AMENDED IN ASSEMBLY JUNE 1, 2007

AMENDED IN ASSEMBLY APRIL 25, 2007

AMENDED IN ASSEMBLY APRIL 11, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 1554

Introduced by Assembly Member Jones

February 23, 2007

An act to amend Section 1386 of, and to add Article 6.2 (commencing with Section 1385.01) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 4.5 (commencing with Section 10181) to Chapter 1 of Part 2 of Division 2 of the Insurance Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1554, as amended, Jones. Health care coverage: rate approval.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance and makes the violation of a final order by the Insurance Commissioner relating to rates subject to assessment of a civil penalty and makes the willful violation of specified rate provisions a misdemeanor. Under existing law, no change in premium rates or coverage in a health care service plan or a health insurance policy may become effective without prior written notification of the change to the contractholder or policyholder. Existing law prohibits a plan and insurer during the term

of a plan contract or policy from changing the rate of the premium, copayment, coinsurance, or deductible during specified time periods.

This bill would, *subject to specified exceptions,* require approval by the Department of Managed Health Care or the Department of Insurance of an increase in the amount of the premium, copayment, coinsurance obligation, deductible, and other charges under a health care service plan or disability insurance policy~~, other than a Medicare supplement contract or policy~~. The bill would require a plan or insurer to submit to the Department of Managed Health Care or the Department of Insurance, respectively, an application for a rate increase that would be effective on or after January 1, 2009, and would require review of the application in accordance with regulations that each department would be required to adopt no later than January 1, 2009. The bill would subject a rate increase that became effective January 1, 2007, to December 31, 2008, inclusive, to review by the appropriate department.

The bill would require each department to notify the public of a rate application and would deem the application approved within 60 days of the date of that notice unless *certain conditions exist and* the department holds a hearing on the application, as specified. The bill would authorize the initiation of, and intervention in, proceedings relating to rate approvals and the award of advocacy fees and costs in those proceedings in specified circumstances. The bill would require the departments to work together in implementation of these provisions, and to take specified actions in order to ensure coordination and consistency in implementation.

The bill would authorize each department to assess a charge in connection with its costs associated with a rate application. The bill would direct the deposit of these fees into the respective department's Health Rate Approval Fund, which would be created by the bill, and would continuously appropriate the revenue to each department, thereby making an appropriation.

Because the bill would specify that its violation is punishable by criminal sanctions under the Knox-Keene Act and under provisions applicable to insurers, 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.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Article 6.2 (commencing with Section 1385.01) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 6.2. Approval of Rates

1385.01. (a) The following definitions apply for the purposes of this article:

(1) "Applicant" means a health care service plan seeking to increase the rate it charges its subscribers.

(2) "Rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, and other charges.

(b) ~~No~~ *Except as otherwise provided in this article, no* applicant shall increase the rate it charges a subscriber unless it submits an application to the department, and the application is approved by the department.

(c) This article shall not apply to Medicare supplement contracts.

(d) This article shall not apply to a proposed rate increase of less than 5 percent if the health care service plan's medical loss ratio during each of its three most recently completed reporting years is 90 percent or higher, as defined by regulations of the department.

1385.02. (a) No rate shall be approved or remain in effect that is excessive, inadequate, unfairly discriminatory, or otherwise in violation of this article. In considering whether a rate is excessive, inadequate, or unfairly discriminatory, the department shall consider whether the rate mathematically reflects the health care service plan's investment income and is reasonable in comparison to coverage benefits. The department shall not consider the degree of competition in determining whether a rate is excessive, inadequate, or unfairly discriminatory.

(b) The department shall review a rate application pursuant to regulations it promulgates to determine reasonable rates for medical expenses and all nonmedical expenses, including the rate of return, surplus, overhead, and administration.

1385.03. (a) A health care service plan shall file a complete rate application with the department for a rate increase that will become effective on or after January 1, 2009.

(b) The rate application shall be signed by the officers of the health care service plan who exercise the functions of a chief executive and chief financial officer. Each officer shall certify that the representations, data, and information provided to the department to support the application are true.

(c) No health care service plan shall submit more than one rate application each calendar year.

(d) A rate application submitted to the department pursuant to this section shall include the following information:

(1) The rate of return that will result if the rate application is approved.

(2) The average rate change per affected enrollee or group that will result from approval of the application.

(3) The overhead loss ratio, reserves, excess tangible net equity, and surpluses that will result if the application is approved. For the purposes of this section, "overhead loss ratio" means the ratio of revenue dedicated to all nonmedical expenses and expenditures, including profit, to revenue dedicated to medical expenses. A medical expense is any payment to a hospital, physician, or other provider for the provision of medical care or health care services directly to, or for the benefit of, the enrollee.

(4) Salary and bonus compensation paid to the 10 highest paid officers and employees of the applicant for the most recent fiscal year.

(5) Dollar amounts of shareholder dividends paid, financial or capital disbursements to affiliates, and management agreements and service contracts.

(6) A statement setting forth all of the applicant's nonmedical expenses for the most recent fiscal year, including administration, dividends, rate of return, advertising, and salaries.

(7) A line-item report of medical expenses, including aggregate totals paid to hospitals and physicians, and the amount paid by the applicant for the 100 most common medical expenses incurred by enrollees during the previous calendar year.

(e) The health care service plan has the burden to provide the department with evidence and documents establishing, by a

proponderance of the evidence, the application's compliance with the requirement of this article.

(f) Rate applications shall be submitted by the health care service plan electronically, and the department shall post the applications on its Internet Web site within 10 days of the date of their receipt by the department.

(g) All information in a rate application and all materials submitted in its support by the applicant shall constitute a public record for purposes of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) except for financial data the disclosure of which would be competitively injurious to the applicant, as determined by the director.

1385.04. A rate increase by a health care service plan that became effective during the period January 1, 2007, to December 31, 2008, inclusive, shall be subject to review by the department for compliance with this article.

1385.05. (a) The department shall notify the public of any rate application by a health care service plan.

(b) If a proposed rate increase is less than 5 percent and the health care service plan's medical loss ratio during each of its three most recently completed reporting years, as defined by regulations of the department, is at least 88 percent and during any one or two of those three years is less than 90 percent, the application shall be deemed approved by the department 60 days after the date of the public notice provided under subdivision (a).

~~(b) The~~

(c) If a proposed rate increase is 5 percent or greater or the health care service plan's medical loss ratio during any of its three most recently completed reporting years is less than 88 percent, as defined by regulations of the department, the application shall be deemed approved by the department 60 days after the date of the public notice provided under subdivision (a) unless the department conducts a hearing on the application on any of the following grounds:

(1) A consumer, or his or her representative, requests a hearing within 45 days of the date of the public notice, and the department grants the request for a hearing. If the department determines not to grant the request for a hearing, it shall issue written findings in support of that decision.

(2) The department determines for any reason to hold a hearing on the application.

(3) The proposed increase would exceed 7 percent of the amount of the current rate under the plan contract.

~~(c)~~

(d) The public notice required by this section shall be posted on the department's Internet Web site and distributed to major statewide media and to any member of the public who requests placement on a mailing list or electronic mail list to receive the notice.

1385.06. All hearings under this article shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, with the following exceptions:

(a) The hearing shall be conducted by an administrative law judge for purposes of Sections 11512 and 11517 of the Government Code, appointed pursuant to Section 11502 of the Government Code or by the director.

(b) The hearing shall be commenced by filing a notice, in lieu of Sections 11503 and 11504 of the Government Code.

(c) The director shall adopt, amend, or reject a decision only under Section 11518.5 of the Government Code and subdivisions (b) and (c) of Section 11517 of the Government Code and solely on the basis of the record as provided in Section 11425.50 of the Government Code.

(d) The right to discovery shall be liberally construed, and discovery disputes shall be determined by the administrative law judge as provided in Section 11507.7 of the Government Code.

(e) Judicial review shall be in accordance with Section 1858.6 of the Insurance Code. For purposes of judicial review, a decision by the department to hold a hearing on the application is not a final order or decision; however a decision not to hold a hearing on an application is a final order or decision for purposes of judicial review.

1385.07. (a) A person may initiate or intervene in any proceeding permitted or established pursuant to this article, challenge any action of the department under this article, and enforce any provision of this article on behalf of himself or herself or members of the public.

1 (b) (1) The department or a court shall award reasonable
2 advocacy fees and costs, including witness fees, in a proceeding
3 described in subdivision (a) to a person who demonstrates both of
4 the following:
5 (A) The person represents the interests of consumers.
6 (B) The person has made a substantial contribution to the
7 adoption of any order, regulation, or decision by the department
8 or a court.
9 (2) The award made under this section shall be paid by the rate
10 applicant.
11 1385.08. A violation of this article is subject to the penalties
12 set forth in Sections 1386 and 1390. The director may also suspend
13 or revoke the license of a health care service plan for a violation
14 of this article.
15 1385.09. (a) The department may charge a health care service
16 plan a fee for the actual, reasonable costs associated with an
17 application filed by the plan under this article.
18 (b) The fees shall be deposited into the Department of Managed
19 Health Care Health Rate Approval Fund, which is hereby created
20 in the State Treasury. Notwithstanding Section 13340 of the
21 Government Code, all moneys in this fund are continuously
22 appropriated to the department for the sole purpose of
23 implementing this article.
24 1385.10. The department, working in coordination with the
25 Department of Insurance, shall have all necessary and proper
26 powers to implement this article and shall adopt regulations to
27 implement this article no later than January 1, 2009. In
28 implementing this article, the department and the Department of
29 Insurance shall jointly develop any regulations, rate review
30 standards, staff training, policies, and procedures in order to ensure
31 maximum coordination and consistency of implementation. *The*
32 *regulations adopted pursuant to this section shall define the terms*
33 *“medical loss ratio” and “reporting year” for purposes of this*
34 *article and Article 4.5 (commencing with Section 10181) of Chapter*
35 *1 of Part 2 of Division 2 of the Insurance Code.*
36 SEC. 2. Section 1386 of the Health and Safety Code is amended
37 to read:
38 1386. (a) The director may, after appropriate notice and
39 opportunity for a hearing, by order suspend or revoke any license
40 issued under this chapter to a health care service plan or assess

1 administrative penalties if the director determines that the licensee
2 has committed any of the acts or omissions constituting grounds
3 for disciplinary action.
4 (b) The following acts or omissions constitute grounds for
5 disciplinary action by the director:
6 (1) The plan is operating at variance with the basic
7 organizational documents as filed pursuant to Section 1351 or
8 1352, or with its published plan, or in any manner contrary to that
9 described in, and reasonably inferred from, the plan as contained
10 in its application for licensure and annual report, or any
11 modification thereof, unless amendments allowing the variation
12 have been submitted to, and approved by, the director.
13 (2) The plan has issued, or permits others to use, evidence of
14 coverage or uses a schedule of charges for health care services that
15 do not comply with those published in the latest evidence of
16 coverage found unobjectionable by the director.
17 (3) The plan does not provide basic health care services to its
18 enrollees and subscribers as set forth in the evidence of coverage.
19 This subdivision shall not apply to specialized health care service
20 plan contracts.
21 (4) The plan is no longer able to meet the standards set forth in
22 Article 5 (commencing with Section 1367).
23 (5) The continued operation of the plan will constitute a
24 substantial risk to its subscribers and enrollees.
25 (6) The plan has violated or attempted to violate, or conspired
26 to violate, directly or indirectly, or assisted in or abetted a violation
27 or conspiracy to violate any provision of this chapter, any rule or
28 regulation adopted by the director pursuant to this chapter, or any
29 order issued by the director pursuant to this chapter.
30 (7) The plan has engaged in any conduct that constitutes fraud
31 or dishonest dealing or unfair competition, as defined by Section
32 17200 of the Business and Professions Code.
33 (8) The plan has permitted, or aided or abetted any violation by
34 an employee or contractor who is a holder of any certificate,
35 license, permit, registration, or exemption issued pursuant to the
36 Business and Professions Code or this code that would constitute
37 grounds for discipline against the certificate, license, permit,
38 registration, or exemption.
39 (9) The plan has aided or abetted or permitted the commission
40 of any illegal act.

1 (10) The engagement of a person as an officer, director,
2 employee, associate, or provider of the plan contrary to the
3 provisions of an order issued by the director pursuant to subdivision
4 (c) of this section or subdivision (d) of Section 1388.
5 (11) The engagement of a person as a solicitor or supervisor of
6 solicitation contrary to the provisions of an order issued by the
7 director pursuant to Section 1388.
8 (12) The plan, its management company, or any other affiliate
9 of the plan, or any controlling person, officer, director, or other
10 person occupying a principal management or supervisory position
11 in the plan, management company, or affiliate, has been convicted
12 of or pleaded nolo contendere to a crime, or committed any act
13 involving dishonesty, fraud, or deceit, which crime or act is
14 substantially related to the qualifications, functions, or duties of a
15 person engaged in business in accordance with this chapter. The
16 director may revoke or deny a license hereunder irrespective of a
17 subsequent order under the provisions of Section 1203.4 of the
18 Penal Code.
19 (13) The plan violates Section 510, 2056, or 2056.1 of the
20 Business and Professions Code or Section 1375.7 of the Health
21 and Safety Code.
22 (14) The plan has been subject to a final disciplinary action
23 taken by this state, another state, an agency of the federal
24 government, or another country for any act or omission that would
25 constitute a violation of this chapter.
26 (15) The plan violates the Confidentiality of Medical
27 Information Act (Part 2.6 (commencing with Section 56) of
28 Division 1 of the Civil Code).
29 (16) The plan violates Section 806 of the Military and Veterans
30 Code.
31 (17) The plan has failed to comply with the requirements of
32 Article 6.2 (commencing with Section 1385.01).
33 (c) (1) The director may prohibit any person from serving as
34 an officer, director, employee, associate, or provider of any plan
35 or solicitor firm, or of any management company of any plan, or
36 as a solicitor, if either of the following applies:
37 (A) The prohibition is in the public interest and the person has
38 committed, caused, participated in, or had knowledge of a violation
39 of this chapter by a plan, management company, or solicitor firm.

(B) The person was an officer, director, employee, associate, or provider of a plan or of a management company or solicitor firm of any plan whose license has been suspended or revoked pursuant to this section and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a plan under this section or may constitute a separate proceeding, subject in either case to subdivision (d).

(d) A proceeding under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

SEC. 3. Article 4.5 (commencing with Section 10181) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 4.5. Approval of Rates

10181. (a) The following definitions apply for the purposes of this article:

(1) "Applicant" means a disability insurer seeking to increase the rate it charges its policyholders for health insurance, as defined in Section 106.

(2) "Rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, and other charges.

(b) ~~No~~ *Except as otherwise provided in this article, no* applicant shall increase the rate it charges a policyholder unless it submits an application to the department, and the application is approved by the department.

(c) This article shall not apply to Medicare supplement policies.

(d) This article shall not apply to a proposed rate increase of less than 5 percent if the disability insurer's medical loss ratio during each of its three most recently completed reporting years is 90 percent or higher, as defined by regulations of the department.

10181.01. (a) No rate shall be approved or remain in effect that is excessive, inadequate, unfairly discriminatory, or otherwise in violation of this article. In considering whether a rate is excessive, inadequate, or unfairly discriminatory, the department

1 shall consider whether the rate mathematically reflects the disability
2 insurer's investment income and is reasonable in comparison to
3 coverage benefits. The department shall not consider the degree
4 of competition in determining whether a rate is excessive,
5 inadequate, or unfairly discriminatory.
6 (b) The department shall review a rate application pursuant to
7 regulations it promulgates to determine reasonable rates for medical
8 expenses and all nonmedical expenses, including the rate of return,
9 surplus, overhead, and administration.
10 10181.02. (a) A disability insurer shall file a complete rate
11 application with the department for a rate increase that will become
12 effective on or after January 1, 2009.
13 (b) The rate application shall be signed by the officers of the
14 disability insurer who exercise the functions of a chief executive
15 and chief financial officer. Each officer shall certify that the
16 representations, data, and information provided to the department
17 to support the application are true.
18 (c) No disability insurer shall submit more than one rate
19 application each calendar year.
20 (d) A rate application submitted to the department pursuant to
21 this section shall include the following information:
22 (1) The rate of return that will result if the rate application is
23 approved.
24 (2) The average rate change per affected insured or group that
25 will result from approval of the application.
26 (3) The overhead loss ratio, reserves, excess tangible net equity,
27 and surpluses that will result if the application is approved. For
28 the purposes of this section, "overhead loss ratio" means the ratio
29 of revenue dedicated to all nonmedical expenses and expenditures,
30 including profit, to revenue dedicated to medical expenses. A
31 medical expense is any payment to a hospital, physician, or other
32 provider for the provision of medical care or health care services
33 directly to, or for the benefit of, the insured.
34 (4) Salary and bonus compensation paid to the 10 highest paid
35 officers and employees of the applicant for the most recent fiscal
36 year.
37 (5) Dollar amounts of shareholder dividends paid, financial or
38 capital disbursements to affiliates, and management agreements
39 and service contracts.

1 (6) A statement setting forth all of the applicant's nonmedical
2 expenses for the most recent fiscal year, including administration,
3 dividends, rate of return, advertising, and salaries.
4 (7) A line-item report of medical expenses, including aggregate
5 totals paid to hospitals and physicians, and the amount paid by the
6 applicant for the 100 most common medical expenses incurred by
7 insureds during the previous calendar year.
8 (e) The disability insurer has the burden to provide the
9 department with evidence and documents establishing, by a
10 proponderance of the evidence, the application's compliance with
11 the requirement of this article.
12 (f) Rate applications shall be submitted by the disability insurer
13 electronically, and the department shall post the applications on
14 its Internet Web site within 10 days of the date of their receipt by
15 the department.
16 (g) All information in a rate application and all materials
17 submitted in its support by the applicant shall constitute a public
18 record for purposes of the California Public Records Act (Chapter
19 3.5(commencing with Section 6250) of Division 7 of Title 1 of
20 the Government Code) except for financial data the disclosure of
21 which would be competitively injurious to the applicant, as
22 determined by the commissioner.
23 10181.03. A rate increase by a disability insurer that became
24 effective during the period January 1, 2007, to December 31, 2008,
25 inclusive, shall be subject to review by the department for
26 compliance with this article.
27 10181.04. (a) The department shall notify the public of any
28 rate application by a disability insurer.
29 *(b) If a proposed rate increase is less than 5 percent and the*
30 *disability insurer's medical loss ratio during each of its three most*
31 *recently completed reporting years, as defined by regulations of*
32 *the department, is at least 88 percent and during any one or two*
33 *of those three years is less than 90 percent, the application shall*
34 *be deemed approved by the department 60 days after the date of*
35 *the public notice provided under subdivision (a).*
36 ~~(b) The~~
37 *(c) If a proposed rate increase is 5 percent or greater or the*
38 *disability insurer's medical loss ratio during any of its three most*
39 *recently completed reporting years is less than 88 percent, as*
40 *defined by regulations of the department, the* application shall be

deemed approved by the department 60 days after the date of the public notice provided under subdivision (a) unless the department conducts a hearing on the application on any of the following grounds:

(1) A consumer, or his or her representative, requests a hearing within 45 days of the date of the public notice, and the department grants the request for a hearing. If the department determines not to grant the request for a hearing, it shall issue written findings in support of that decision.

(2) The department determines for any reason to hold a hearing on the application.

(3) The proposed increase would exceed 7 percent of the amount of the current rate under the policy.

~~(c)~~

(d) The public notice required by this section shall be posted on the department's Internet Web site and distributed to major statewide media and to any member of the public who requests placement on a mailing list or electronic mail list to receive the notice.

10181.05. All hearings under this article shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, with the following exceptions:

(a) The hearing shall be conducted by an administrative law judge for purposes of Sections 11512 and 11517 of the Government Code, appointed pursuant to Section 11502 of the Government Code or by the commissioner.

(b) The hearing shall be commenced by filing a notice, in lieu of Sections 11503 and 11504 of the Government Code.

(c) The commissioner shall adopt, amend, or reject a decision only under Section 11518.5 of the Government Code and subdivisions (b) and (c) of Section 11517 of the Government Code and solely on the basis of the record as provided in Section 11425.50 of the Government Code.

(d) The right to discovery shall be liberally construed, and discovery disputes shall be determined by the administrative law judge as provided in Section 11507.7 of the Government Code.

(e) Judicial review shall be in accordance with Section 1858.6. For purposes of judicial review, a decision by the department to hold a hearing on the application is not a final order or decision;

however a decision not to hold a hearing on an application is a final order or decision for purposes of judicial review.

10181.06. (a) A person may initiate or intervene in any proceeding permitted or established pursuant to this article, challenge any action of the department under this article, and enforce any provision of this article on behalf of himself or herself or members of the public.

(b) (1) The department or a court shall award reasonable advocacy fees and costs, including witness fees, in a proceeding described in subdivision (a) to a person who demonstrates both of the following:

(A) The person represents the interests of consumers.

(B) The person has made a substantial contribution to the adoption of any order, regulation, or decision by the department or a court.

(2) The award made under this section shall be paid by the rate applicant.

10181.07. A violation of this article is subject to the penalties set forth in Section 1859.1. The commissioner may also suspend or revoke in whole or in part the certificate of authority of a disability insurer for a violation of this article.

10181.08. (a) The department may charge a disability insurer a fee for the actual, reasonable costs associated with an application filed by the insurer under this article.

(b) The fees shall be deposited into the Department of Insurance Health Rate Approval Fund, which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in this fund are continuously appropriated to the department for the sole purpose of implementing this article.

10181.09. The department, working in coordination with the Department of Managed Health Care, shall have all necessary and proper powers to implement this article and shall adopt regulations to implement this article no later than January 1, 2009. In implementing this article, the department and the Department of Managed Health Care shall jointly develop any regulations, rate review standards, staff training, policies, and procedures in order to ensure maximum coordination and consistency of implementation. *The regulations adopted pursuant to this section shall define the terms "medical loss ratio" and "reporting year" for purposes of this article and Article 6.2 (commencing with*

1 *Section 1385.01) of Chapter 2.2 of Division 2 of the Health and*
2 *Safety Code.*
3 SEC. 4. No reimbursement is required by this act pursuant to
4 Section 6 of Article XIII B of the California Constitution because
5 the only costs that may be incurred by a local agency or school
6 district will be incurred because this act creates a new crime or
7 infraction, eliminates a crime or infraction, or changes the penalty
8 for a crime or infraction, within the meaning of Section 17556 of
9 the Government Code, or changes the definition of a crime within
10 the meaning of Section 6 of Article XIII B of the California
11 Constitution.
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13 ———
14 **CORRECTIONS:**
15 **Text—Page 13.**
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