

**Analysis of State Legislation Implementing
Affordable Care Act Insurance Market Reforms**

**SB 961 (Hernandez) Amended April 9, 2012
AB 1461 (Monning) Amended April 9, 2012**

PURPOSE

SB 961 and AB 1461 are identical bills implementing individual and small group insurance market reforms contained in the federal Patient Protection and Affordable Care Act (ACA, Public Law 111-148) regarding guaranteed issue, modified community rating and limited enrollment periods. The two bills will be referred to in this analysis as “the legislation.”

SUMMARY

The legislation would enact various provisions implementing ACA insurance market reforms, including the following:

- Beginning in 2014, would prohibit health care service plans and insurers from imposing any group or individual contract provision excluding coverage for pre-existing medical conditions.
- Beginning in 2014, would require health care service plans and insurers that offer individual coverage to issue coverage to all otherwise eligible individuals that apply for that coverage, regardless of health status.
- Beginning in 2014, would require health care service plans and insurers to use only age, geographic region and family size factors when establishing premium rates for individual coverage.
- Beginning in 2014, would require health care service plans and insurers to limit enrollment to initial and annual open enrollment periods and special enrollment periods resulting from triggering events, such as loss of coverage, marriage, birth, adoption or court order.
- Would specify that ACA grandfathered plans are not subject to the legislation’s insurance market reform provisions.

RECOMMENDED POSITION: SUPPORT

The legislation would significantly increase the number of Californians that are able to access affordable and comprehensive health care coverage, including currently uninsurable individuals with pre-existing conditions. Such an expansion would advance the Managed Risk Medical Insurance Board’s (MRMIB) mission and legislative principles regarding the Major Risk Medical Insurance Program (MRMIP) and individuals with pre-existing conditions.

BACKGROUND

California's Individual Health Care Market

A recent report from the California Health Interview Survey (CHIS) indicates that 1 million working adults were covered in state's individual insurance market in 2009. CHIS reports that individuals who purchase coverage in the individual market are significantly more likely to report that they are in excellent or very good health. In contrast, uninsured individuals are the least likely to report good health and the most likely to report fair or poor health. This is not surprising, given that, under current California law, health care plans and insurers are able to deny coverage to individuals with pre-existing conditions.

Individuals who are denied coverage based on pre-existing conditions are currently able to enroll in the state-funded MRMIP or the federally-funded Pre-Existing Condition Insurance Plan (PCIP), both administered by MRMIB. Unfortunately, MRMIP is expensive and includes annual and lifetime benefit limits. Although PCIP is significantly more affordable, the program will conclude in 2014, and the state must then transition individuals into California's Health Benefit Exchange thereafter. Together, MRMIP and PCIP provide coverage for approximately 16,000 individuals.

The Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed the ACA into law. The ACA includes several significant reforms to the private insurance market to take effect beginning in 2014, including the following:

- Requires most U.S. citizens to obtain health care coverage. This is often referred to as the "individual mandate." Those individuals who do not obtain coverage will be assessed an annual penalty.
- Creates state-based health benefit exchanges through which U.S. citizens and legal residents can purchase coverage and, if eligible, receive income-based premium and cost-sharing tax credits. Refundable premium credits will be available for eligible individuals and families with incomes between 133 and 400 percent of the Federal Poverty Level (currently \$26,030 to \$80,120 for a family of four).
- Requires health care coverage to be offered to all individuals regardless of health status. This is often referred to as guaranteed issue.
- Prohibits health care coverage from including any provision excluding coverage for pre-existing conditions.

- Requires premium rates for health care coverage to vary based only on age (limited to 3 to 1 ratio), geographic location, family size and tobacco use (limited to 1.5 to 1 ratio).
- Requires health care coverage to offer at least a minimum level of coverage determined by the state to be essential health benefits under the ACA.
- Defines grandfathered plans as those in which an individual was enrolled prior to March 23, 2010, and exempts them from various provisions, including community rating and essential health benefits.

Court Challenge of the Individual Mandate

The Supreme Court of the United States heard oral arguments from March 26 to 28, 2012, regarding the constitutionality of two provisions of the ACA. The Court is expected to issue a decision in June of this year.

The Court is specifically considering the following issues:

- The constitutionality of the individual mandate.
- The severability of the mandate from other provisions of the ACA.
- The constitutionality of the Medicaid expansions.

If the individual mandate is found to be unconstitutional and the guaranteed issue, community rating and pre-existing condition exclusion provisions of this legislation are enacted, there is a concern that California's health care service plans and health insurers would be subject to unmanageable levels of adverse selection. Many experts believe that if carriers are no longer allowed to deny coverage, charge higher premiums for sick individuals or exclude coverage for pre-existing conditions, premiums will increase in order to cover the claims costs associated with newly insured high risk individuals. This could cause many healthy individuals to exit the market altogether and premiums to spiral upward.¹ The individual mandate was designed to mitigate these risks.

If the court strikes down the law in whole or in part, many of the provisions of health care reform could be enacted by the states, as in Massachusetts, where there is an individual mandate and guaranteed issue.

LEGISLATIVE HISTORY

AB 2244 (Feuer), Chapter 656, Statutes of 2010, required guaranteed issue of health plan contracts and health insurance policies for children and limited premium variation based on health status, as required by the ACA for health plans and health insurers

¹ Chandra, A., J. Gruber, and R. McKnight, "The Importance of the Individual Mandate—Evidence from Massachusetts," *New England Journal of Medicine*, Vol. 364, No. 4, January 2011, pp. 293–295.

that are not grandfathered plans. As a result, health plans and health insurers that fail to issue child-only plan contracts or insurance policies are prohibited from issuing any individual market plan contracts for five years. MRMIB did not take a position on AB 2244.

SB 900 (Alquist), Chapter 659, Statutes of 2010, and **AB 1602 (Perez)**, Chapter 655, Statutes of 2010, established the California Health Benefit Exchange consistent with the ACA. MRMIB did not take a position on SB 900 or AB 1602.

SB 227 (Alquist), Chapter 31, Statutes of 2010, and **AB 1887 (Villines)**, Chapter 32, Statutes of 2010, established the federally funded Pre-Existing Condition Insurance Plan in California. The program provides coverage to medically uninsurable persons through December 31, 2013, consistent with the ACA. MRMIB adopted support positions on both SB 227 and AB 1887.

AB X1 1 (Nunez), of 2007, would have enacted the Health Care Security and Cost Reduction Act, a comprehensive health reform proposal including provisions to require all Californians who could afford it to have a minimum level of health coverage. The bill also would have required health plans to issue coverage to all individuals, regardless of health status. MRMIB did not take a position on AB X1 1, which failed passage in the Senate Health Committee.

AB 1971 (Chan), of 2005, **AB 2 (Dymally)**, of 2007, and **AB X1 3 (Dymally)**, of 2007, would have required health plans to issue coverage to all individuals, regardless of health status, or to pay a monthly “per covered life” fee to supplement MRMIP’s fixed appropriation. MRMIB adopted a support position on AB 1971 and AB 2. AB 1971 failed passage. AB 2 passed, but was vetoed. AB X1 3 failed passage.

ANALYSIS

SB 961 / AB 1461 would do the following:

Pre-existing Condition Provisions: Beginning in 2014, the legislation would prohibit a health plan or health insurance policy from imposing any group or individual contract provision excluding coverage for pre-existing conditions. ACA grandfathered plans would not be required to comply with these requirements for individual coverage.

Guaranteed Issue: Beginning in 2014, the legislation would require a health plan or health insurer that is not an ACA grandfathered plan to offer, market and sell all plans and insurance policies to all individuals in each service area in which the plan or insurer provides coverage. The legislation specifies that health plans and health insurers are required to offer health coverage without regard to health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or any other health status-related factor as determined by the Department of Managed Health Care or the Department of Insurance, respectively.

Enrollment Periods: The legislation requires health plans and health insurers that are not ACA grandfathered plans to limit enrollment to initial and annual open enrollment periods and special enrollment periods, the latter of which occur for 63 days following the date of triggering events, such as loss of coverage, marriage, birth, adoption or court order.

Effective Dates of Coverage: The legislation requires health plans and health insurers that are not ACA grandfather plans to provide various prospective effective dates of coverage depending upon the day of the month an individual submits premium payments or in the event of a marriage or a loss of minimum essential coverage. The legislation requires health plans and health insurers that are not ACA grandfathered plans to provide retroactive effective dates of coverage in the event of a birth, adoption or placement for adoption.

Prohibited Activities: Beginning in 2014, the legislation prohibits health plans and insurers that are not ACA grandfathered plans from encouraging an individual to either refrain from applying for coverage or apply to another plan or insurer because of health status, claims experience, industry, occupation or geographic location. The legislation prohibits arrangements with solicitors that provide compensation for enrolling individuals based on any of the factors listed above.

Community Rating: The legislation requires all health plan contracts and health insurance policies issued, amended or renewed after January 1, 2014, to use only the following characteristics of an individual for the purposes of establishing premium rates:

- Age: Rates based on age shall vary by no more than three to one.
- Geographic region: For the initial 2014 year, the regions shall be the same as CalPERS. For subsequent plan years, the regions shall be determined by the Exchange.
- Family size

Exceptions: The legislation specifies that health plans and health insurers are not required to offer health plans or health insurance policies or accept applications in any of the following situations:

- When the individual seeking coverage does not work or reside within the plan's or insurer's approved service area.
- When a plan or insurer reasonably anticipates and demonstrates to the director of DMHC or the Insurance Commissioner that it cannot ensure the availability and accessibility of health care services to an individual located within a particular service area because of the plan's obligations to existing enrollees or insureds. In that case, the health plan or insurer cannot offer coverage to employers within that service area until it notifies the director or the commissioner that it has the ability to deliver services to individuals and certifies that it will begin offering individual coverage.

Plan Viability: The legislation allows the director of DMHC and the Insurance Commissioner to require a plan or insurer to cease offering health plans or insurance policies or accepting applications for health plans or insurance policies upon a determination that the plan does not have sufficient financial, organizational or administrative viability to ensure the delivery of health care services to its enrollees or insureds.

Discussion

MRMIB was established by law in 1989 with two main objectives:

- To implement and administer the Major Risk Medical Insurance Program to secure adequate health coverage for Californians with pre-existing conditions.
- “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.” [Insurance Code Section 12711, Subdivision (c)]

Since that time, MRMIB has been committed to increasing access to comprehensive and affordable health care coverage for all individuals. By requiring all health plans and health insurers to offer coverage to all individuals regardless of health status, this legislation would enable California to take a significant step toward achieving this goal.

At the March 22, 2006, public meeting, MRMIB adopted the following specific principles to guide the Board in evaluating legislation affecting MRMIP:

- Coverage for high risk persons should be available to all willing to purchase it.
- The structure of coverage for medically uninsured persons should not provide health plans with a disincentive to participate in the purchasing pool.
- The structure of benefits should be compatible with the medical needs of the population. It should not provide a disincentive for utilizing needed health care.
- The program should be structured and administered in a way to encourage and promote consumer choice of health plans.
- Coverage should be affordable.
- There should be some mechanism to ensure that the public is aware of the availability of coverage for medically uninsured persons.

The passage of SB 961 and AB 1461 would advance several of these principles for all Californians:

- Availability of coverage: Under this legislation, health care coverage will be available to all Californians who are willing and able to purchase it.
- Structure of benefits compatible with medical needs of the population: Under the ACA, coverage provided for by this legislation will include essential health benefits without annual or lifetime benefit limits.

- Consumer choice of health plans: Under this legislation, for the very first time, Californians with pre-existing conditions will have the same choice of health coverage available to those without pre-existing conditions.
- Affordability: Under this legislation, premiums would not be allowed to vary based on health status or claims history. Health plans and health insurers would only be allowed to calculate premiums using age, geographic location and family size factors. As a result, the rates would be significantly less than MRMIP and similar to PCIP, the latter of which are based on standard market rates. Furthermore, income-qualified citizens and legal immigrants who purchase coverage within the Exchange will be eligible for refundable tax credits.

Finally, this legislation would further MRMIB’s mission by significantly improving Californians access to affordable, comprehensive, high quality and cost effective health care services.

MRMIB Mission Statement

“The California Managed Risk Medical Insurance Board provides and promotes access to affordable coverage for comprehensive, high quality, cost effective health care services to improve the health of Californians.”

FISCAL IMPACT

If the legislation were to pass, there would be no cost to MRMIB’s programs. However, the guaranteed issue and community rating provisions could create unknown savings by decreasing the demand for MRMIP and the Access for Infants and Mothers program. For example, under this legislation individuals who would otherwise enroll in MRMIP may be able to receive more affordable coverage without annual or lifetime benefit limits both inside and outside of the exchange and therefore would not apply for MRMIP.

PRO / CON ARGUMENTS

- Pro**
- The legislation would allow those individuals who need health care most to enroll in the comprehensive coverage of their choice.
 - The legislation would increase affordability of coverage for those individuals who need health care the most by prohibiting health plans and insurers from charging individuals based on health status or claims experience.
 - The legislation would provide those individuals newly able to purchase coverage with the security of knowing that their health care needs will be met without the risk of incurring debt.
 - The legislation would further MRMIB’s mission and stated principles by reforming the market to increase access to comprehensive and affordable health coverage for individuals with pre-existing conditions.

- Con** • If the individual mandate in the ACA is ruled unconstitutional, health plans may be exposed to unsustainable levels of adverse selection under this legislation.

SUPPORT/OPPOSITION

SB 961

Support

California Chiropractic Association
 California Commission on Aging
 California Pan-Ethnic Health Network
 California Primary Care Association
 The Greenlining Institute
 Health Access California
 National Association of Social Workers

Opposition

California Association of Health Plans
 Blue Shield of California

AB 1461

Support

California Black Health Network
 California Chiropractic Association
 California Pan-Ethnic Health Network
 California Primary Care Association

Opposition

California Association of Health Plans
 (unless amended to include an individual mandate)

VOTES

SB 961

Date	Location	Vote	Result
4/18/12	Sen. Health	(Yes: 6 No: 2 Abstain: 1)	Pass
5/7/12	Sen. Approp.	(Yes: 7 No: 0 Abstain: 0)	To Suspense

AB 1461

Date	Location	Vote	Result
4/17/12	Asm. Health	(Yes: 13 No: 6 Abstain: 0)	Pass

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