

AMENDED IN ASSEMBLY APRIL 23, 2012

AMENDED IN ASSEMBLY APRIL 10, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1921**

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**Introduced by Assembly Member Hill**

February 22, 2012

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An act to add and repeal Article 4.4 (commencing with Section 1366.10) of Chapter 2.2 of Division 2 of the Health and Safety Code, and to add and repeal Chapter 8.3 (commencing with Section 10760) of Part 2 of Division 2 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1921, as amended, Hill. Health insurance: transitional reinsurance program.

Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. A willful violation of provisions governing health care service plans is a crime. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. Existing federal law, the Patient Protection and Affordable Care Act, provides for implementation of certain reforms relative to health care coverage.

This bill, until January 1, 2018, would establish a transitional reinsurance program for health plans *to be jointly administered by the Department of Insurance and the Department of Managed Health Care*, and require participation by health care service plans and health insurers. The bill would require the Insurance Commissioner *and the Director of the Department of Managed Health Care* to jointly select a

reinsurance entity, which would collect payments from contributing health plans and the United States Department of Health and Human Services on behalf of self-insured group plans and pay claims, as specified. The bill would authorize the commissioner and the Director of Managed Health Care to take various actions to implement the program. *The bill would also authorize the Director of the Department of Managed Health Care to opt out of administration of the program and defer to the Department of Insurance.* The bill would require contributing entities to make payments to the reinsurance entity no earlier than October 1, 2013, and would provide for the reinsurance entity to pay claims to a reinsurance-eligible recipient no earlier than January 1, 2014, with payments and claims to cease on December 31, 2016, except for necessary adjustments. Because a willful violation of the bill’s provisions with respect to health care service plans would be a crime, this bill would impose a state-mandated local program.

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

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

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

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

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

4  
 5 Article 4.4. Reinsurance

6  
 7 1366.10. For purposes of this article, the following terms have  
 8 the following meanings:

9 (a) “Applicable reinsurance entity” means a nonprofit entity  
 10 that carries out the duties as described in Section 10760.5 of the  
 11 Insurance Code.

12 (b) “Attachment point” means the threshold dollar amount of  
 13 costs incurred by a contributing entity for payment of health  
 14 benefits provided to an enrolled individual, after which threshold  
 15 the costs for health benefits are eligible for reinsurance payments.

1 (c) “Benefit year” means a calendar year for which a health plan  
2 provides coverage for health benefits.

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

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

13 (f) “Contributing entity” means ~~the following: an entity licensed~~  
14 ~~as a health care service plan by the department; however, no~~  
15 ~~contributing entity shall have to make contributions on behalf of~~  
16 ~~plans that consists solely of excepted benefits, as defined in the~~  
17 ~~federal Public Health Service Act (42 U.S.C. Sec. 300gg-91(e))~~  
18 *department.*

19 (g) “Covered individual claim” means a properly documented  
20 claim submitted by a reinsurance-eligible recipient for a reinsurance  
21 payment from the transitional reinsurance program.

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

27 (i) “Grandfathered health plan” shall have the meaning set forth  
28 in Section 1251 of ~~the~~ PPACA.

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

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

1 (l) “Reinsurance contribution payment” means the required  
 2 payment by any contributing entity to the applicable reinsurance  
 3 entity, as further defined by regulation.

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

7 (n) “Reinsurance-eligible recipient” means, for purposes of the  
 8 transitional reinsurance program, the issuer of any health *care*  
 9 *service* plan or health insurance coverage offered in the California  
 10 individual market that is not a grandfathered *health* plan, a plan  
 11 consisting solely of excepted benefits as defined in the federal  
 12 Public Health Service Act (42 U.S.C. Sec. 300gg-91(c)), or a plan  
 13 provided in the Medi-Cal program (Chapter 7 (commencing with  
 14 Section 14000) of Part 3 of Division 9 of the Welfare and  
 15 Institutions Code), or Medicare plans to the extent consistent with  
 16 PPACA.

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

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

29 1366.11. The director and the Insurance Commissioner may  
 30 jointly modify the federal reinsurance benefits and payment  
 31 parameters by issuing a California-specific notice of benefits and  
 32 payment parameters by March 1 of the year prior to the benefit  
 33 year.

34 The notice shall contain at least both of the following:

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

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

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

4 1366.12. (a) A contributing entity that is licensed by the  
5 department shall be required to do all of the following, *except on*  
6 *behalf of plans or coverage that consist solely of excepted benefits*  
7 *as defined in the federal Public Health Service Act (42 U.S.C. Sec.*  
8 *300gg-91(c)) or on behalf of a plan provided in the Medi-Cal*  
9 *program (Chapter 7 (commencing with Section 14000) of Part 3*  
10 *of Division 9 of the Welfare and Institutions Code) or Medicare*  
11 *plans to the extent consistent with PPACA:*

12 (1) Make payments to the applicable reinsurance entity  
13 according to the procedures established by ~~the PPACA or state~~  
14 ~~regulations~~ *any state or federal regulations, rules, or guidance*  
15 *issued consistent with that law.*

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

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

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

23 (1) Submit documentation on covered individual claims to the  
24 applicable reinsurance entity in a format as established by any  
25 federal benefit or payment parameters or any California-specific  
26 benefit and payments parameters.

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

30 (3) Comply with any additional requirements as established by  
31 ~~the PPACA, state regulations~~ *or any state or federal regulations,*  
32 *rules, or guidance issued consistent with that law, or any*  
33 *California-specific reinsurance benefit and payment parameters.*

34 1366.13. The director may issue orders to a contributing entity  
35 licensed by the department whenever the director determines that  
36 it is reasonably necessary to ensure compliance with Section  
37 1366.12. A licensee to which an order pursuant to this section is  
38 issued may, within 15 days of receipt of that order, request a  
39 hearing at which the licensee may challenge the order.

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

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

15 (c) The director may adopt regulations in accordance with the  
 16 Administrative Procedure Act (Chapter 3.5 (commencing with  
 17 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
 18 Code) to implement this article. The department shall consult with  
 19 the Insurance Commissioner in adopting necessary regulations.  
 20 For purposes of Chapter 3.5 (commencing with Section 11340) of  
 21 Part 1 of Division 3 of Title 2 of the Government Code, including  
 22 Section 11349.6 of the Government Code, the adoption or  
 23 amendment of the regulations required to be adopted pursuant to  
 24 this article is an emergency and shall be considered by the Office  
 25 of Administrative Law as necessary for the immediate preservation  
 26 of the public peace, health and safety, and general welfare.

27 1366.15. This article shall remain in effect only until January  
 28 1, 2018, and as of that date is repealed, unless a later enacted  
 29 statute, that is enacted before January 1, 2018, deletes or extends  
 30 that date.

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

33  
 34 CHAPTER 8.3. REINSURANCE  
 35

36 10760. For purposes of this chapter, the following terms have  
 37 the following meanings:

38 (a) “Applicable reinsurance entity” means a nonprofit entity  
 39 that carries out the duties as described in Section 10760.5.

1 (b) “Attachment point” means the threshold dollar amount of  
2 costs incurred by a contributing entity for payment of health  
3 benefits provided to an individual, after which threshold the costs  
4 for health benefits are eligible for reinsurance payments.

5 (c) “Benefit year” means a calendar year for which a health plan  
6 provides coverage for health benefits.

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

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

17 (f) “Contributing entity” means ~~the following:~~ an insurer  
18 licensed by the commissioner to offer ~~individual or group disability~~  
19 ~~coverage providing hospital, medical, or surgical benefits within~~  
20 ~~the meaning of health insurance as defined in~~ subdivision (b) of  
21 Section 106; ~~however, no contributing entity shall have to make~~  
22 ~~contributions with respect to any insurance coverage that consists~~  
23 ~~solely of excepted benefits, as defined in the federal Public Health~~  
24 ~~Service Act (42 U.S.C. Sec. 300gg-91(e)).~~

25 (g) “Covered individual claim” means a properly documented  
26 claim submitted by a reinsurance-eligible recipient for a reinsurance  
27 payment from the transitional reinsurance program.

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

33 (i) “Grandfathered health plan” shall have the meaning set forth  
34 in Section 1251 of ~~the~~ PPACA.

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

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

8 (l) “Reinsurance contribution payment” means the required  
9 payment by any contributing entity to the applicable reinsurance  
10 entity, as further defined by regulation.

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

14 (n) “Reinsurance-eligible recipient” means, for purposes of the  
15 transitional reinsurance program, the issuer of any ~~health plan or~~  
16 health insurance coverage offered in the California individual  
17 market that is not a grandfathered *health plan or coverage*  
18 *consisting solely of excepted benefits, as defined in the federal*  
19 *Public Health Service Act (42 U.S.C. Sec. 300gg-91(c)), or*  
20 *coverage provided in the Medi-Cal program (Chapter 7*  
21 *(commencing with Section 14000) of Part 3 of Division 9 of the*  
22 *Welfare and Institutions Code) or Medicare coverage to the extent*  
23 *consistent with PPACA.*

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

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

36 10760.5. (a) There shall be established a California  
37 Transitional Reinsurance Program, *which shall be jointly*  
38 *administered by the Department of Insurance and the Department*  
39 *of Managed Health Care, in which contributing entities are*  
40 *required to make payments to the applicable reinsurance entity,*

1 and reinsurance-eligible recipients will receive reinsurance  
2 payments for covered individual claims. Based upon a competitive  
3 bidding process, the Insurance Commissioner *and the Director of*  
4 *the Department of Managed Health Care* shall jointly select the  
5 applicable reinsurance entity.

6 (b) *Notwithstanding subdivision (a), the Director of the*  
7 *Department of Managed Health Care shall have the option to opt*  
8 *out of the administration of a portion of, or all of, the program*  
9 *and instead defer to the Department of Insurance.*

10 10761. The Insurance Commissioner and the Director of  
11 Managed Health Care may jointly modify the federal reinsurance  
12 benefits and payment parameters by issuing a California-specific  
13 notice of benefits and payment parameters by March 1 of the year  
14 prior to the benefit year.

15 The notice shall contain at least both of the following:

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

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

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

25 10761.5. The applicable reinsurance entity selected pursuant  
26 to the procedures in Section 10760.5 shall have all of the following  
27 duties:

28 (a) Collect reinsurance contributions from contributing entities  
29 and from the United States Department of Health and Human  
30 Services on behalf of self-insured group plans.

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

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

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

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

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

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

6 (h) Maintain a complete accounting of collections from  
 7 contributing entities, payments to reinsurance-eligible recipients  
 8 and its own administrative expenses, and make timely reports of  
 9 the accounting to the commissioner and the Director of the  
 10 Department of Managed Health Care in a format and on a schedule  
 11 to be established by regulation.

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

14 (j) Any other duties as further defined by ~~the PPACA, state~~  
 15 ~~regulations, state or federal regulations, rules, or guidance issued~~  
 16 *consistent with that law*, or any California-specific reinsurance  
 17 and benefit payment parameters.

18 10761.7. Records relating to claims data, reinsurance  
 19 contributions and payments, remittances to the United States  
 20 Treasury, and those pertaining to the administrative expenses of  
 21 the applicable reinsurance entity shall be maintained by the  
 22 applicable reinsurance entity for a period of 10 years following  
 23 the termination of the last applicable benefit year of the transitional  
 24 reinsurance program, as further defined by ~~the PPACA or state~~  
 25 ~~regulations~~. Those records shall be available to the Commissioner  
 26 and the Director of the Department of Managed Health Care for  
 27 inspection. The applicable reinsurance entity shall adhere at all  
 28 times to the confidentiality requirements in the maintenance of  
 29 those records as established in the federal Health Insurance  
 30 Portability and Accountability Act of 1996 (HIPAA) and the  
 31 Confidentiality of Medical Information Act (Part 2.6 (commencing  
 32 with Section 56) of Division 1 of the Civil Code).

33 10762. (a) A contributing entity that is licensed by the  
 34 commissioner shall be required to do all of the following, *except*  
 35 *on behalf of policies or coverage that consist solely of excepted*  
 36 *benefits as defined in the federal Public Health Service Act (42*  
 37 *U.S.C. Sec. 300gg-91(c)) or on behalf of coverage provided in the*  
 38 *Medi-Cal program (Chapter 7 (commencing with Section 14000)*  
 39 *of Part 3 of Division 9 of the Welfare and Institutions Code) or on*  
 40 *behalf of Medicare coverage to the extent consistent with PPACA:*

1 (1) Make payments to the applicable reinsurance entity  
2 according to the procedures established by ~~the PPACA or state~~  
3 ~~regulations~~ *state or federal regulations, rules, or guidance issued*  
4 *consistent with that law.*

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

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

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

13 (1) Submit documentation on covered individual claims to the  
14 applicable reinsurance entity in a format as established by any  
15 federal benefit or payment parameters or any California-specific  
16 benefit and payments parameters.

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

20 (3) Comply with any additional requirements as established by  
21 ~~the PPACA, state regulations,~~ *state or federal regulations, rules,*  
22 *or guidance issued consistent with that law,* or any  
23 California-specific reinsurance benefit and payment parameters.

24 10763. The commissioner may issue orders to a contributing  
25 entity that is a health insurer regulated by this code whenever the  
26 commissioner determines that it is reasonably necessary to ensure  
27 compliance with Section 10762. A health insurer to which an order  
28 pursuant to this section is issued may, within 15 days of receipt of  
29 that order, request a hearing at which the licensee may challenge  
30 the order.

31 10764. (a) This chapter shall be effective on January 1, 2013,  
32 for purposes of selecting an applicable reinsurance entity and  
33 adopting regulations, including emergency regulations to  
34 implement the transitional reinsurance program; however, no  
35 contributing entity shall be required to remit any payment to the  
36 applicable reinsurance entity before October 1, 2013, and no  
37 payment to a reinsurance-eligible recipient shall occur before  
38 January 1, 2014.

39 (b) The applicable reinsurance entity shall cease requiring  
40 collections from contributing entities and making payments to

1 reinsurance-eligible recipients after December 31, 2016, except  
2 to require adjustments relating to any final reconciliation of  
3 collections, and payments. The transitional reinsurance program  
4 shall fully terminate on January 1, 2018.

5 (c) The commissioner may adopt regulations in accordance with  
6 the Administrative Procedure Act (Chapter 3.5 (commencing with  
7 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
8 Code) to implement this chapter. The commissioner shall consult  
9 with the Department of Managed Health Care in adopting necessary  
10 regulations. For purposes of Chapter 3.5 (commencing with Section  
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
12 including Section 11349.6 of the Government Code, the adoption  
13 or amendment of the regulations required to be adopted pursuant  
14 to this chapter is an emergency and shall be considered by the  
15 Office of Administrative Law as necessary for the immediate  
16 preservation of the public peace, health and safety, and general  
17 welfare.

18 10765. This chapter shall remain in effect only until January  
19 1, 2018, and as of that date is repealed, unless a later enacted  
20 statute, that is enacted before January 1, 2018, deletes or extends  
21 that date.

22 SEC. 3. No reimbursement is required by this act pursuant to  
23 Section 6 of Article XIII B of the California Constitution because  
24 the only costs that may be incurred by a local agency or school  
25 district will be incurred because this act creates a new crime or  
26 infraction, eliminates a crime or infraction, or changes the penalty  
27 for a crime or infraction, within the meaning of Section 17556 of  
28 the Government Code, or changes the definition of a crime within  
29 the meaning of Section 6 of Article XIII B of the California  
30 Constitution.