

**Introduced by Senator Leno**February 18, 2010

---

---

An act to amend Sections 1389.25 and 1389.4 of, and to add Sections 1389.26 and 1389.45 to, the Health and Safety Code, and to amend Sections 10113.9 and 10113.95 of, and to add Sections 10113.91 and 10113.96 to, the Insurance Code, relating to health care coverage.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1163, as introduced, Leno. Health care coverage: denials: premium rates.

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 willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

Existing law requires 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 offers coverage at a rate higher than the standard rate with the specific reason or reasons for that decision in writing. Existing law also prohibits a health care service plan or a health insurer offering coverage in the individual market from changing the premium rate or coverage without providing specified notice.

This bill would require a health insurer that offers health care coverage in the individual market to provide an individual to whom it denies coverage or enrollment or offers coverage at a rate higher than the standard rate with the specific reason or reasons for that decision in writing. With respect to both health insurers and health care service plans issuing individual policies or contracts, the bill would require that

the reasons for a denial or a higher than standard rate be stated in clear, easily understandable language.

The bill would also require a health care service plan or health insurer that offers health care coverage in the large group market to provide a group to which it denies coverage or enrollment or to which it offers coverage at a higher than standard rate, with the specific reason or reasons for that decision in writing in clear, easily understandable language.

Existing law requires a health care service plan and a health insurer to annually file with the Department of Managed Health Care or the Department of Insurance a general description of the criteria, policies, procedures, or guidelines the plan or insurer uses for rating and underwriting decisions related to individual contracts and policies.

This bill would require a plan or insurer to annually disclose to the Department of Managed Health Care or the Department of Insurance the standards, processes, and criteria used by the plan or insurer to deny issuance of a large group contract or policy. The bill would also require a plan or insurer issuing coverage in the individual or large group market to annually disclose to the Department of Managed Health Care or the Department of Insurance the number and proportion of individual or group applicants denied coverage during the preceding year, and the reasons therefor, the number and proportion of enrollees, insureds, or groups that paid a premium rate other than the standard rate, and the reasons therefor, and the standards, processes, and criteria used by the plan or insurer for adjusting premiums applicable to individual or large group contracts or policies based on health status or any other risk factor, as specified. The bill would require the departments to disclose this information, and the information obtained from plans and insurers from the annual filing described above, to the public, the Managed Risk Medical Insurance Board, and the relevant policy and budget committees of the Legislature, as specified.

Because a willful violation of the bill's requirements relative 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.

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. Section 1389.25 of the Health and Safety Code  
2 is amended to read:  
3 1389.25. (a) (1) This section shall apply only to a full service  
4 health care service plan offering health coverage in the individual  
5 market in California and shall not apply to a specialized health  
6 care service plan, a health care service plan contract in the  
7 Medi-Cal program (Chapter 7 (commencing with Section 14000)  
8 of Part 3 of Division 9 of the Welfare and Institutions Code), a  
9 health care service plan conversion contract offered pursuant to  
10 Section 1373.6, a health care service plan contract in the Healthy  
11 Families Program (Part 6.2 (commencing with Section 12693) of  
12 Division 2 of the Insurance Code), or a health care service plan  
13 contract offered to a federally eligible defined individual under  
14 Article 4.6 (commencing with Section 1366.35).  
15 (2) A local initiative, as defined in subdivision (v) of Section  
16 53810 of Title 22 of the California Code of Regulations, that is  
17 awarded a contract by the State Department of Health Care  
18 Services pursuant to subdivision (b) of Section 53800 of Title 22  
19 of the California Code of Regulations, shall not be subject to this  
20 section unless the plan offers coverage in the individual market to  
21 persons not covered by Medi-Cal or the Healthy Families Program.  
22 (b) (1) A health care service plan that declines to offer coverage  
23 or denies enrollment for an individual or his or her dependents  
24 applying for individual coverage or that offers individual coverage  
25 at a rate that is higher than the standard rate, shall, *at the time of*  
26 *the denial or offer of coverage*, provide the individual applicant  
27 with the specific reason or reasons for the decision in writing—~~at~~  
28 ~~the time of the denial or offer of coverage~~, *in clear, easily*  
29 *understandable language*.  
30 (2) No change in the premium rate or coverage for an individual  
31 plan contract shall become effective unless the plan has delivered  
32 a written notice of the change at least 30 days prior to the effective  
33 date of the contract renewal or the date on which the rate or  
34 coverage changes. A notice of an increase in the premium rate  
35 shall include the reasons for the rate increase.

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

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

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

30 SEC. 2. Section 1389.26 is added to the Health and Safety  
31 Code, to read:

32 1389.26. (a) (1) This section shall apply only to a full service  
33 health care service plan offering large group health plan contracts  
34 in California and shall not apply to a specialized health care service  
35 plan, a health care service plan contract in the Medi-Cal program  
36 (Chapter 7 (commencing with Section 14000) of Part 3 of Division  
37 9 of the Welfare and Institutions Code), a health care service plan  
38 conversion contract offered pursuant to Section 1373.6, a health  
39 care service plan contract in the Healthy Families Program (Part  
40 6.2 (commencing with Section 12693) of Division 2 of the

1 Insurance Code), or a health care service plan contract offered to  
2 a federally eligible defined individual under Article 4.6  
3 (commencing with Section 1366.35).

4 (2) A local initiative, as defined in subdivision (v) of Section  
5 53810 of Title 22 of the California Code of Regulations, that is  
6 awarded a contract by the State Department of Health Care Services  
7 pursuant to subdivision (b) of Section 53800 of Title 22 of the  
8 California Code of Regulations, shall not be subject to this section  
9 unless the plan offers large group health plan contracts to persons  
10 not covered by Medi-Cal or the Healthy Families Program.

11 (b) A health care service plan that declines to offer coverage to  
12 or denies enrollment of a large group or that offers large group  
13 coverage at a rate that is higher than the standard rate, shall, at the  
14 time of the denial or offer of coverage, provide the group applicant  
15 with the specific reason or reasons for the decision in writing, in  
16 clear, easily understandable language.

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

22 (d) For purposes of this subdivision, “large group health plan  
23 contract” or “large group coverage” means a group health care  
24 service plan contract other than a contract issued to a small  
25 employer, as defined in Section 1357.

26 SEC. 3. Section 1389.4 of the Health and Safety Code is  
27 amended to read:

28 1389.4. (a) A full service health care service plan that issues,  
29 renews, or amends individual health plan contracts shall be subject  
30 to this section.

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

39 (c) (1) On or before June 1, 2006, and annually thereafter, every  
40 health care service plan shall file with the department a general

1 description of the criteria, policies, procedures, or guidelines the  
2 plan uses for rating and underwriting decisions related to individual  
3 health plan contracts, which means automatic declinable health  
4 conditions, health conditions that may lead to a coverage decline,  
5 height and weight standards, health history, health care utilization,  
6 lifestyle, or behavior that might result in a decline for coverage or  
7 severely limit the plan products for which they would be eligible.  
8 A plan may comply with this ~~section~~ *paragraph* by submitting to  
9 the department underwriting materials or resource guides provided  
10 to plan solicitors or solicitor firms, provided that those materials  
11 include the information required to be submitted by this section.

12 *(2) Commencing January 1, 2011, a plan shall include all of*  
13 *the following in the annual filing required under paragraph (1):*

14 *(A) The number and proportion of applicants denied individual*  
15 *coverage during the preceding year and the reasons for those*  
16 *denials.*

17 *(B) The standards, processes, and criteria used by the plan for*  
18 *adjusting premiums applicable to individual plan contracts based*  
19 *on health status or any other risk factor.*

20 *(C) The number and proportion of individual plan contract*  
21 *enrollees who paid a premium rate other than the standard rate*  
22 *and the reasons for that nonstandard rate.*

23 *(d) The department shall disclose the information obtained*  
24 *pursuant to subdivision (c) to the Managed Risk Medical Insurance*  
25 *Board and the relevant policy and budget committees of the*  
26 *Legislature. The department shall also disclose this information*  
27 *to the public by posting the information on its Internet Web site*  
28 *in a manner accessible and understandable to consumers. The*  
29 *information disclosed pursuant to this subdivision shall be company*  
30 *specific.*

31 ~~(d)~~

32 *(e) Commencing September 1, 2006, in addition to the*  
33 *disclosure required under subdivision (d), the director shall post*  
34 *on the department's Internet Web site, in a manner accessible and*  
35 *understandable to consumers, general, noncompany specific*  
36 *information about rating and underwriting criteria and practices*  
37 *in the individual market and information about the Major Risk*  
38 *Medical Insurance Program. The director shall develop the*  
39 *information for the Web site in consultation with the Department*  
40 *of Insurance to enhance the consistency of information provided*

1 to consumers. Information about individual health coverage shall  
2 also include the following notification:

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

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

12 (f) This section shall not apply to a closed block of business, as  
13 defined in Section 1367.15.

14 SEC. 4. Section 1389.45 is added to the Health and Safety  
15 Code, to read:

16 1389.45. (a) A full service health care service plan that issues,  
17 renews, or amends large group health plan contracts shall be subject  
18 to this section.

19 (b) On or before June 1, 2011, and annually thereafter, a plan  
20 shall disclose to the department all of the following:

21 (1) The standards, processes, and criteria used by the plan to  
22 deny issuance of a large group plan contract.

23 (2) The number and proportion of groups denied issuance of a  
24 large group plan contract during the preceding year and the reasons  
25 for those denials.

26 (3) The standards, processes, and criteria used by the plan for  
27 adjusting premiums applicable to large group plan contracts based  
28 on health status or any other risk factor.

29 (4) The number and proportion of large groups that paid a  
30 premium rate other than the standard rate and the reasons for that  
31 nonstandard rate.

32 (c) The department shall disclose the information obtained  
33 pursuant to subdivision (b) to the Managed Risk Medical Insurance  
34 Board and the relevant policy and budget committees of the  
35 Legislature. The department shall also disclose this information  
36 to the public by posting the information on its Internet Web site  
37 in a manner accessible and understandable to consumers. The  
38 information disclosed pursuant to this section shall be company  
39 specific.

1 (d) For purposes of this subdivision, “large group health plan  
2 contract” means a group health care service plan contract other  
3 than a contract issued to a small employer as defined in Section  
4 1357.

5 (e) This section shall not apply to a closed block of business,  
6 as defined in Section 1367.15.

7 SEC. 5. Section 10113.9 of the Insurance Code is amended to  
8 read:

9 10113.9. (a) This section shall not apply to short-term limited  
10 duration health insurance, vision-only, dental-only, or  
11 Champus-supplement insurance, or to hospital indemnity,  
12 hospital-only, accident-only, or specified disease insurance that  
13 does not pay benefits on a fixed benefit, cash payment only basis.

14 (b) (1) *A health insurer that declines to offer coverage or denies*  
15 *enrollment for an individual or his or her dependents applying for*  
16 *individual coverage or that offers individual coverage at a rate*  
17 *that is higher than the standard rate shall, at the time of the denial*  
18 *or offer of coverage, provide the individual applicant with the*  
19 *specific reason or reasons for the decision in writing, in clear,*  
20 *easily understandable language.*

21 ~~(b)~~

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

28 ~~(e)~~

29 (3) The written notice required pursuant to ~~subdivision (b)~~  
30 *paragraph (2)* shall be delivered to the individual policyholder at  
31 his or her last address known to the insurer, at least 30 days prior  
32 to the effective date of the change. The notice shall state in italics  
33 either the actual dollar amount of the premium increase or the  
34 specific percentage by which the current premium will be  
35 increased. The notice shall describe in plain, understandable  
36 English any changes in the policy or any changes in benefits,  
37 including a reduction in benefits or changes to waivers, exclusions,  
38 or conditions, and highlight this information by printing it in italics.  
39 The notice shall specify in a minimum of 10-point bold typeface,

1 the reason for a premium rate change or a change in coverage or  
2 benefits.

3 ~~(d)~~

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

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

21 SEC. 6. Section 10113.91 is added to the Insurance Code, to  
22 read:

23 10113.91. (a) This section shall apply only to a health insurer  
24 offering large group health insurance policies in California. This  
25 section shall not apply to short-term limited duration health  
26 insurance, vision-only, dental-only, or Champus-supplement  
27 insurance, or to hospital indemnity, hospital-only, accident-only,  
28 or specified disease insurance that does not pay benefits on a fixed  
29 benefit, cash payment only basis.

30 (b) A health insurer that declines to offer coverage to or denies  
31 enrollment of a large group or that offers large group coverage at  
32 a rate that is higher than the standard rate shall, at the time of the  
33 denial or offer of coverage, provide the group applicant with the  
34 specific reason or reasons for the decision in writing, in clear,  
35 easily understandable language.

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

1 (d) For purposes of this subdivision, “large group policy” or  
2 “large group coverage” means a group health insurance policy  
3 other than a policy issued to a small employer, as defined in Section  
4 10700.

5 SEC. 7. Section 10113.95 of the Insurance Code is amended  
6 to read:

7 10113.95. (a) A health insurer that issues, renews, or amends  
8 individual health insurance policies shall be subject to this section.

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

17 (c) (1) On or before June 1, 2006, and annually thereafter, every  
18 insurer shall file with the commissioner a general description of  
19 the criteria, policies, procedures, or guidelines that the insurer uses  
20 for rating and underwriting decisions related to individual health  
21 insurance policies, which means automatic declinable health  
22 conditions, health conditions that may lead to a coverage decline,  
23 height and weight standards, health history, health care utilization,  
24 lifestyle, or behavior that might result in a decline for coverage or  
25 severely limit the health insurance products for which they would  
26 be eligible. An insurer may comply with this ~~section~~ *paragraph*  
27 by submitting to the department underwriting materials or resource  
28 guides provided to agents and brokers, provided that those materials  
29 include the information required to be submitted by this section.

30 (2) *Commencing January 1, 2011, an insurer shall include all*  
31 *of the following in the annual filing required under paragraph (1):*

32 (A) *The number and proportion of applicants denied individual*  
33 *coverage during the preceding year and the reasons for those*  
34 *denials.*

35 (B) *The standards, processes, and criteria used by the insurer*  
36 *for adjusting premiums applicable to individual policies based on*  
37 *health status or any other risk factor.*

38 (C) *The number and proportion of insureds under an individual*  
39 *policy who paid a premium rate other than the standard rate and*  
40 *the reasons for that nonstandard rate.*

1 (d) *The commissioner shall disclose the information obtained*  
2 *pursuant to subdivision (c) to the Managed Risk Medical Insurance*  
3 *Board and the relevant policy and budget committees of the*  
4 *Legislature. The department shall also disclose this information*  
5 *to the public by posting the information on its Internet Web site*  
6 *in a manner accessible and understandable to consumers. The*  
7 *information disclosed pursuant to this subdivision shall be company*  
8 *specific.*

9 ~~(d)~~

10 (e) Commencing September 1, 2006, in addition to the  
11 disclosure required under subdivision (d), the commissioner shall  
12 post on the department's Internet Web site, in a manner accessible  
13 and understandable to consumers, general, noncompany specific  
14 information about rating and underwriting criteria and practices  
15 in the individual market and information about the Major Risk  
16 Medical Insurance Program. The commissioner shall develop the  
17 information for the Web site in consultation with the Department  
18 of Managed Health Care to enhance the consistency of information  
19 provided to consumers. Information about individual health  
20 insurance shall also include the following notification:

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

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

30 (f) This section shall not apply to a closed block of business, as  
31 defined in Section 10176.10.

32 SEC. 8. Section 10113.96 is added to the Insurance Code, to  
33 read:

34 10113.96. (a) A health insurer that issues, renews, or amends  
35 large group health insurance policies shall be subject to this section.

36 (b) On or before June 1, 2011, and annually thereafter, an insurer  
37 shall disclose to the commissioner all of the following:

38 (1) The standards, processes, and criteria used by the insurer to  
39 deny issuance of a large group health insurance policy.

1 (2) The number and proportion of groups denied issuance of a  
2 large group health insurance policy during the preceding year and  
3 the reasons for those denials.

4 (3) The standards, processes, and criteria used by the insurer  
5 for adjusting premiums applicable to large group health insurance  
6 policies based on health status or any other risk factor.

7 (4) The number and proportion of large groups that paid a  
8 premium rate other than the standard rate and the reasons for that  
9 nonstandard rate.

10 (c) The commissioner shall disclose the information obtained  
11 pursuant to subdivision (b) to the Managed Risk Medical Insurance  
12 Board and the relevant policy and budget committees of the  
13 Legislature. The commissioner shall also disclose this information  
14 to the public by posting the information on the department’s  
15 Internet Web site in a manner accessible and understandable to  
16 consumers. The information disclosed pursuant to this section shall  
17 be company specific.

18 (d) For purposes of this subdivision, “large group health  
19 insurance policy” means a group health insurance policy other  
20 than a policy issued to a small employer, as defined in Section  
21 10700.

22 (e) This section shall not apply to a closed block of business,  
23 as defined in Section 10176.10.

24 SEC. 9. No reimbursement is required by this act pursuant to  
25 Section 6 of Article XIII B of the California Constitution because  
26 the only costs that may be incurred by a local agency or school  
27 district will be incurred because this act creates a new crime or  
28 infraction, eliminates a crime or infraction, or changes the penalty  
29 for a crime or infraction, within the meaning of Section 17556 of  
30 the Government Code, or changes the definition of a crime within  
31 the meaning of Section 6 of Article XIII B of the California  
32 Constitution.

O