Assembly Bill No. 356

CHAPTER 526

An act to amend Section 1366.24 of, and to add Sections 1389.25 and 1389.3 to, the Health and Safety Code, to amend Section 10128.54 of, to add Sections 10113.9 and 10113.95 to, the Insurance Code, and to amend Section 2800.2 of the Labor Code, relating to health care coverage.

[Approved by Governor October 5, 2005. Filed with Secretary of State October 5, 2005.]

LEGISLATIVE COUNSEL'S DIGEST

AB 356, Chan. Health care coverage: rating and underwriting criteria.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a violation of the act's provisions a crime. Existing law also provides for the licensure and regulation of health insurers by the Department of Insurance.

This bill would, except as specified, require a health care service plan that offers health care coverage in the individual market to provide an individual to whom it denies coverage or enrollment or to whom it offers coverage at a higher than standard rate, with the specific reason or reasons for that decision in writing. The bill would also require such a plan or a health insurer to notify the contractholder or policyholder of a change in premium rate or coverage, including the reasons for a rate increase. The bill would, except as specified, require a health care service plan and a health insurer to inform an applicant of the California Major Risk Medical Insurance Program if it rejects an applicant or his or her dependents for coverage or offers individual coverage at a rate that is higher than the standard rate. The bill would also require a health care service plan and a health insurer to have written policies, procedures, or underwriting guidelines establishing the criteria and process for denial of coverage decisions with regard to individuals and ratesetting for that coverage. The bill would require a health care service plan or health insurer to submit these policies, procedures, or guidelines and certain additional information annually to the Director of the Department of Managed Health Care or the Commissioner of the Department of Insurance, respectively. The bill would, commencing September 1, 2006, require the director and the commissioner to make specified information related to rating and underwriting criteria and practices available via their Web sites. The bill would also require certain disclosure forms issued, amended, or renewed on and after September 1, 2006, for specified group benefit plans to include a notice advising consumers to examine their options before declining continuation coverage.

Because a violation of the bill's provisions with respect to health care service plans would be a crime, the 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.

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

SECTION 1. (a) The Legislature finds and declares the following:

(1) Private individual health coverage is generally the only option for most individuals who do not have employment-based health coverage or who are not eligible for government-sponsored health coverage programs.

(2) Individuals seeking to purchase individual coverage face a complex marketplace. It can be difficult to assess the coverage options and products available and to obtain coverage, especially for people who are in less than perfect health. Access to individual coverage and the cost of coverage are dependent on a person's health status, age, place of residence, and other factors.

(3) The complexity of the individual health insurance market means that individuals who are seeking and trying to maintain coverage need good information about what they can expect in terms of coverage and rates.

(4) Most consumers generally do not know all of the health conditions or risk factors that carriers use in making coverage decisions for individuals. This information could help consumers make more informed choices about their health coverage.

(5) If an individual is denied coverage, or charged a rate that is higher than the standard rate, he or she has a right to know the reasons and to have the opportunity to verify, and potentially to supplement if inaccurate, any health status, health history, medical information, or any other information that may have led to the denial or higher rate.

(b) It is the intent of the Legislature to improve the information and guidance available to consumers about individual health care coverage, including those purchasing or attempting to purchase individual health care coverage.

SEC. 2. Section 1366.24 of the Health and Safety Code is amended to read:

1366.24. (a) Every health care service plan evidence of coverage, provided for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all enrollees who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 1366.21, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the health care service plan, or the employer if the employer contracts to perform the administrative services as provided for in Section 1366.25, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 1366.21 within 60 days of the date of the qualifying event. This disclosure shall inform enrollees that failure to make the notification to the health care service plan, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 1366.25, within the 60-day period following the later of (1) the date that the enrollee's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the enrollee was sent notice pursuant to subdivision (e) of Section 1366.25 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the health care service plan, in accordance with the terms and conditions of the plan contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 1366.25, the amount of the required premium payment, as set forth in Section 1366.26. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the employer if the employer has contracted with the plan to perform the administrative services pursuant to subdivision (d) of Section 1366.25, within 45 days of the date the qualified beneficiary provided written notice to the health care service plan or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under

a prior group benefit plan pursuant to subdivision (b) of Section 1366.27 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every health care service plan shall provide to all covered employees of employers subject to this article a written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this section a new or amended evidence of coverage that includes the disclosures required by this section. Any specialized health care service plan that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchasers of benefits.

(e) Every plan disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an enrollee may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the plan's evidence of coverage.

(f) Every disclosure issued, amended, or renewed on and after July 1, 2006, for a group benefit plan subject to this article shall include the following notice:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

SEC. 3. Section 1389.25 is added to the Health and Safety Code, to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage 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, 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), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(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 this section unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) A health care service plan that declines to offer coverage or denies enrollment for an individual or his or her dependents applying for individual coverage or that offers individual coverage at a rate that is higher than the standard rate, shall provide the individual applicant with the specific reason or reasons for the decision in writing at the time of the denial or offer of coverage.

(2) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has delivered a written notice of the change at least 30 days prior to the effective date of the contract renewal or the date on which the rate or coverage changes. A notice of an increase in the premium rate shall include the reasons for the rate increase.

(3) The written notice required pursuant to paragraph (2) shall be delivered to the individual contractholder at his or her last address known to the plan, at least 30 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium rate increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change to the plan design or benefits.

(4) If a plan rejects an applicant or the dependents of an applicant for coverage or offers individual coverage at a rate that is higher than the standard rate, the plan shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code). The information provided to the applicant by the plan shall specifically include the program's toll-free telephone number and its Internet Web site address. The requirement to notify applicants of the availability of the California Major Risk Medical Insurance Program shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

(c) A notice provided pursuant to this section is a private and confidential communication and at the time of application, the plan shall give the individual applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

SEC. 4. Section 1389.3 is added to the Health and Safety Code, to read:

1389.3. (a) A full service health care service plan that markets and sells individual health plan contracts shall be subject to this section.

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 1365.5 and 1389.1 and all other applicable provisions of state and federal law.

(c) On or before June 1, 2006, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual health plan contracts, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

(d) Commencing September 1, 2006, the director shall post on the department's Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the Major Risk Medical Insurance Program. The director shall develop the information for the Web site in consultation with the Department of Insurance to enhance the consistency of information provided to consumers. Information about individual health coverage shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company-specific rating and underwriting criteria and practices submitted to the director.

SEC. 5. Section 10113.9 is added to the Insurance Code, to read:

10113.9. (a) This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, or Champus-supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) No change in the premium rate or coverage for an individual health insurance policy shall become effective unless the insurer has delivered a written notice of the change at least 30 days prior to the effective date of the contract renewal or the date on which the rate or coverage changes. A notice of an increase in the premium rate shall include the reasons for the rate increase.

(c) The written notice required pursuant to subdivision (b) shall be delivered to the individual policyholder at his or her last address known to the insurer, at least 30 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(d) If an insurer rejects an applicant or the dependents of an applicant for coverage or offers individual coverage at a rate that is higher than the standard rate, the insurer shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700). The information provided to the applicant by the insurer shall specifically include the program's toll-free telephone number and its Internet Web site address. The requirement to notify applicants of the availability of the California Major Risk Medical Insurance Program shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

SEC. 6. Section 10113.95 is added to the Insurance Code, to read:

10113.95. (a) A health insurer that markets and sells individual health insurance policies shall be subject to this section.

(b) An insurer subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 10140 and 10291.5 and all other applicable provisions.

(c) On or before June 1, 2006, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which they would be eligible. An insurer may comply with this section by submitting to the department underwriting materials or resource guides

provided to agents and brokers, provided that those materials include the information required to be submitted by this section.

(d) Commencing September 1, 2006, the commissioner shall post on the department's Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the Major Risk Medical Insurance Program. The commissioner shall develop the information for the Web site in consultation with the Department of Managed Health Care to enhance the consistency of information provided to consumers. Information about individual health insurance shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company-specific rating and underwriting criteria and practices submitted to the commissioner.

SEC. 7. Section 10128.54 of the Insurance Code is amended to read:

10128.54. (a) Every insurer's evidence of coverage for group benefit plans subject to this article, that is issued, amended, or renewed on or after January 1, 1999, shall disclose to covered employees of group benefit plans subject to this article the ability to continue coverage pursuant to this article, as required by this section.

(b) This disclosure shall state that all insureds who are eligible to be qualified beneficiaries, as defined in subdivision (c) of Section 10128.51, shall be required, as a condition of receiving benefits pursuant to this article, to notify, in writing, the insurer, or the employer if the employer contracts to perform the administrative services as provided for in Section 10128.55, of all qualifying events as specified in paragraphs (1), (3), (4), and (5) of subdivision (d) of Section 10128.51 within 60 days of the date of the qualifying event. This disclosure shall inform insureds that failure to make the notification to the insurer, or to the employer when under contract to provide the administrative services, within the required 60 days will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article. The disclosure shall further state that a qualified beneficiary who wishes to continue coverage under the group benefit plan pursuant to this article must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the plan has contracted with the employer for administrative services pursuant to subdivision (d) of Section 10128.55, within the 60-day period following the later of (1) the date that the insured's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the insured was sent notice pursuant to subdivision (e) of Section

10128.55 of the ability to continue coverage under the group benefit plan. The disclosure required by this section shall also state that a qualified beneficiary electing continuation shall pay to the disability insurer, in accordance with the terms and conditions of the policy or contract, which shall be set forth in the notice to the qualified beneficiary pursuant to subdivision (d) of Section 10128.55, the amount of the required premium payment, as set forth in Section 10128.56. The disclosure shall further require that the qualified beneficiary's first premium payment required to establish premium payment be delivered by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the disability insurer, or to the employer if the employer has contracted with the insurer to perform the administrative services pursuant to subdivision (d) of Section 10128.55, within 45 days of the date the qualified beneficiary provided written notice to the insurer or the employer, if the employer has contracted to perform the administrative services, of the election to continue coverage in order for coverage to be continued under this article. This disclosure shall also state that the first premium payment must equal an amount sufficient to pay all required premiums and all premiums due, and that failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

(c) The disclosure required by this section shall also describe separately how qualified beneficiaries whose continuation coverage terminates under a prior group benefit plan pursuant to Section 10128.57 may continue their coverage for the balance of the period that the qualified beneficiary would have remained covered under the prior group benefit plan, including the requirements for election and payment. The disclosure shall clearly state that continuation coverage shall terminate if the qualified beneficiary fails to comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group benefit plan within 30 days of receiving notice of the termination of the prior group benefit plan.

(d) Prior to August 1, 1998, every insurer shall provide to all covered employees of employers subject to this article written notice containing the disclosures required by this section, or shall provide to all covered employees of employers subject to this article a new or amended evidence of coverage that includes the disclosures required by this section. Any insurer that, in the ordinary course of business, maintains only the addresses of employer group purchasers of benefits, and does not maintain addresses of covered employees, may comply with the notice requirements of this section through the provision of the notices to its employer group purchases of benefits.

(e) Every disclosure form issued, amended, or renewed on and after January 1, 1999, for a group benefit plan subject to this article shall provide a notice that, under state law, an insured may be entitled to continuation of group coverage and that additional information regarding eligibility for this coverage may be found in the evidence of coverage.

(f) Every disclosure form issued, amended, or renewed on and after July 1, 2006, for a group benefit plan subject to this article shall include the following notice:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

SEC. 8. Section 2800.2 of the Labor Code is amended to read:

2800.2. (a) Any employer, employee association, or other entity otherwise providing hospital, surgical, or major medical benefits to its employees or members is solely responsible for notification of its employees or members of the conversion coverage made available pursuant to Part 6.1 (commencing with Section 12670) of Division 2 of the Insurance Code or Section 1373.6 of the Health and Safety Code.

(b) Any employer, employee association, or other entity, whether private or public, that provides hospital, medical, or surgical expense coverage that a former employee may continue under Section 4980B of Title 26 of the United States Code, Section 1161 et seq. of Title 29 of the United States Code, or Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as may be later amended (hereafter "COBRA"), shall, in conjunction with the notification required by COBRA that COBRA continuation coverage will cease and conversion coverage is available, and as a part of the notification required by subdivision (a), also notify the former employee, spouse, or former spouse of the availability of the continuation coverage under Section 1373.621 of the Health and Safety Code, and Sections 10116.5 and 11512.03 of the Insurance Code.

(c) On or after July 1, 2006, notification provided to employees, members, former employees, spouses, or former spouses under subdivisions (a) and (b) shall also include the following notification:

"Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

SEC. 9. 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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