Assembly Bill No. 1401

CHAPTER 794

An act to amend Section 1366.27, to amend, repeal, and add Section 1373.6 of, to add Sections 1363.06, 1363.07, 1366.29, and 1373.622 to, and to add and repeal Section 1373.62 of, the Health and Safety Code, and to amend Sections 10128.57, 12711, 12725, 12739, 12739.1, and 12739.2 of, to add Sections 10113.8, 10127.14, 10127.16, 10128.59, and 12682.1 to, and to add and repeal Sections 10127.15 and 12712.5 of, the Insurance Code, relating to health care coverage, and making an appropriation therefor.

[Approved by Governor September 22, 2002. Filed with Secretary of State September 22, 2002.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1401, Thomson. Health benefit coverage.

(1) The California COBRA Program (Cal-COBRA) and other provisions of existing law require health care service plans and health insurers to offer health benefit coverage to specified individuals who are without that coverage. Existing law also creates the Managed Risk Medical Insurance Board which administers the California Major Risk Medical Insurance Program (MRMIP) to provide major risk medical coverage to residents who are unable to secure adequate private health coverage. Under existing law, designated amounts from the Cigarette and Tobacco Products Surtax Fund are deposited annually into the Major Risk Medical Insurance Fund, which is continuously appropriated to pay for the MRMIP expenses. Existing law imposes requirements relating to the obligation of a health insurance issuer to provide coverage through a converted policy to certain individuals after they become ineligible for coverage through a group plan.

This bill would revise certain provisions of Cal-COBRA and other existing laws that require plans and insurers to offer health benefit coverage to certain individuals. The bill, in this regard, would, effective September 1, 2003, revise coverage requirements for converted policies and would also require a health care service plan and a health insurer to offer specified individuals who begin receiving continuation coverage on or after January 1, 2003, and who have exhausted their continuation coverage under federal continuation coverage provisions an opportunity to extend the term of their coverage to 36 months. The bill would also extend continuation coverage for specified individuals under Cal-COBRA to 36 months.

This bill additionally would establish a 4-year pilot program, commencing September 1, 2003, and terminating September 1, 2007, requiring that health care service plans and health insurers offer a standard benefit plan, based on benefit designs offered through the MRMIP. Under the pilot program, plans and insurers would be precluded from rejecting an application for coverage from an individual who was previously covered under the MRMIP for a period of 36 consecutive months. The bill would specify the amount of the individual or insured contribution required in the pilot program and would require the board to make payments from the Major Risk Medical Insurance Fund to plans and insurers for the provision of health care services under the standard benefit plan. Because the bill would authorize the expenditure of funds in a continuously appropriated fund for a new purpose, it would make an appropriation.

This bill would require the Legislative Analyst to report to the Legislature on the effectiveness of these provisions in providing health benefits to individuals who otherwise are unable to obtain that coverage. The bill would authorize the Managed Risk Medical Insurance Board, the Department of Managed Health Care, and the Department of Insurance to adopt emergency regulations to implement the provisions of the bill.

(2) Under existing law, a violation of the provisions of Cal-COBRA or the Knox-Keene Health Care Service Plan Act of 1975 which regulates the operations of health care service plans is punishable as a misdemeanor offense.

Because this bill would impose additional requirements with respect to the Knox-Keene Health Care Service Plan Act of 1975 and Cal-COBRA, the violation of which would be punishable as a criminal offense, it would impose a state-mandated local program.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Appropriation: yes.

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

SECTION 1. Section 1363.06 is added to the Health and Safety Code, to read:

1363.06. (a) The Department of Managed Health Care and the Department of Insurance shall compile information as required by this

section and Section 10127.14 of the Insurance Code into two comparative benefit matrices. The first matrix shall compare benefit packages offered pursuant to Section 1373.62 and Section 10127.15 of the Insurance Code. The second matrix shall compare benefit packages offered pursuant to Sections 1366.35, 1373.6, and 1399.804 and Sections 10785, 10901.2, and 12682.1 of the Insurance Code.

(b) The comparative benefit matrix shall include:

(1) Benefit information submitted by health care service plans pursuant to subdivision (d) and by health insurers pursuant to Section 10127.14 of the Insurance Code.

(2) The following statements in at least 12-point type at the top of the matrix:

(A) ''This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer.''

(B) ''The comparative benefit summary is updated annually, or more often if necessary to be accurate.''

(C) ''The most current version of this comparative benefit summary is available on (address of the plan's or insurer's site).''

This subparagraph applies only to those plans or insurers that maintain an Internet Web site.

(3) The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Insurance, as appropriate, for further assistance.

(c) The Department of Managed Health Care and the Department of Insurance shall jointly prepare two standardized templates for use by health care service plans and health insurers in submitting the information required pursuant to subdivision (d) and subdivision (d) of Section 10127.14 of the Insurance Code. The templates shall be exempt from the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Health care service plans, except specialized health care service plans, shall submit the following to the department by January 31, 2003, and annually thereafter:

(1) A summary explanation of the following for each product described in subdivision (a).

(A) Eligibility requirements.

(B) The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside.

(C) When and under what circumstances benefits cease.

(D) The terms under which coverage may be renewed.

(E) Other coverage that may be available if benefits under the described benefit package cease.

(F) The circumstances under which choice in the selection of physicians and providers is permitted.

(G) Lifetime and annual maximums.

(H) Deductibles.

(2) A summary explanation of coverage for the following, together with the corresponding copayments and limitations, for each product described in subdivision (a):

(A) Professional services.

(B) Outpatient services.

(C) Hospitalization services.

(D) Emergency health coverage.

(E) Ambulance services.

(F) Prescription drug coverage.

(G) Durable medical equipment.

(H) Mental health services.

(I) Residential treatment.

(J) Chemical dependency services.

(K) Home health services.

(L) Custodial care and skilled nursing facilities.

(3) The telephone number or numbers that may be used by an applicant to access a health care service plan customer service representative and to request additional information about the plan contract.

(4) Any other information specified by the department in the template.

(e) Each health care service plan shall provide the department with updates to the information required by subdivision (d) at least annually, or more often if necessary to maintain the accuracy of the information.

(f) The department and the Department of Insurance shall make the comparative benefit matrices available on their respective Internet Web sites and to the health care service plans and health insurers for dissemination as required by Section 1373.6 and Section 12682.1 of the Insurance Code, after confirming the accuracy of the description of the matrices with the health care service plans and health insurers.

(g) As used in this section and Section 1363.07, ''benefit matrix'' shall have the same meaning as benefit summary.

SEC. 2. Section 1363.07 is added to the Health and Safety Code, to read:

1363.07. (a) Each health care service plan shall send copies of the comparative benefit matrix prepared pursuant to Section 1363.06 on an annual basis, or more frequently as the matrix is updated by the

department and the Department of Insurance, to solicitors and solicitor firms and employers with whom the plan contracts.

(b) Each health care service plan shall require its representatives and solicitors and soliciting firms with which it contracts, to provide a copy of the comparative benefit matrix to individuals when presenting any benefit package for examination or sale.

(c) Each health care service plan that maintains an Internet Web site shall make a downloadable copy of the comparative benefit matrix described in Section 1373.06 available through its site and shall ensure that the most current update of the matrix is available on its site.

SEC. 3. Section 1366.27 of the Health and Safety Code is amended to read:

1366.27. (a) The continuation coverage provided pursuant to this article shall terminate at the first to occur of the following:

(1) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event.

(2) The end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the plan contract. In the case of nonpayment of premiums, reinstatement shall be governed by the terms and conditions of the plan contract.

(3) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (1), (3), (4), or (5) of subdivision (d) of Section 1366.21, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

(4) The requirements of this article no longer apply to the qualified beneficiary pursuant to the provisions of Section 1366.22.

(5) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage pursuant to this article, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified beneficiary shall notify the plan, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end

of the original 36-month continuation coverage period in order to be eligible for coverage pursuant to this subdivision. If the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act, the benefits provided in this paragraph shall terminate on the later of the date provided by paragraph (1), or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the United States Social Security Act that the qualified beneficiary is no longer disabled. A qualified beneficiary eligible for 36 months of continuation coverage as a result of a disability shall notify the plan, or the employer or administrator that contracts to perform the notice and administrative services, within 30 days of a determination that the qualified beneficiary is no longer disabled.

(6) In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 1366.21, but who has another qualifying event, as described in paragraph (1), (3), (4), or (5) of subdivision (d) of Section 1366.21, within 36 months of the date of the first qualifying event, and the qualified beneficiary has notified the plan, or the employer or administrator under contract to provide administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

(7) The employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees.

(8) The qualified beneficiary moves out of the plan's service area or the qualified beneficiary commits fraud or deception in the use of plan services.

(b) If the group contract between the plan and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate pursuant to this section, coverage under the prior plan shall terminate and the qualified beneficiary may elect continuation coverage under the subsequent group benefit plan, if any, pursuant to the requirements of subdivision (b) of Section 1366.23 and subdivision (c) of Section 1366.24.

(c) The amendments made to this section by Assembly Bill 1401 of the 2001–02 Regular Session shall apply to individuals who begin receiving continuation coverage under this article on or after January 1, 2003.

SEC. 4. Section 1366.29 is added to the Health and Safety Code, to read:

1366.29. (a) A health care service plan shall offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to

continue coverage for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under COBRA. The health care service plan shall offer coverage pursuant to the terms of this article, including the rate limitations contained in Section 1366.26.

(b) Notification of the coverage available under this section shall be included in the notice of the pending termination of COBRA coverage that is required to be provided to COBRA beneficiaries and that is required to be provided under Section 1366.24.

(c) For purposes of this section, ''COBRA'' means Section 4980B of Title 26 of the United States Code, Sections 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code.

(d) This section shall not apply to specialized health care service plans providing noncore coverage, as defined in subdivision (g) of Section 1366.21.

(e) This section shall become operative on September 1, 2003, and shall apply to individuals who begin receiving COBRA coverage on or after January 1, 2003.

SEC. 5. Section 1373.6 of the Health and Safety Code is amended to read:

1373.6. This section does not apply to a specialized health care service plan contract or to a plan contract that primarily or solely supplements Medicare. The director may adopt rules consistent with federal law to govern the discontinuance and replacement of plan contracts that primarily or solely supplement Medicare.

(a) (1) Every group contract entered into, amended, or renewed on or after September 1, 2003, that provides hospital, medical, or surgical expense benefits for employees or members shall provide that an employee or member whose coverage under the group contract has been terminated by the employer shall be entitled to convert to nongroup membership, without evidence of insurability, subject to the terms and conditions of this section.

(2) If the health care service plan provides coverage under an individual health care service plan contract, other than conversion coverage under this section, it shall offer one of the two plans that it is required to offer to a federally eligible defined individual pursuant to Section 1366.35. The plan shall provide this coverage at the same rate established under Section 1399.805 for a federally eligible defined individual. A health care service plan that is federally qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) may charge a rate for the coverage that is consistent with the provisions of that act.

(3) If the health care service plan does not provide coverage under an individual health care service plan contract, it shall offer a health benefit plan contract that is the same as a health benefit contract offered to a federally eligible defined individual pursuant to Section 1366.35. The health care service plan may offer either the most popular health maintenance organization model plan or the most popular preferred provider organization plan, each of which has the greatest number of enrolled individuals for its type of plan as of January 1 of the prior year, as reported by plans that provide coverage under an individual health care service plan contract to the department or the Department of Insurance by January 31, 2003, and annually thereafter. A health care service plan subject to this paragraph shall provide this coverage with the same cost-sharing terms and at the same premium as a health care service plan providing coverage to that individual under an individual health care service plan contract pursuant to Section 1399.805. The health care service plan shall file the health benefit plan it will offer, including the premium it will charge and the cost-sharing terms of the plan, with the Department of Managed Health Care.

(b) A conversion contract shall not be required to be made available to an employee or member if termination of his or her coverage under the group contract occurred for any of the following reasons:

(1) The group contract terminated or an employer's participation terminated and the group contract is replaced by similar coverage under another group contract within 15 days of the date of termination of the group coverage or the subscriber's participation.

(2) The employee or member failed to pay amounts due the health care service plan.

(3) The employee or member was terminated by the health care service plan from the plan for good cause.

(4) The employee or member knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan.

(5) The employer's hospital, medical, or surgical expense benefit program is self-insured.

(c) A conversion contract is not required to be issued to any person if any of the following facts are present:

(1) The person is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act.

(2) The person is covered by or is eligible for hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured.

(3) The person is covered for similar benefits by an individual policy or contract.

(4) The person has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(d) Benefits of a conversion contract shall meet the requirements for benefits under this chapter.

(e) Unless waived in writing by the plan, written application and first premium payment for the conversion contract shall be made not later than 63 days after termination from the group. A conversion contract shall be issued by the plan which shall be effective on the day following the termination of coverage under the group contract if the written application and the first premium payment for the conversion contract are made to the plan not later than 63 days after the termination of coverage, unless these requirements are waived in writing by the plan.

(f) The conversion contract shall cover the employee or member and his or her dependents who were covered under the group contract on the date of their termination from the group.

(g) A notification of the availability of the conversion coverage shall be included in each evidence of coverage. However, it shall be the sole responsibility of the employer to notify its employees of the availability, terms, and conditions of the conversion coverage which responsibility shall be satisfied by notification within 15 days of termination of group coverage. Group coverage shall not be deemed terminated until the expiration of any continuation of the group coverage. For purposes of this subdivision, the employer shall not be deemed the agent of the plan for purposes of notification of the availability, terms, and conditions of conversion coverage.

(h) As used in this section, ''hospital, medical, or surgical benefits under state or federal law'' do not include benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Title XIX of the United States Social Security Act.

(i) Every group contract entered into, amended, or renewed before September 1, 2003, shall be subject to the provisions of this section as it read prior to its amendment by Assembly Bill 1401 of the 2001–02 Regular Session.

SEC. 6. Section 1373.62 is added to the Health and Safety Code, to read:

1373.62. (a) (1) This section shall apply only to a health care service plan offering hospital, medical, or surgical benefits in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care

service plan conversion contract offered pursuant to Section 1373.6, or a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations shall not be subject to the requirements of this section.

(b) For the purposes of this section, ''program'' means the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code).

(c) (1) Each health care service plan subject to this section shall offer a standard benefit plan. The calendar year limit on benefits under the plan shall be at least two hundred thousand dollars ($200,000), and the lifetime maximum benefit under the plan shall be at least seven hundred fifty thousand dollars ($750,000). No health care service plan is required to provide calendar year benefits or a lifetime maximum benefit under the plan that exceed these limits. In calculating the calendar year and lifetime maximum benefits for any person receiving coverage through a standard benefit plan, the health care service plan shall not include any health care benefits or services that person received while enrolled in the program.

(2) The standard benefit plan of a health care service plan participating in the program shall be the same benefit design it offers through the program, except for the annual limit required under paragraph (1). If the health care service plan offers more than one benefit design in the program, it shall offer only one of those benefit designs as its standard benefit plan.

(3) (A) The standard benefit plan of a health care service plan that is not a participating health plan within the program shall be any one benefit design that is offered through the program by a health care service plan participating in the program, except for the annual limit required under paragraph (1).

(B) A health care service plan that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health insurer that is also an insurer in the individual market may satisfy the requirements of this section and Section 10127.15 of the Insurance Code if either the plan or insurer offers a standard benefit plan.

(C) A health care service plan that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health insurer that is in

the individual market and that is a participating health plan in the program is exempt from the provisions of this section if the insurer meets the requirements of Section 10127.15 of the Insurance Code in offering a standard benefit plan.

(d) (1) A health care service plan may not reject an application for coverage under its standard benefit plan for an individual who meets any of the following criteria: (A) Applies for coverage within 63 days of the termination date of his or her previous coverage under the program if the individual has had continuous coverage under the program for a period of 36 consecutive months.

(B) Has been enrolled in a standard benefit plan, moves to an area within the state that is not in the service area of the health care service plan or health insurer he or she has chosen, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(C) Has been enrolled in standard benefit plan that is no longer available where he or she resides, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(2) Notwithstanding any other provision of this section, a health care service plan is not required by this section to accept an application for coverage under its standard benefit plan for any individual who is eligible for Part A and Part B of Medicare at the time of application and who is not on Medicare solely because of end-stage renal disease.

(e) The amount paid by an individual for the standard benefit plan shall be 110 percent of the contribution the individual would pay in the program for the benefit design providing the same coverage, using the same methodology in effect on July 1, 2002, for calculating the rates in the program. If a health care service plan offers calendar year and lifetime maximum benefits in its standard benefit plan that exceed those in the benefit design offered through the program, it may not increase the amount paid by the individual for the standard benefit plan. The limitation on the amount paid by an individual pursuant to this section for a standard benefit plan shall not apply to any individual who is eligible for Part A and Part B of Medicare and who is not on Medicare solely because of end-stage renal disease.

(f) (1) Prior to offering a health benefit plan contract pursuant to this section, every health care service plan shall file a notice of material modification pursuant to Section 1352. Prior to renewing the contract, the plan shall file an amendment or a notice of material modification, as appropriate, pursuant to Section 1352.

(2) Prior to making any changes in the premium charged for its standard benefit plan, the health care service plan shall file an amendment in accordance with the provisions of Section 1352 and shall

include a statement certifying the plan is in compliance with subdivision (e).

(3) All other changes to a plan contract that was previously filed with the director shall be filed as an amendment in accordance with the provisions of Section 1352, unless the change otherwise would require the filing of a material modification.

(g) (1) Each health care service plan shall report to the Managed Risk Medical Insurance Board the amount it has expended for health care services for individuals covered under a standard benefit plan under this section and the total amount of individual payments it has charged individuals for the standard benefit plan. The board shall establish by regulation the format for these reports. The report shall be prepared for each of the following reporting periods and shall be submitted within 12 months of the final date of the reporting period:

(A) September 1, 2003, to December 31, 2003, inclusive.

(B) January 1, 2004, to December 31, 2004, inclusive.

(C) January 1, 2005, to December 31, 2005, inclusive.

(D) January 1, 2006, to December 31, 2006, inclusive.

(E) January 1, 2007, to August 30, 2007, inclusive.

(2) ''Health care services'' means the aggregate health care expenses paid by the health care service plan or insurer during the reporting period plus the aggregate value of the standard monthly administrative fee. Health care expenses do not include costs that have been incurred but not reported by the health care service plan. The calculation of health care expenses shall be consistent with the methodology used on July 1, 2002, to calculate such expenses for participating health plans in the program. The ''standard monthly administrative fee'' is the average monthly, per person administrative fee paid by the program to participating health plans during the reporting period.

(3) The "total amount of individual payments'' is the aggregate of the monthly individual payments charged by the health care service plan during the reporting period. The calculation of the total amount of individual payments charged shall be consistent with the methodology used on July 1, 2002, to calculate subscriber contributions in the program. The Managed Risk Medical Insurance Board shall by regulation establish the format for submitting documentation of the individual payments.

(4) The Managed Risk Medical Insurance Board may verify the health care expenses incurred by a health care service plan and the individual payments received by the plan. The verification shall include assurance that the individual was enrolled in the standard benefit plan during the reporting period in which the health care service plan paid

health care expenses on the individual's behalf, and that the expenses reported are consistent with the standard benefit plan.

(h) (1) The program shall pay each health care service plan an amount that is equal to one-half of the difference between the total aggregate amount the health care service plan expended for health care services for individuals covered under a standard benefit plan who have had 36 consecutive months of coverage under the program and the total aggregate amount of individual payments charged to those individuals who have had continuous coverage under the program for a period of 36 consecutive months. For purposes of determining the amount the program shall pay each health care service plan, the total aggregate amount the health care service plan expended and the total aggregate amount of individual payments shall not include amounts paid by or on behalf of an individual who is eligible for Medicare Part A and Medicare Part B and who is not on Medicare solely because of end-stage renal disease. The program shall make this payment from the Major Risk Medical Insurance Fund or from any funds appropriated in the annual Budget Act or by another statute to the program for the purposes of this section. The state shall not be liable for any amount in excess of the moneys in the Major Risk Medical Insurance Fund or other funds that were appropriated for the purposes of this section. If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health care service plan, the health care service plan may increase the monthly payments that individuals are required to pay for any standard benefit plan to the amount that the Managed Risk Medical Insurance Board would charge without a state subsidy for the same plan issued to the same individual within the program.

(2) The Managed Risk Medical Insurance Board shall make a biannual interim payment to each health care service plan providing coverage pursuant to this section. For the first two reporting periods described in this section, biannual interim payments shall be calculated for each individual as the product of the average premium in the program for the period of time the individual was enrolled during that reporting period and one-half of the difference between the program's prior calendar year loss ratio and 110 percent. For subsequent reporting periods, the Managed Risk Medical Insurance Board may, by regulation, adopt for each health care service plan a specific method for calculating biannual interim payments based on the plan's actual experience in providing the benefits described in this section. Each health care service plan shall submit a six-month interim report of monthly individual enrollment in its standard benefit plan. The Managed Risk Medical Insurance Board shall make an interim payment to each health care

service plan pursuant to this section no later than 45 days after the receipt of the plan's enrollment reports. Final payment by the board or refund from the health care service plan shall be made upon the completion of verification activities conducted pursuant to this section.

(i) The provisions of this section constitute a pilot program that shall terminate on September 1, 2007.

(j) This section shall become operative on September 1, 2003, and shall become inoperative on September 1, 2007. As of January 1, 2008, this section is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2008, deletes or extends the dates on which this section becomes inoperative and is repealed.

SEC. 7. Section 1373.622 is added to the Health and Safety Code, to read:

1373.622. (a) After the termination of the pilot program under Section 1373.62, a health care service plan shall continue to provide coverage under the same terms and conditions specified in Section 1376.62 as it existed on January 1, 2006, including the terms of the standard benefit plan and the subscriber payment amount, to each individual who was terminated from the program pursuant to subdivision (f) of Section 12725 of the Insurance Code during the term of the pilot program and who enrolled or applied to enroll in a standard benefit plan within 63 days of termination. The Managed Risk Medical Insurance Board shall continue to pay the amount described in Section 1376.62 for each of those individuals. A health care service plan shall not be required to offer the coverage described in Section 1373.62 after the termination of the pilot program to individuals not already enrolled in the program.

(b) If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health care service plan, the health care service plan may increase the monthly payments that its subscribers are required to pay for any standard benefit plan to the amount that the Managed Risk Medical Insurance Board would charge without a state subsidy for the same plan issued to the same individual within the program.

SEC. 8. Section 10113.8 is added to the Insurance Code, to read:

10113.8. (a) Each health insurer that maintains an Internet Web site shall make a downloadable copy of the comparative benefit matrix prepared pursuant to Section 10127.14 available through its site and ensure that the most current update of the matrix is available on its site.

(b) Each health insurer shall send copies of the comparative benefit matrix on an annual basis, or more frequently as the matrix is updated by the department and the Department of Managed Health Care, to solicitors and solicitor firms and employers with whom it contracts.

Each health insurer shall require its representatives and the solicitors and soliciting firms with which it contracts, to provide a copy of the comparative benefit matrix to individuals when presenting any benefit package for examination or sale.

(c) This section shall not apply to accident-only, specified disease, hospital indemnity, CHAMPUS supplement, long-term care, Medicare supplement, dental-only, or vision-only insurance policies.

SEC. 9. Section 10127.14 is added to the Insurance Code, to read:

10127.14. (a) The department and the Department of Managed Health Care shall compile information required by this section and Section 1363.06 of the Health and Safety Code into two comparative benefit matrices. The first matrix shall compare benefit packages offered pursuant to Section 1373.62 of the Health and Safety Code and Section 10127.15. The second matrix shall compare benefit packages offered pursuant to Sections 1366.35, 1373.6, and 1399.804 of the Health and Safety Code and Sections 10785, 10901.2, and 12682.1.

(b) The comparative benefit matrix shall include:

(1) Benefit information submitted by health care service plans pursuant to Section 1363.06 of the Health and Safety Code and by health insurers pursuant to subdivision (d).

(2) The following statements in at least 12-point type at the top of the matrix:

(A) ''This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer.''

(B) ''The comparative benefit summary is updated annually, or more often if necessary to be accurate.''

(C) ''The most current version of this comparative benefit summary is available on (address of the plan's or insurer's site).''

This subparagraph applies only to those health insurers that maintain an Internet Web site.

(3) The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Managed Health Care, as appropriate, for further assistance.

(c) The department and the Department of Managed Health Care shall jointly prepare two standardized templates for use by health care service plans and health insurers in submitting the information required pursuant to subdivision (d) of Section 1363.06 and subdivision (d). The templates shall be exempt from the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Health insurers shall submit the following to the department by January 31, 2003, and annually thereafter:

(1) A summary explanation of the following for each product described in subdivision (a):

(A) Eligibility requirements.

(B) The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside.

(C) When and under what circumstances benefits cease.

(D) The terms under which coverage may be renewed.

(E) Other coverage that may be available if benefits under the described benefit package cease.

(F) The circumstances under which choice in the selection of physicians and providers is permitted.

(G) Lifetime and annual maximums.

(H) Deductibles.

(2) A summary explanation of the following coverages, together with the corresponding copayments and limitations, for each product described in subdivision (a):

(A) Professional services.

(B) Outpatient services.

(C) Hospitalization services.

(D) Emergency health coverage.

(E) Ambulance services.

(F) Prescription drug coverage.

(G) Durable medical equipment.

(H) Mental health services.

(I) Residential treatment.

(J) Chemical dependency services.

(K) Home health services.

(L) Custodial care and skilled nursing facilities.

(3) The telephone number or numbers that may be used by an applicant to access a health insurer customer service representative and to request additional information about the insurance policy.

(4) Any other information specified by the department in the template.

(e) Each health insurer shall provide the department with updates to the information required by subdivision (d) at least annually, or more often if necessary to maintain the accuracy of the information.

(f) The department and the Department of Managed Health Care shall make the comparative benefit matrices available on their respective Internet Web sites and to the health care service plans and health insurers for dissemination as required by Section 1373.6 of the Health and Safety Code and Section 12682.1, after confirming the accuracy of the

description of the matrices with the health insurers and health care service plans.

(g) As used in this section, ‘‘benefit matrix’’ shall have the same meaning as benefit summary.

(h) This section shall not apply to accident-only, specified disease, hospital indemnity, CHAMPUS supplement, long-term care, Medicare supplement, dental-only, or vision-only insurance policies.

SEC. 10. Section 10127.15 is added to the Insurance Code, to read:

10127.15. (a) (1) This section shall apply only to a health insurer offering hospital, medical, or surgical benefits in the individual market in California and shall not apply to accident-only, specified disease, long-term care, CHAMPUS supplement, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies or a health insurance conversion policy issued pursuant to Part 6.1 (commencing with Section 12670) of the Insurance Code.

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations shall not be subject to the requirements of this section.

(b) For the purposes of this section, ‘‘program’’ means the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)).

(c) (1) Each health insurer subject to this section shall offer a standard benefit plan. The calendar year limit on benefits under the plan shall be at least two hundred thousand dollars ($200,000), and the lifetime maximum benefit under the plan shall be at least seven hundred fifty thousand dollars ($750,000). No health insurer is required to provide calendar year benefits or a lifetime maximum benefit under the plan that exceed these limits. In calculating the calendar year and lifetime maximum benefits for any person receiving coverage through a standard benefit plan, the health insurer shall not include any health care benefits or services that person received while enrolled in the program.

(2) The standard benefit plan of a health insurer participating in the program shall be the same benefit design it offers through the program, except for the annual limit required under paragraph (1). If the health insurer offers more than one benefit design in the program, it shall offer only one of those benefit designs as its standard benefit plan.

(3) (A) The standard benefit plan of a health insurer that is not a participating health plan within the program shall be any one benefit design that is offered through the program by a health care service plan

participating in the program except for the annual limit required under paragraph (1).

(B) A health insurer that is not a participating health plan within the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health care service plan that is in the individual market, may satisfy the requirements of this section and Section 1373.62 of the Health and Safety Code if either the plan or insurer offers a standard benefit plan.

(C) A health insurer that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with a health care service plan that is in the individual market and that is a participating health plan in the program is exempt from the provisions of this section if the plan meets the requirements of Section 1373.62 of the Health and Safety Code in offering a standard benefit plan.

(d) (1) A health insurer may not reject an application for coverage under its standard benefit plan for an individual who meets any of the following criteria:

(A) Applies for coverage within 63 days of the termination date of his or her previous coverage under the program if the individual has had continuous coverage under the program for a period of 36 consecutive months.

(B) Has been enrolled in a standard benefit plan, moves to an area within the state that is not in the service area of the health care service plan or health insurer he or she has chosen, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(C) Has been enrolled in standard benefit plan that is no longer available where he or she resides, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(2) Notwithstanding any other provision of this section, a health insurer is not required by this section to accept an application for coverage under its standard benefit plan for any individual who is eligible for Part A and Part B of Medicare at the time of application and who is not on Medicare.

(e) The amount paid by an insured for the standard benefit plan shall be 110 percent of the contribution the insured would pay in the program for the benefit design providing the same coverage, using the same methodology in effect on July 1, 2002, for calculating the rates in the program. If a health insurer offers calendar year and lifetime maximum benefits in its standard benefit plan that exceed those in the benefit design offered through the program, it may not increase the amount paid by the insured for the standard benefit plan. The limitation on the amount paid by an individual pursuant to this section for a standard benefit plan

shall not apply to any individual who is eligible for Part A and Part B of Medicare and who is not on Medicare solely because of end-stage renal disease.

(f) (1) Prior to offering a health insurance policy pursuant to this section, every insurer shall file a notice of any changes pursuant to Section 10290 and to Section 2202 of Title 10 of the California Code of Regulations. Prior to renewing a policy, the insurer shall file an amendment or notice of any changes, as appropriate, pursuant to Section 10290 and to Section 2202 of Title 10 of the California Code of Regulations.

(2) Prior to making any changes in the premium charged for its standard benefit policy, the insurer shall file an amendment in accordance with the provisions of Section 10290 and of Section 2202 of Title 10 of the California Code of Regulations.

(3) All other changes to an insurance policy that were previously filed with the commissioner shall be filed as amendments in accordance with the provisions of Section 10290 and of Section 2202 of Title 10 of the California Code of Regulations.

(g) (1) Each health insurer shall report to the Managed Risk Medical Insurance Board the amount it has expended for health care services for individuals covered under a standard benefit plan under this section and the total amount of insured payments it has charged individuals for the standard benefit plan. The board shall establish by regulation the format for these reports. The report shall be prepared for each of the following reporting periods and shall be submitted within 12 months of the final date of the reporting period:

(A) September 1, 2003, to December 31, 2003, inclusive.

(B) January 1, 2004, to December 31, 2004, inclusive.

(C) January 1, 2005, to December 31, 2005, inclusive.

(D) January 1, 2006, to December 31, 2006, inclusive.

(E) January 1, 2007, to August 30, 2007, inclusive.

(2) ''Health care services'' means the aggregate health care expenses paid by the health insurer during the reporting period plus the aggregate value of the standard monthly administrative fee. Health care expenses do not include costs that have been incurred but not reported by the health insurer. The calculation of health care expenses shall be consistent with the methodology used on July 1, 2002, to calculate such expenses for participating health insurers in the program. The ''standard monthly administrative fee'' is the average monthly, per person administrative fee paid by the program to participating health insurers during the reporting period.

(3) The ''total amount of insured payments'' is the aggregate of the monthly insured payments charged by the health insurer during the

reporting period. The calculation of the total amount of insured payments charged shall be consistent with the methodology used on July 1, 2002, to calculate subscriber contributions in the program. The Managed Risk Medical Insurance Board shall by regulation establish the format for submitting documentation of insured payments.

(4) The Managed Risk Medical Insurance Board may verify the health care expenses incurred by a health insurer and the insured payments received by the insurer. The verification shall include assurance that the insured was covered in the standard benefit plan during the reporting period in which the health insurer paid health care expenses on the insured's behalf, and that the expenses reported are consistent with the standard benefit plan.

(h) (1) The program shall pay each health insurer an amount that is equal to one-half of the difference between the total aggregate amount the health insurer expended for health care services for individuals covered under a standard benefit plan who have had 36 months of continuous coverage under the program and the total aggregate amount of insured payments charged to those individuals who have had continuous coverage under the program for a period of 36 consecutive months. For purposes of determining the amount the program shall pay each health insurer, the total aggregate amount the health insurer expended and the total aggregate amount of individual payments shall not include amounts paid by or on behalf of an individual who is eligible for Medicare Part A and Medicare Part B and who is not on Medicare solely because of end-stage renal disease. The program shall make this payment from the Major Risk Medical Insurance Fund or from any funds appropriated in the annual Budget Act or by another statute to the program for the purposes of this section. The state shall not be liable for any amount in excess of the Major Risk Medical Insurance Fund or other funds that were appropriated for the purposes of this section. If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health insurer, the health insurer may increase the monthly payments that its insureds are required to pay for any standard benefit plan to the amount that the Managed Risk Medical Insurance Board would charge without a state subsidy for the same plan issued to the same individual within the program.

(2) The Managed Risk Medical Insurance Board shall make a biannual interim payment to each health insurer providing coverage pursuant to this section. For the first two reporting periods described in this section, biannual interim payments shall be calculated for each insured as the product of the average premium in the program for that period of time the individual was covered during the reporting period and one-half of the difference between the program's prior calendar year

loss ratio and 110 percent. For subsequent reporting periods, the Managed Risk Medical Insurance Board may, by regulation, adopt for each health insurer a specific method for calculating biannual interim payments based on the insurer's actual experience in providing the benefits described in this section. Each health insurer shall submit a six-month interim report of monthly insured enrollment in its standard benefit plan. The Managed Risk Medical Insurance Board shall make an interim payment to each health insurer pursuant to this section no later than 45 days after receipt of the insurer's coverage reports. Final payment by the board or refund from the insurer shall be made upon the completion of verification activities conducted pursuant to this section.

(i) The provisions of this section constitute a pilot program that shall terminate on September 1, 2007.

(j) This section shall become operative on September 1, 2003, and shall become inoperative on September 1, 2007. As of January 1, 2008, this section is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2008, deletes or extends the date on which the section becomes inoperative and is repealed.

SEC. 11. Section 10127.16 is added to the Insurance Code, to read:

10127.16. (a) After the termination of the pilot program under Section 10127.15, a health insurer shall continue to provide coverage under the same terms and conditions specified in Section 10127.15 as it existed on January 1, 2006, including the terms of the standard benefit plan and the subscriber payment amount, to each individual who was terminated from the program, pursuant to subdivision (f) of Section 12725 of the Insurance Code during the term of the pilot program and who enrolled or applied to enroll in a standard benefit plan within 63 days of termination. The Managed Risk Medical Insurance Board shall continue to pay the amount described in Section 10127.15 for each of those individuals. A health insurer shall not be required to offer the coverage described in Section 10127.15 after the termination of the pilot program to individuals not already enrolled in the program.

(b) If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health insurer, the health insurer may increase the monthly payments that its subscribers are required to pay for any standard benefit plan to the amount that the Managed Risk Medical Insurance Board would charge without a state subsidy for the same insurance product issued to the same individual within the program.

SEC. 12. Section 10128.57 of the Insurance Code is amended to read:

10128.57. (a) The continuation coverage provided pursuant to this article shall terminate at the first to occur of the following:

(1) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 10128.51, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event.

(2) The end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the policy or contract. In the case of nonpayment of premiums, reinstatement shall be governed by the terms and conditions of the plan contract.

(3) In the case of a qualified beneficiary who is eligible to continuation coverage pursuant to paragraph (1), (3), (4), or (5) of subdivision (d) of Section 10116.51, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated by reason of a qualifying event.

(4) The requirements of this article no longer apply to the qualified beneficiary pursuant to the provisions of Section 10128.52.

(5) In the case of a qualified beneficiary who is eligible for continuation coverage pursuant to paragraph (2) of subdivision (d) of Section 10128.51, and determined, under Title II or Title XVI of the Social Security Act, to be disabled any time during the first 60 days of continuation coverage, and the spouse or dependent who has elected coverage pursuant to this article, the date 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified beneficiary shall notify the insurer, or the employer or administrator that contracts to perform administrative services, of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period in order to be eligible for coverage pursuant to this subdivision. If the qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act, the benefits provided in this paragraph shall terminate on the later of the date provided by paragraph (1), or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the United States Social Security Act that the qualified beneficiary is no longer disabled. A qualified beneficiary eligible for 36 months of continuation coverage as a result of a disability shall notify the insurer, or the employer or administrator that contracts to perform the notice and administrative services, within 30 days of a determination that the qualified beneficiary is no longer disabled.

(6) In the case of a qualified beneficiary who is initially eligible for and elects continuation coverage pursuant to paragraph (2) of

subdivision (d) of Section 10128.51, but who has another qualifying event, as described in paragraph (1), (3), (4), or (5) of subdivision (d) of Section 10128.51, within 36 months of the date of the first qualifying event, and has notified the insurer, or employer or administrator under contract to provide administrative services, of the second qualifying event within 60 days of the date of the second qualifying event, the date 36 months after the date of the first qualifying event.

(7) The employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees.

(8) The qualified beneficiary moves out of the insurer's service area, or the qualified beneficiary commits fraud or deception in the use of benefits.

(b) If the group benefits contracts between the insurer and the employer is terminated prior to the date the qualified beneficiary's continuation coverage would terminate pursuant to this section, coverage under the prior plan shall terminate and the qualified beneficiary may elect continuation coverage under the subsequent group benefit plan, if any, pursuant to the requirements of subdivision (b) of Section 10128.53 and subdivision (c) of Section 10128.54.

(c) The amendments made to this section by Assembly Bill 1401 of the 2001–02 Regular Session shall apply to individuals who begin receiving continuation coverage under this article on or after January 1, 2003.

SEC. 13. Section 10128.59 is added to the Insurance Code, to read:

10128.59. (a) A health insurer that provides coverage under a group benefit plan to an employer shall offer an insured who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the insured's continuation coverage began if the insured is entitled to less than 36 months of continuation coverage under COBRA. The health insurer shall offer coverage pursuant to terms of this article, including the rate limitations contained in Section 10128.56.

(b) Notification of the coverage available under this section shall be included in the notice of the pending termination of COBRA coverage that is required to be provided to COBRA beneficiaries and that is required to be provided under Section 10128.54.

(c) For purposes of this section, ''COBRA'' means Section 4980B of Title 26 of the United States Code, Sections 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code.

(d) This section shall not apply to accident-only, specified disease, hospital indemnity, CHAMPUS supplement, long-term care, Medicare supplement, dental-only, or vision-only insurance policies.

(e) This section shall become operative on September 1, 2003, and shall apply to individuals who begin receiving COBRA coverage on or after January 1, 2003.

SEC. 14. Section 12682.1 is added to the Insurance Code, to read:

12682.1. This section does not apply to a policy that primarily or solely supplements Medicare. The commissioner may adopt rules consistent with federal law to govern the discontinuance and replacement of plan policies that primarily or solely supplement Medicare.

(a) (1) Every group policy entered into, amended, or renewed on or after September 1, 2003, that provides hospital, medical, or surgical expense benefits for employees or members shall provide that an employee or member whose coverage under the group policy has been terminated by the employer shall be entitled to convert to nongroup membership, without evidence of insurability, subject to the terms and conditions of this section.

(2) If the health insurer provides coverage under an individual health insurance policy, other than conversion coverage under this part, it shall offer one of the two health insurance policies that the insurer is required to offer to a federally eligible defined individual pursuant to Section 10785. The health insurer shall provide this coverage at the same rate established under Section 10901.3 for a federally eligible defined individual.

(3) If the health insurer does not provide coverage under an individual health insurance policy, it shall offer a health benefit plan contract that is the same as a health benefit contract offered to a federally eligible defined individual pursuant to Section 1366.35. The health insurer shall offer the most popular preferred provider organization plan that has the greatest number of enrolled individuals for its type of plan as of January 1 of the prior year, as reported by plans by January 31, 2003, and annually thereafter, that provide coverage under an individual health care service plan contract to the department or the Department of Managed Health Care. A health insurer subject to this paragraph plan shall provide this coverage with the same cost-sharing terms and at the same premium as a health care service plan providing coverage to that individual under an individual health care service plan contract pursuant to Section 1399.805. The health insurer shall file the health benefit plan contract it will offer, including the premium it will charge and the cost-sharing terms of the contract, with the Department of Insurance.

(b) A conversion policy shall not be required to be made available to an employee or insured if termination of his or her coverage under the group policy occurred for any of the following reasons:

(1) The group policy terminated or an employer's participation terminated and the insurance is replaced by similar coverage under another group policy within 15 days of the date of termination of the group coverage or the employer's participation.

(2) The employee or insured failed to pay amounts due the health insurer.

(3) The employee or insured was terminated by the health insurer from the policy for good cause.

(4) The employee or insured knowingly furnished incorrect information or otherwise improperly obtained the benefits of the policy.

(5) The employer's hospital, medical, or surgical expense benefit program is self-insured.

(c) A conversion policy is not required to be issued to any person if any of the following facts are present:

(1) The person is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act.

(2) The person is covered by or is eligible for hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured.

(3) The person is covered for similar benefits by an individual policy or contract.

(4) The person has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(d) Benefits of a conversion policy shall meet the requirements for benefits under this chapter.

(e) Unless waived in writing by the insurer, written application and first premium payment for the conversion policy shall be made not later than 63 days after termination from the group. A conversion policy shall be issued by the insurer which shall be effective on the day following the termination of coverage under the group contract if the written application and the first premium payment for the conversion contract are made to the insurer not later than 63 days after the termination of coverage, unless these requirements are waived in writing by the insurer.

(f) The conversion policy shall cover the employee or insured and his or her dependents who were covered under the group policy on the date of their termination from the group.

(g) A notification of the availability of the conversion coverage shall be included in each evidence of coverage or other legally required document explaining coverage. However, it shall be the sole

responsibility of the employer to notify its employees of the availability, terms, and conditions of the conversion coverage which responsibility shall be satisfied by notification within 15 days of termination of group coverage. Group coverage shall not be deemed terminated until the expiration of any continuation of the group coverage. For purposes of this subdivision, the employer shall not be deemed the agent of the insurer for purposes of notification of the availability, terms, and conditions of conversion coverage.

(h) As used in this section, ''hospital, medical, or surgical benefits under state or federal law'' do not include benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Title XIX of the United States Social Security Act.

(i) This section shall become operative on September 1, 2003.

SEC. 15. Section 12711 of the Insurance Code is amended to read:

12711. The board shall have the authority:

(a) To determine the eligibility of applicants.

(b) To determine the major risk medical coverage to be provided program subscribers.

(c) To research and assess the needs of persons not adequately covered by existing private and public health care delivery systems and promote means of assuring the availability of adequate health care services.

(d) To approve subscriber contributions, and plan rates, and establish program contribution amounts.

(e) To provide major risk medical coverage for subscribers or to contract with a participating health plan or plans to provide or administer major risk medical coverage for subscribers.

(f) To authorize expenditures from the fund to pay program expenses which exceed subscriber contributions.

(g) To contract for administration of the program or any portion thereof with any public agency, including any agency of state government, or with any private entity.

(h) To issue rules and regulations to carry out the purposes of this part.

(i) To authorize expenditures from the fund or from other moneys appropriated in the annual Budget Act for purposes relating to Section 10127.15 of this code or Section 1373.62 of the Health and Safety Code.

(j) To exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed upon it under this part.

SEC. 16. Section 12712.5 is added to the Insurance Code, to read:

12712.5. (a) For the period commencing on September 1, 2003, to September 1, 2007, inclusive, the board shall maintain the major risk

medical coverage benefits offered by participating health plans in the program at a level that is not less than the actuarial equivalent of the minimum benefits available within the program on September 1, 2002.

(b) This section shall become operative on September 1, 2003, and shall become inoperative on September 1, 2007. As of January 1, 2008, this section is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2008, deletes or extends the dates on which the section becomes inoperative and is repealed.

SEC. 17. Section 12725 of the Insurance Code is amended to read:

12725. (a) Each resident of the state meeting the eligibility criteria of this section and who is unable to secure adequate private health coverage is eligible to apply for major risk medical coverage through the program. For these purposes, ''resident'' includes a member of a federally recognized California Indian tribe.

(b) To be eligible for enrollment in the program, an applicant shall have been rejected for health care coverage by at least one private health plan. An applicant shall be deemed to have been rejected if the only private health coverage that the applicant could secure would do one of the following:

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

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

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

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

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

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

(f) For the period commencing September 1, 2003, to September 1, 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 September 1, 2007.

SEC. 18. Section 12739 of the Insurance Code is amended to read:

12739. (a) There is hereby created in the State Treasury a special fund known as the Major Risk Medical Insurance Fund that is, notwithstanding Section 13340 of the Government Code, 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.

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

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

SEC. 19. Section 12739.1 of the Insurance Code is amended to read:

12739.1. Except as provided in Section 12739.2, the board shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions, and to cover expenses relating to Section 10127.15, or to Section 1373.62 of the Health and Safety Code. The board shall determine the amount of funds expended for each of these purposes, taking into consideration the requirements of this part, Section 10127.15, and Section 1373.62 of the Health and Safety Code.

SEC. 20. Section 12739.2 of the Insurance Code is amended to read:

12739.2. From money appropriated by the Legislature to the fund, the board may expend sufficient funds to carry out the purposes of this part and of Section 10127.15 and Section 1373.62 of the Health and Safety Code.

However, the state shall not be liable beyond the assets of the fund for any obligations incurred, or liabilities sustained, in the operation of the California Major Risk Medical Insurance Program or for the

expenditures described in Section 10127.15 and Section 1373.62 of the Health and Safety Code.

SEC. 21. The Managed Risk Medical Insurance Board, the Department of Managed Health Care, and the Department of Insurance shall have the authority to issue rules and to adopt regulations to implement the provisions of this act and to exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed upon it under this act. Until July 1, 2004, any rules and regulations issued by the board pertaining to the implementation of this act 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 and one readoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare and shall be exempt from review by the Office of Administrative Law. Any emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and shall remain in effect for no more than 180 days. The regulations shall become effective immediately upon filing with the Secretary of State.

SEC. 22. (a) The Legislative Analyst shall study and evaluate the provisions of this act, including the pilot program described in Section 1373.62 of the Health and Safety Code and Section 10127.15 of the Insurance Code, to determine their effectiveness in providing coverage to individuals who are otherwise unable to obtain health benefits and the act's impact on the accessibility and affordability of health benefits. The evaluation shall include, based on information provided by the Managed Risk Medical Insurance Board, health care service plans and health insurers, all of the following:

(1) The number, age, and gender of individuals receiving coverage under the California Major Risk Medical Insurance Program pursuant to the provisions of this act by calendar year compared with the enrollment in the program in the four calendar years prior to the enactment of this act.

(2) The number, age, and gender of individuals receiving coverage under the provisions of this act after leaving the California Major Risk Medical Insurance Program.

(3) The number, age, and gender of individuals receiving conversion coverage under the provisions of this act.

(4) The number, age, and gender of individuals receiving Cal-COBRA coverage under the provisions of this act.

(5) The number, age, and gender of individuals receiving coverage under the provisions of the Health Insurance Portability and Accountability Act of 1996 and the provisions of Article 4.6 (commencing with Section 1366.35) and Article 10.5 (commencing with Section 1399.801) of Chapter 2.2 of Division 2 of the Health and Safety Code, and the provisions of Chapter 8.5 (commencing with Section 10785) and Chapter 9.5 (commencing with Section 10900) of Part 2 of Division 2 of the Insurance Code, and Section 10844 of the Insurance Code.

(6) Whether the cost of coverage under the California Major Risk Medical Insurance Program and for individuals leaving the program for guaranteed issue coverage should be changed.

(7) Whether the level of benefits provided under the California Major Risk Medical Insurance Program and for individuals leaving the program for guaranteed issue coverage should be changed.

(8) The effect of this act on the affordability and accessibility of health insurance in the health insurance market for individuals receiving coverage under this act.

(b) The Legislative Analyst shall report the results of the study and evaluation to the appropriate policy and fiscal committees of the Legislature on or before October 30, 2005, and shall include in the report any recommendations for changes to the pilot program, including whether it should continue beyond its designated termination date.

SEC. 23. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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