" shall not include a condition likely to
30 require chronic, ongoing care.
31 12738.2. This chapter shall remain in effect only until January
32 1, 2014, and as of that date is repealed, unless a later enacted
33 statute, that is enacted before January 1, 2014, deletes or extends
34 that date.
35 SEC. 21. Section 12739 of the Insurance Code is amended to
36 read:
37 12739. (a) *(1)* There is hereby created in the State Treasury
38 a special fund known as the Major Risk Medical Insurance Fund
39 that is, notwithstanding Section 13340 of the Government Code,
40 continuously appropriated to the board for the purposes specified

in ~~Sections 10127.15 and 12739.1 and Section 1373.62 of the Health and Safety Code~~ *Section 12739.1*.

(2) Notwithstanding paragraph (1), funds deposited in the account pursuant to Section 1341.45 of the Health and Safety Code shall not be continuously appropriated.

(b) After June 30, 1991, the following amounts shall be deposited annually in the Major Risk Medical Insurance Fund:

(1) Eighteen million dollars ($18,000,000) from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund.

(2) (A) Eleven million dollars ($11,000,000) from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund.

(B) Notwithstanding subparagraph (A), for the 2007–08 fiscal year only, the Controller shall reduce the amount deposited into the Major Risk Medical Insurance Fund from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund to one million dollars ($1,000,000).

(3) One million dollars ($1,000,000) from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund.

SEC. 22. Section 12739.5 is added to the Insurance Code, to read:

12739.5. It is the intent of the Legislature to enact legislation that would, until January 1, 2014, do all of the following:

(a) Place an assessment on health care service plans and health insurers, on a per covered life per month or total covered lives per year basis, that would supplement available program funding.

(b) Require the board to establish the anticipated program costs, the subscriber premium payments, and the level of assessments to be paid by health care service plans and health insurers pursuant to subdivision (a).

(c) Provide health care service plans and health insurers a tax deduction that would offset the assessments paid by the plans and insurers, as described in subdivision (a).

O