AMENDED IN SENATE APRIL 5, 2010

SENATE BILL No. 1163

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 amended, 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 *at least 30 days prior to the effective date of the change*.

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 require notice of a change to the premium rate of coverage to be provided at least 180 days prior to the effective date of the change.*

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~~ *that was higher* 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. *For large groups, the bill would also require reporting of the number and proportion of those groups that paid a premium rate lower than the standard rate, and the reasons therefor.* 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:

SECTION 1. Section 1389.25 of the Health and Safety Code is amended 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 Care 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, at the time of the denial or offer of coverage, provide the individual applicant

with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(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~~ *180* 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~~ *180* 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. 2. Section 1389.26 is added to the Health and Safety Code, to read:

1389.26. (a) (1) This section shall apply only to a full service health care service plan offering large group health plan contracts 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 Care 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 large group health plan contracts to persons not covered by Medi-Cal or the Healthy Families Program.

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

(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 group 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.

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

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

1389.4. (a) A full service health care service plan that issues, renews, or amends 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) (1) 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 paragraph 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.

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

(A) The number and proportion of applicants denied individual coverage during the preceding year ~~and the reasons for those denials~~*, including the age, gender, race or ethnicity, occupation, and geographic region of the applicants denied*.

(B) The reasons for the denial of coverage by the demographic characteristics in subparagraph (A).

~~(B)~~

(C) The standards, processes, and criteria used by the plan for *determining and* adjusting premiums applicable to individual plan contracts based on health status or any other risk factor*, including the actuarial basis for determining premiums for individual plan contracts*.

~~(C)~~

(D) (i) The number and proportion of individual plan contract enrollees who paid a premium rate ~~other~~ *that was higher* than the standard rate and the reasons for ~~that nonstandard rate.~~ *the higher rate as well as the number and proportion of individual plan*

contract enrollees who paid a premium rate that was lower than the standard rate and the reasons for the lower rate.

(ii) Demographic information on the number and proportion of individual plan contract enrollees charged a higher rate than the standard rate, including age, gender, occupation, race or ethnicity, and geographic location.

(iii) Demographic information on the number and proportion of individual plan contract enrollees charged a lower rate than the standard rate, including age, gender, occupation, race or ethnicity, and geographic location.

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

(e) ~~Commencing September 1, 2006, in~~ *In* addition to the disclosure required under subdivision (d), the director shall post on the department's Internet 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 *Internet* 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."

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

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

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

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

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

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

(3) The standards, processes, and criteria used by the plan for adjusting premiums applicable to large group plan contracts based on health status or any other risk factor, *including the actuarial basis for the rate*.

(4) The number and proportion of large groups that paid a premium rate ~~other~~ *higher* than the standard rate and the reasons for that ~~nonstandard~~ *higher* rate.

(5) The number and proportion of large groups that paid a premium rate lower than the standard rate and the reasons for that lower rate.

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

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

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

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

10113.9. (a) This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, or ~~Champus-supplement~~ *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) (1) A health insurer 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, at the time of the denial or offer of coverage, provide the individual applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(2) 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~~ *180* days prior to the effective date of the policy 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 policyholder at his or her last address known to the insurer, at least ~~30~~ *180* 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.

(4) 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~~) *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.

(c) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the insurer 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. 6. Section 10113.91 is added to the Insurance Code, to read:

10113.91. (a) This section shall apply only to a health insurer offering large group health insurance policies in California. This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, or ~~Champus-supplement~~ *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) A health insurer that declines to offer coverage to or denies enrollment of a large group or that offers large group coverage at a rate that is higher than the standard rate shall, at the time of the denial or offer of coverage, provide the group applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(c) A notice provided pursuant to this section is a private and confidential communication and at the time of application, the insurer shall give the group 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.

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

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

10113.95. (a) A health insurer that issues, renews, or amends 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) (1) 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 paragraph 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.

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

(A) The number and proportion of applicants denied individual coverage during the preceding year ~~and the reasons for those denials~~*, including the age, gender, race or ethnicity, occupation, and geographic region of the applicants denied*.

(B) The reasons for the denial of coverage by the demographic characteristics in subparagraph (A).

~~(B)~~

(C) The standards, processes, and criteria used by the insurer for *determining and* adjusting premiums applicable to individual policies based on health status or any other risk factor*, including the actuarial basis for determining premiums for individual policies*.

~~(C)~~

(D) (i) The number and proportion of insureds under an individual policy who paid a premium rate ~~other~~ *that was higher* than the standard rate and the reasons for ~~that nonstandard rate.~~ *the higher rate as well as the number and proportion of individual policyholders who paid a premium rate that was lower than the standard rate and the reasons for the lower rate.*

(ii) Demographic information on the number and proportion of individual policyholders charged a higher rate than the standard rate, including age, gender, occupation, race or ethnicity, and geographic location.

(iii) Demographic information on the number and proportion of individual policyholders charged a lower rate than the standard rate, including age, gender, occupation, race or ethnicity, and geographic location.

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

(e) ~~Commencing September 1, 2006, in~~ *In* addition to the disclosure required under subdivision (d), the commissioner shall post on the department's Internet 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 *Internet* 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."

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

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

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

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

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

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

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

(4) The number and proportion of large groups that paid a premium rate ~~other~~ *higher* than the standard rate and the reasons for that ~~nonstandard~~ *higher* rate.

(5) The number and proportion of large groups that paid a premium rate lower than the standard rate and the reasons for that lower rate.

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

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

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

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.

CORRECTIONS:

Text—Pages 6, 7, 11 and 12.

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