

AMENDED IN ASSEMBLY JUNE 23, 2010

AMENDED IN SENATE APRIL 28, 2010

AMENDED IN SENATE APRIL 19, 2010

AMENDED IN SENATE APRIL 5, 2010

**SENATE BILL**

**No. 1163**

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**Introduced by Senator Leno  
(Coauthor: Senator Pavley)**

February 18, 2010

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An act to amend ~~Section~~ *Sections 1342, 1342.4, 1367, and 1389.25* of, to add Sections ~~1389.45 and 1389.46~~ *1389.90, 1389.91, 1389.92, 1389.93, and 1389.94* to, and to add and repeal Section 1389.26 of, the Health and Safety Code, and to amend ~~Section 10113.9~~ *Sections 10113.9 and 12923.5* of, to add Sections ~~10113.96 and 10113.97~~ *12969.1, 12969.2, 12969.3, 12969.4, and 12969.5* to, and to add and repeal Section 10113.91 of, 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 care service plan and a health insurer that offers health care coverage in the individual or group market to provide an individual or group 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 or group 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 declines to offer coverage to, or denies enrollment of, any individual ~~or large group~~ to report quarterly, until January 1, 2014, to the Department of Managed Health Care or the Department of Insurance, the Managed Risk Medical Insurance Board, and the public, on the number of applicants that are denied coverage and various related matters. The bill would require the departments to post certain information in that regard on the Internet. The bill would require that reports to the public maintain patient privacy.

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 health insurer to annually disclose to the Department of Managed Health Care or the Department of Insurance ~~written policies, procedures, or underwriting guidelines under which the plan or insurer makes its decision to determine the standard rate and to issue a contract or policy at a rate higher or lower than the standard rate. The bill would also require, among other things, disclosure of the various rates for each product in the individual and small group markets, and the number and proportion of contract holders and policyholders in each rate category for~~ *specified information for rate filings* in the individual, small group, and large group markets, *including*

*information on product types, rate increases, and changes in benefits. The bill would require the departments to review each rate filing and post summary information in that regard on the Internet and to provide access to the full information on request, including accompanying documentation regarding rate changes. The bill would also require plans and insurers to annually disclose certain information relating to rate increases for each product. require the departments to provide data to the United States Secretary of Health and Human Services on health insurance rate trends in premium ratings and information summarizing the nature of consumer inquiries and complaints relating to health care coverage rates, as specified. The bill would also require the departments to apply for grant funding from the federal government for the purposes of rate review and would authorize the departments to impose fees on health care service plans and health insurers for rate review.*

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 1342 of the Health and Safety Code is
- 2     amended to read:
- 3     1342. It is the intent and purpose of the Legislature to promote
- 4     the delivery and the quality of health and medical care to the people
- 5     of the State of California who enroll in, or subscribe for the services
- 6     rendered by, a health care service plan or specialized health care
- 7     service plan by accomplishing all of the following:
- 8     (a) Ensuring the continued role of the professional as the
- 9     determiner of the patient’s health needs which fosters the traditional
- 10    relationship of trust and confidence between the patient and the
- 11    professional.

1 (b) Ensuring that subscribers and enrollees are educated and  
2 informed of the benefits and services available in order to enable  
3 a rational consumer choice in the marketplace.

4 (c) Prosecuting malefactors who make fraudulent solicitations  
5 or who use deceptive methods, misrepresentations, or practices  
6 which are inimical to the general purpose of enabling a rational  
7 choice for the consumer public.

8 (d) Helping to ensure the best possible health care for the public  
9 at the lowest possible cost by transferring the financial risk of  
10 health care from patients to providers.

11 (e) Promoting effective representation of the interests of  
12 subscribers and enrollees.

13 (f) Ensuring the financial stability thereof by means of proper  
14 regulatory procedures.

15 (g) Ensuring that subscribers and enrollees receive available  
16 and accessible health and medical services rendered in a manner  
17 providing continuity of care.

18 (h) Ensuring that subscribers and enrollees have their grievances  
19 expeditiously and thoroughly reviewed by the department.

20 (i) *Ensuring that the rates charged to subscribers and enrollees*  
21 *are consistent with state and federal law.*

22 *SEC. 2. Section 1342.4 of the Health and Safety Code is*  
23 *amended to read:*

24 1342.4. (a) The Department of Managed Health Care and the  
25 Department of Insurance shall maintain a joint senior level working  
26 group to ensure clarity for health care consumers about who  
27 enforces their patient rights and consistency in the regulations of  
28 these departments.

29 (b) The joint working group shall undertake a review and  
30 examination of the Health and Safety Code, the Insurance Code,  
31 and the Welfare and Institutions Code as they apply to the  
32 Department of Managed Health Care and the Department of  
33 Insurance to ensure consistency in consumer protection.

34 (c) The joint working group shall review and examine all of the  
35 following processes in each department:

36 (1) Grievance and consumer complaint processes, including,  
37 but not limited to, outreach, standard complaints, including  
38 coverage and medical necessity complaints, independent medical  
39 review, and information developed for consumer use.

1 (2) The processes used to ensure enforcement of the law,  
2 including, but not limited to, the medical survey and audit process  
3 in the Health and Safety Code and market conduct exams in the  
4 Insurance Code.

5 (3) The processes for regulating the timely payment of claims.

6 (4) *Rates in the individual and group markets consistent with*  
7 *federal law.*

8 (d) The joint working group shall report its findings to the  
9 Insurance Commissioner and the Director of the Department of  
10 Managed Health Care for review and approval. The commissioner  
11 and the director shall submit the approved final report under  
12 signature to the Legislature by January 1 of every year for five  
13 years.

14 *SEC. 3. Section 1367 of the Health and Safety Code is amended*  
15 *to read:*

16 1367. A health care service plan and, if applicable, a specialized  
17 health care service plan shall meet the following requirements:

18 (a) Facilities located in this state including, but not limited to,  
19 clinics, hospitals, and skilled nursing facilities to be utilized by  
20 the plan shall be licensed by the State Department of Health  
21 Services, where licensure is required by law. Facilities not located  
22 in this state shall conform to all licensing and other requirements  
23 of the jurisdiction in which they are located.

24 (b) Personnel employed by or under contract to the plan shall  
25 be licensed or certified by their respective board or agency, where  
26 licensure or certification is required by law.

27 (c) Equipment required to be licensed or registered by law shall  
28 be so licensed or registered, and the operating personnel for that  
29 equipment shall be licensed or certified as required by law.

30 (d) The plan shall furnish services in a manner providing  
31 continuity of care and ready referral of patients to other providers  
32 at times as may be appropriate consistent with good professional  
33 practice.

34 (e) (1) All services shall be readily available at reasonable times  
35 to each enrollee consistent with good professional practice. To the  
36 extent feasible, the plan shall make all services readily accessible  
37 to all enrollees consistent with Section 1367.03.

38 (2) To the extent that telemedicine services are appropriately  
39 provided through telemedicine, as defined in subdivision (a) of  
40 Section 2290.5 of the Business and Professions Code, these

1 services shall be considered in determining compliance with  
2 Section 1300.67.2 of Title 28 of the California Code of  
3 Regulations.

4 (3) The plan shall make all services accessible and appropriate  
5 consistent with Section 1367.04.

6 (f) The plan shall employ and utilize allied health manpower  
7 for the furnishing of services to the extent permitted by law and  
8 consistent with good medical practice.

9 (g) The plan shall have the organizational and administrative  
10 capacity to provide services to subscribers and enrollees. The plan  
11 shall be able to demonstrate to the department that medical  
12 decisions are rendered by qualified medical providers, unhindered  
13 by fiscal and administrative management.

14 (h) (1) Contracts with subscribers and enrollees, including  
15 group contracts, and contracts with providers, and other persons  
16 furnishing services, equipment, or facilities to or in connection  
17 with the plan, shall be fair, reasonable, and consistent with the  
18 objectives of this chapter. All contracts with providers shall contain  
19 provisions requiring a fast, fair, and cost-effective dispute  
20 resolution mechanism under which providers may submit disputes  
21 to the plan, and requiring the plan to inform its providers upon  
22 contracting with the plan, or upon change to these provisions, of  
23 the procedures for processing and resolving disputes, including  
24 the location and telephone number where information regarding  
25 disputes may be submitted.

26 (2) A health care service plan shall ensure that a dispute  
27 resolution mechanism is accessible to noncontracting providers  
28 for the purpose of resolving billing and claims disputes.

29 (3) On and after January 1, 2002, a health care service plan  
30 shall annually submit a report to the department regarding its  
31 dispute resolution mechanism. The report shall include information  
32 on the number of providers who utilized the dispute resolution  
33 mechanism and a summary of the disposition of those disputes.

34 (i) A health care service plan contract shall provide to  
35 subscribers and enrollees all of the basic health care services  
36 included in subdivision (b) of Section 1345, except that the director  
37 may, for good cause, by rule or order exempt a plan contract or  
38 any class of plan contracts from that requirement. The director  
39 shall by rule define the scope of each basic health care service that  
40 health care service plans are required to provide as a minimum for

1 licensure under this chapter. Nothing in this chapter shall prohibit  
2 a health care service plan from charging subscribers or enrollees  
3 a copayment or a deductible for a basic health care service or from  
4 setting forth, by contract, limitations on maximum coverage of  
5 basic health care services, provided that the copayments,  
6 deductibles, or limitations are reported to, and held unobjectionable  
7 by, the director and set forth to the subscriber or enrollee pursuant  
8 to the disclosure provisions of Section 1363.

9 (j) A health care service plan shall not require registration under  
10 the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.)  
11 as a condition for participation by an optometrist certified to use  
12 therapeutic pharmaceutical agents pursuant to Section 3041.3 of  
13 the Business and Professions Code.

14 ~~Nothing in this section shall be construed to permit the director~~  
15 ~~to establish the rates charged subscribers and enrollees for~~  
16 ~~contractual health care services.~~

17 The director's enforcement of Article 3.1 (commencing with  
18 Section 1357) shall not be deemed to establish the rates charged  
19 subscribers and enrollees for contractual health care services.

20 The obligation of the plan to comply with this section shall not  
21 be waived when the plan delegates any services that it is required  
22 to perform to its medical groups, independent practice associations,  
23 or other contracting entities.

24 ~~SECTION 4.~~

25 *SEC. 4.* Section 1389.25 of the Health and Safety Code is  
26 amended to read:

27 1389.25. (a) (1) This section shall apply only to a full service  
28 health care service plan offering health coverage in the individual  
29 or group market in California and shall not apply to a specialized  
30 health care service plan, a health care service plan contract in the  
31 Medi-Cal program (Chapter 7 (commencing with Section 14000)  
32 of Part 3 of Division 9 of the Welfare and Institutions Code), a  
33 health care service plan conversion contract offered pursuant to  
34 Section 1373.6, a health care service plan contract in the Healthy  
35 Families Program (Part 6.2 (commencing with Section 12693) of  
36 Division 2 of the Insurance Code), or a health care service plan  
37 contract offered to a federally eligible defined individual under  
38 Article 4.6 (commencing with Section 1366.35).

39 (2) A local initiative, as defined in subdivision (v) of Section  
40 53810 of Title 22 of the California Code of Regulations, that is

1 awarded a contract by the State Department of Health Care Services  
2 pursuant to subdivision (b) of Section 53800 of Title 22 of the  
3 California Code of Regulations, shall not be subject to this section  
4 unless the plan offers coverage to persons not covered by Medi-Cal  
5 or the Healthy Families Program.

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

13 (2) No change in the premium rate or coverage for a plan  
14 contract shall become effective unless the plan has delivered a  
15 written notice of the change at least 180 days prior to the effective  
16 date of the contract renewal or the date on which the rate or  
17 coverage changes. A notice of an increase in the premium rate  
18 shall include the reasons for the rate increase.

19 (3) The written notice required pursuant to paragraph (2) shall  
20 be delivered to the contractholder at his or her last address known  
21 to the plan, at least 180 days prior to the effective date of the  
22 change. The notice shall state in italics either the actual dollar  
23 amount of the premium rate increase or the specific percentage by  
24 which the current premium will be increased. The notice shall  
25 describe in plain, understandable English any changes in the plan  
26 design or any changes in benefits, including a reduction in benefits  
27 or changes to waivers, exclusions, or conditions, and highlight this  
28 information by printing it in italics. The notice shall specify in a  
29 minimum of 10-point bold typeface, the reason for a premium rate  
30 change or a change to the plan design or benefits.

31 (4) If a plan rejects an individual applicant or the dependents  
32 of an individual applicant for individual coverage or offers  
33 individual coverage at a rate that is higher than the standard rate,  
34 the plan shall inform the applicant about the state's high-risk health  
35 insurance pool, the California Major Risk Medical Insurance  
36 Program (Part 6.5 (commencing with Section 12700) of Division  
37 2 of the Insurance Code). The information provided to the applicant  
38 by the plan shall specifically include the program's toll-free  
39 telephone number and its Internet Web site address. The  
40 requirement to notify applicants of the availability of the California



1 Major Risk Medical Insurance Program shall not apply when a  
2 health plan rejects an applicant for Medicare supplement coverage.

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

8 ~~SEC. 2.~~

9 *SEC. 5.* Section 1389.26 is added to the Health and Safety  
10 Code, to read:

11 1389.26. (a) (1) A health care service plan subject to Section  
12 1389.25 that declines to offer coverage to or denies enrollment of  
13 any individual shall quarterly provide to the department, the  
14 Managed Risk Medical Insurance Board, and the public ~~all~~ *both*  
15 of the following:

16 (A) The number and proportion of applicants for individual  
17 coverage that were denied coverage for each product offered by  
18 the plan.

19 (B) The health status and risk factors for each applicant denied  
20 coverage, by product.

21 ~~(C) Demographic information about applicants denied coverage,~~  
22 ~~including age, gender, language spoken, occupation, and~~  
23 ~~geographic region of the applicant, by product.~~

24 ~~(D) The written policies, procedures, or underwriting guidelines~~  
25 ~~whereby the plan makes its decision to provide or to deny coverage~~  
26 ~~to applicants.~~

27 (2) Public reporting shall be done in a manner consistent with  
28 maintaining patient privacy. Academic institutions and other  
29 entities, including those eligible for the Consumer Participation  
30 Program, as defined in Section 1348.9, and that have the capacity  
31 to maintain patient privacy, shall be able to obtain patient-specific  
32 data without patient name or identifier.

33 ~~(b) (1) A health care service plan subject to Section 1389.25~~  
34 ~~that declines to offer coverage to or denies enrollment of any large~~  
35 ~~group shall quarterly provide to the department, the Managed Risk~~  
36 ~~Medical Insurance Board, and the public all of the following:~~

37 ~~(A) The number and proportion of applicants for large group~~  
38 ~~coverage that were denied coverage for each product offered by~~  
39 ~~the plan.~~

1     ~~(B) The health status and risk factors for each applicant denied~~  
2     ~~coverage, by product.~~

3     ~~(C) Demographic information about applicants denied coverage,~~  
4     ~~including age, gender, language spoken, occupation, and~~  
5     ~~geographic region of the applicant, by product.~~

6     ~~(D) The written policies, procedures, or underwriting guidelines~~  
7     ~~whereby the plan makes its decision to provide or to deny coverage~~  
8     ~~to applicants.~~

9     ~~(2) Public reporting shall be done in a manner consistent with~~  
10    ~~maintaining patient privacy. Academic institutions and other~~  
11    ~~entities, including those eligible for the Consumer Participation~~  
12    ~~Program, as defined in Section 1348.9, and that have the capacity~~  
13    ~~to maintain patient privacy, shall be able to obtain patient-specific~~  
14    ~~data without patient name or identifier.~~

15    ~~(e)~~

16    ~~(b) The department shall post on its Internet Web site the~~  
17    ~~following information for each product offered by a health care~~  
18    ~~service plan and for all products offered by the plan:~~

19    ~~(1) The number and proportion of applicants for individual~~  
20    ~~coverage denied coverage as well as aggregate information about~~  
21    ~~health status and demographics of those denied coverage.~~

22    ~~(2) The number and proportion of applicants for large group~~  
23    ~~coverage denied coverage as well as aggregate information about~~  
24    ~~health status and demographics of the employees of those large~~  
25    ~~groups denied coverage.~~

26    ~~(3)~~

27    ~~(2) The written policies, procedures, or underwriting guidelines~~  
28    ~~whereby the plan makes its decision to provide or to deny coverage~~  
29    ~~to applicants.~~

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

34    ~~(e)~~

35    ~~(c) This section shall remain in effect only until January 1, 2014,~~  
36    ~~and as of that date is repealed, unless a later enacted statute, that~~  
37    ~~is enacted before January 1, 2014, deletes or extends that date.~~

38    ~~SEC. 3. Section 1389.45 is added to the Health and Safety~~  
39    ~~Code, to read:~~

1 ~~1389.45. (a) A full service health care service plan that issues,~~  
2 ~~renews, or amends health plan contracts shall be subject to this~~  
3 ~~section.~~

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

6 ~~(1) The written policies, procedures, or underwriting guidelines~~  
7 ~~whereby the plan makes its decision to determine the standard rate~~  
8 ~~and to issue a plan contract at a rate higher or lower than the~~  
9 ~~standard rate.~~

10 ~~(2) For each product in the individual or small group market,~~  
11 ~~the rates charged, including the standard rate, rates that are higher~~  
12 ~~than the standard rate, and rates that are lower than the standard~~  
13 ~~rate.~~

14 ~~(3) For the individual, small group, and large group markets,~~  
15 ~~the number and proportion of subscribers in each category charged~~  
16 ~~a standard rate, a rate that is higher than the standard rate, or a rate~~  
17 ~~that is lower than the standard rate. For each of these categories,~~  
18 ~~demographic information shall be provided, including age, gender,~~  
19 ~~language spoken, and geographic region.~~

20 ~~(e) The department shall disclose the information provided~~  
21 ~~pursuant to this section to the public, both in summary fashion on~~  
22 ~~the department's Internet Web site and in full, on request.~~

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

25 ~~SEC. 4. Section 1389.46 is added to the Health and Safety~~  
26 ~~Code, to read:~~

27 ~~1389.46. (a) A full service health care service plan that issues,~~  
28 ~~renews, or amends health plan contracts shall be subject to this~~  
29 ~~section.~~

30 ~~(b) On or before June 1, 2011, and no less than annually~~  
31 ~~thereafter, a plan shall disclose to the department all of the~~  
32 ~~following with respect to rate increases for each product:~~

33 ~~(1) Any change in rate.~~

34 ~~(2) Any change in cost sharing.~~

35 ~~(3) Any change in covered benefits.~~

36 ~~(e) On or before June 1, 2011, and no less than annually~~  
37 ~~thereafter, a plan shall also disclose to the department all of the~~  
38 ~~following with respect to rate increases for each product:~~

39 ~~(1) Actuarial memorandum.~~

- 1 ~~(2) Assumptions on trends in medical inflation, including~~
- 2 ~~justification.~~
- 3 ~~(3) Specific worksheets or exhibits documenting increases in~~
- 4 ~~costs.~~
- 5 ~~(4) Enrollee population characteristics that increase or decrease~~
- 6 ~~costs.~~
- 7 ~~(5) Utilization increases.~~
- 8 ~~(6) Provider prices.~~
- 9 ~~(7) Administrative costs.~~
- 10 ~~(8) Medical loss ratios.~~
- 11 ~~(9) Reserves and surplus levels, including tangible net equity~~
- 12 ~~and reserves in excess of tangible net equity.~~
- 13 ~~(10) Changes in cost sharing.~~
- 14 *SEC. 6. Section 1389.90 is added to the Health and Safety*
- 15 *Code, to read:*
- 16 *1389.90. (a) A full service health care service plan that issues,*
- 17 *renews, or amends health care service plan contracts shall be*
- 18 *subject to this section. On or before June 1, 2011, and for each*
- 19 *rate filing thereafter, a plan shall disclose to the department all*
- 20 *of the following for each rate filing in the individual, small*
- 21 *employer, and large group health plan markets:*
- 22 *(1) Company name and contact information.*
- 23 *(2) Number of plan contract forms covered by the filing.*
- 24 *(3) Plan contract form numbers covered by the filing.*
- 25 *(4) Product type.*
- 26 *(5) Market segment.*
- 27 *(6) Type of plan, such as for profit or not for profit.*
- 28 *(7) Whether the products are opened or closed.*
- 29 *(8) Enrollment in each plan contract and rating form.*
- 30 *(9) Enrollee months in each plan contract form.*
- 31 *(10) Annual rate.*
- 32 *(11) Total earned premiums in each plan contract form.*
- 33 *(12) Total incurred claims in each plan contract form.*
- 34 *(13) Average rate increase initially requested.*
- 35 *(14) Rate of review category, including approved as originally*
- 36 *submitted, initially rejected, or resubmitted with modifications,*
- 37 *and initially rejected and not resubmitted or initially rejected and*
- 38 *challenged.*
- 39 *(15) Average rate of increase approved.*
- 40 *(16) Effective date of rate increase.*

1 (17) Number of subscribers or enrollees affected by each plan  
2 contract form.

3 (18) Overall annual medical trend factor assumptions in each  
4 rate filing for all benefits and disaggregated by benefit category,  
5 including hospital inpatient, hospital outpatient, physician services,  
6 prescription drugs, and other ancillary services, laboratory, and  
7 radiology.

8 (19) The amount of the projected trend attributable to the use,  
9 price inflation, or fees and risk for annual plan contract trends by  
10 benefit category, such as hospital inpatient, hospital outpatient,  
11 physician services, prescription drugs and other ancillary services,  
12 laboratory, and radiology.

13 (20) A comparison of claims cost and rate of changes over time.

14 (21) Any changes in enrollee cost sharing over the prior year  
15 associated with the submitted rate filing.

16 (22) Any changes in enrollee benefits over the prior year  
17 associated with the submitted rate filing.

18 (23) The number and a summary of the nature of consumer  
19 inquiries and complaints related to health plan rates that have  
20 been received for the past two plan years.

21 (b) A health care service plan subject to subdivision (a) shall  
22 also disclose the following required aggregate data for rate filings  
23 in the individual, small employer, and large group health plan  
24 markets:

25 (1) Number and percentage of rate filings reviewed by the  
26 following:

27 (A) Plan year.

28 (B) Segment type.

29 (C) Product type.

30 (D) Number of subscribers.

31 (E) Number of covered lives affected.

32 (2) The average rate increase by the following:

33 (A) Plan year.

34 (B) Segment type.

35 (C) Product type.

36 (c) For purposes of this section, “large group health plan  
37 contract” means a group health care service plan contract other  
38 than a contract issued to a small employer, as defined in Section  
39 1357.

1 SEC. 7. Section 1389.91 is added to the Health and Safety  
2 Code, to read:

3 1389.91. (a) Each rate filing described in Section 1389.90,  
4 including all supporting material, shall be publicly available on  
5 the department's Internet Web site. All submissions to the  
6 department shall be made electronically in order to facilitate  
7 review by the department and the public. Each rate filing shall  
8 include a summary of rate changes offered in plain language for  
9 consumers.

10 (b) The department shall post to its public Internet Web site  
11 information about the rate filing and justification in an easy to  
12 understand language for the public.

13 (c) A plan shall post all proposed rate increases, including all  
14 accompanying documentation, on its Internet Web site.

15 SEC. 8. Section 1389.92 is added to the Health and Safety  
16 Code, to read:

17 1389.92. (a) The department shall review each rate filing  
18 described in Section 1389.90 for consistency with applicable state  
19 law and regulations as well as federal law, regulations, rules, or  
20 other guidance.

21 (b) The department shall also review each rate filing to  
22 determine that it is actuarially sound.

23 (c) The department shall consider public comment on the rate  
24 filing for no less than 60 days and respond pursuant to Chapter  
25 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
26 Title 2 of the Government Code.

27 (d) The department shall conduct a public hearing on the rate  
28 filing on any of the following grounds:

29 (1) A consumer or consumer advocacy organization requests a  
30 hearing within 45 days of the rate filing. If the department grants  
31 a hearing, it shall issue written findings in support of that decision.

32 (2) The department determines for any reason to hold a hearing.

33 (3) The department finds that the rate filing does not comply  
34 with the provisions of this section.

35 (e) After completing a review pursuant to this section, the  
36 department shall post to its Internet Web site any changes to the  
37 rates and the reason for those changes, including any  
38 documentation to support those changes.

39 SEC. 9. Section 1389.93 is added to the Health and Safety  
40 Code, to read:

1 1389.93. (a) Consistent with federal law, rules, and guidance,  
2 the department shall do all of the following:

3 (1) Provide data to the United States Secretary of Health and  
4 Human Services on health plan rate trends in premium rating  
5 areas.

6 (2) Provide to the United States Secretary of Health and Human  
7 Services the number and summarize the nature of consumer  
8 inquiries and complaints related to health plan rates that have  
9 been received for the past two plan years.

10 (b) Commencing with the creation of the Exchange, provide to  
11 the Exchange such information as may be necessary to allow  
12 compliance with federal law, rules, and guidance. The department  
13 shall develop an interagency agreement with the Exchange to  
14 facilitate the reporting of information regarding rate filings that  
15 is consistent with the responsibilities of the Exchange. As used in  
16 this subdivision, the “Exchange” means the American Health  
17 Benefit Exchange established in California pursuant to Section  
18 1311 of the federal Patient Protection and Affordable Care Act  
19 (Public Law 111-148).

20 SEC. 10. Section 1389.94 is added to the Health and Safety  
21 Code, to read:

22 1389.94. (a) The department shall apply for grant funding  
23 from the federal government for the purposes of rate review  
24 consistent with the requirements of federal law, rules, and  
25 guidance.

26 (b) Additional costs and expenses associated with rate reviews  
27 shall be supported by fees consistent with the provisions of Section  
28 1356.

29 ~~SEC. 5.~~

30 SEC. 11. Section 10113.9 of the Insurance Code is amended  
31 to read:

32 10113.9. (a) This section shall not apply to short-term limited  
33 duration health insurance, vision-only, dental-only, or  
34 CHAMPUS-supplement insurance, or to hospital indemnity,  
35 hospital-only, accident-only, or specified disease insurance that  
36 does not pay benefits on a fixed benefit, cash payment only basis.

37 (b) (1) A health insurer that declines to offer coverage or denies  
38 enrollment for an individual or his or her dependents or a group  
39 applying for coverage or that offers coverage at a rate that is higher  
40 than the standard rate shall, at the time of the denial or offer of

1 coverage, provide the applicant with the specific reason or reasons  
2 for the decision in writing, in clear, easily understandable language.

3 (2) No change in the premium rate or coverage for a health  
4 insurance policy shall become effective unless the insurer has  
5 delivered a written notice of the change at least 180 days prior to  
6 the effective date of the policy renewal or the date on which the  
7 rate or coverage changes. A notice of an increase in the premium  
8 rate shall include the reasons for the rate increase.

9 (3) The written notice required pursuant to paragraph (2) shall  
10 be delivered to the policyholder at his or her last address known  
11 to the insurer, at least 180 days prior to the effective date of the  
12 change. The notice shall state in italics either the actual dollar  
13 amount of the premium increase or the specific percentage by  
14 which the current premium will be increased. The notice shall  
15 describe in plain, understandable English any changes in the policy  
16 or any changes in benefits, including a reduction in benefits or  
17 changes to waivers, exclusions, or conditions, and highlight this  
18 information by printing it in italics. The notice shall specify in a  
19 minimum of 10-point bold typeface, the reason for a premium rate  
20 change or a change in coverage or benefits.

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

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

38 ~~SEC. 6.~~

39 *SEC. 12.* Section 10113.91 is added to the Insurance Code, to  
40 read:



1 10113.91. (a) (1) A health insurer subject to Section 10113.9  
2 that declines to offer coverage to or denies enrollment of any  
3 individual shall quarterly provide to the commissioner, the  
4 Managed Risk Medical Insurance Board, and the public ~~all~~ *both*  
5 of the following:

6 (A) The number and proportion of applicants for individual  
7 coverage that were denied coverage for each product offered by  
8 the insurer.

9 (B) The health status and risk factors for each applicant denied  
10 coverage, by product.

11 ~~(C) Demographic information about applicants denied coverage,~~  
12 ~~including age, gender, language spoken, occupation, and~~  
13 ~~geographic region of the applicant, by product.~~

14 ~~(D) The written policies, procedures, or underwriting guidelines~~  
15 ~~whereby the insurer makes its decision to provide or to deny~~  
16 ~~coverage to applicants.~~

17 (2) Public reporting shall be done in a manner consistent with  
18 maintaining patient privacy. Academic institutions and other  
19 entities, including those eligible for the Consumer Participation  
20 Program, as defined in Section 1348.9 of the Health and Safety  
21 Code, and that have the capacity to maintain patient privacy, shall  
22 be able to obtain patient-specific data without patient name or  
23 identifier.

24 ~~(b) (1) A health insurer subject to Section 10113.9 that declines~~  
25 ~~to offer coverage to or denies enrollment of any large group shall~~  
26 ~~quarterly provide to the commissioner, the Managed Risk Medical~~  
27 ~~Insurance Board, and the public all of the following:~~

28 ~~(A) The number and proportion of applicants for large group~~  
29 ~~coverage that were denied coverage for each product offered by~~  
30 ~~the insurer.~~

31 ~~(B) The health status and risk factors for each applicant denied~~  
32 ~~coverage, by product.~~

33 ~~(C) Demographic information about applicants denied coverage,~~  
34 ~~including age, gender, language spoken, occupation, and~~  
35 ~~geographic region of the applicant, by product.~~

36 ~~(D) The written policies, procedures, or underwriting guidelines~~  
37 ~~whereby the insurer makes its decision to provide or to deny~~  
38 ~~coverage to applicants.~~

39 ~~(2) Public reporting shall be done in a manner consistent with~~  
40 ~~maintaining patient privacy. Academic institutions and other~~

1 entities, including those eligible for the Consumer Participation  
 2 Program, as defined in Section 1348.9 of the Health and Safety  
 3 Code, and that have the capacity to maintain patient privacy, shall  
 4 be able to obtain patient-specific data without patient name or  
 5 identifier.  
 6 (e)  
 7 (b) The commissioner shall post on the department’s Internet  
 8 Web site the following information for each product offered by a  
 9 health insurer and for all products offered by the insurer:  
 10 (1) The number and proportion of applicants for individual  
 11 coverage denied coverage as well as aggregate information about  
 12 health status and demographics of those denied coverage.  
 13 (2) The number and proportion of applicants for large group  
 14 coverage denied coverage as well as aggregate information about  
 15 health status and demographics of the employees of those denied  
 16 coverage.  
 17 (3)  
 18 (2) The written policies, procedures, or underwriting guidelines  
 19 whereby the insurer makes its decision to provide or to deny  
 20 coverage to applicants.  
 21 (d) For purposes of this section, “large group policy” or “large  
 22 group coverage” means a group health insurance policy other than  
 23 a policy issued to a small employer, as defined in Section 10700.  
 24 (e)  
 25 (c) This section shall remain in effect only until January 1, 2014,  
 26 and as of that date is repealed, unless a later enacted statute, that  
 27 is enacted before January 1, 2014, deletes or extends that date.  
 28 SEC. 7. Section 10113.96 is added to the Insurance Code, to  
 29 read:  
 30 10113.96. (a) A health insurer that issues, renews, or amends  
 31 health insurance policies shall be subject to this section.  
 32 (b) On or before June 1, 2011, and annually thereafter, an insurer  
 33 shall disclose to the commissioner all of the following:  
 34 (1) The written policies, procedures, or underwriting guidelines  
 35 whereby the insurer makes its decision to determine the standard  
 36 rate and to issue a policy at a rate higher or lower than the standard  
 37 rate.  
 38 (2) For each product in the individual or small group market,  
 39 the rates charged, including the standard rate, rates that are higher

1 ~~than the standard rate, and rates that are lower than the standard~~  
2 ~~rate.~~

3 ~~(3) For the individual, small group, and large group markets,~~  
4 ~~the number and proportion of policyholders in each category~~  
5 ~~charged a standard rate, a rate that is higher than the standard rate,~~  
6 ~~or a rate that is lower than the standard rate. For each of these~~  
7 ~~categories, demographic information shall be provided, including~~  
8 ~~age, gender, language spoken, and geographic region.~~

9 ~~(e) The commissioner shall disclose the information provided~~  
10 ~~pursuant to this section to the public, both in summary fashion on~~  
11 ~~the department's Internet Web site and in full, on request.~~

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

14 ~~SEC. 8. Section 10113.97 is added to the Insurance Code, to~~  
15 ~~read:~~

16 ~~10113.97. (a) A health insurer that issues, renews, or amends~~  
17 ~~health insurance policies shall be subject to this section.~~

18 ~~(b) On or before June 1, 2011, and no less than annually~~  
19 ~~thereafter, an insurer shall disclose to the commissioner all of the~~  
20 ~~following with respect to rate increases for each product:~~

21 ~~(1) Any change in rate.~~

22 ~~(2) Any change in cost sharing.~~

23 ~~(3) Any change in covered benefits.~~

24 ~~(e) On or before June 1, 2011, and no less than annually~~  
25 ~~thereafter, an insurer shall also disclose to the commissioner all~~  
26 ~~of the following with respect to rate increases for each product:~~

27 ~~(1) Actuarial memorandum.~~

28 ~~(2) Assumptions on trends in medical inflation, including~~  
29 ~~justification.~~

30 ~~(3) Specific worksheets or exhibits documenting increases in~~  
31 ~~costs.~~

32 ~~(4) Insured population characteristics that increase or decrease~~  
33 ~~costs.~~

34 ~~(5) Utilization increases.~~

35 ~~(6) Provider prices.~~

36 ~~(7) Administrative costs.~~

37 ~~(8) Medical loss ratios.~~

38 ~~(9) Reserves and surplus levels, including tangible net equity~~  
39 ~~and reserves in excess of tangible net equity.~~

40 ~~(10) Changes in cost sharing.~~

1     *SEC. 13. Section 12923.5 of the Insurance Code is amended*  
2     *to read:*

3     12923.5. (a) The Department of Managed Health Care and the  
4     Department of Insurance shall maintain a joint senior level working  
5     group to ensure clarity for health care consumers about who  
6     enforces their patient rights and consistency in the regulations of  
7     these departments.

8     (b) The joint working group shall undertake a review and  
9     examination of the Health and Safety Code, the Insurance Code,  
10    and the Welfare and Institutions Code as they apply to the  
11    Department of Managed Health Care and the Department of  
12    Insurance to ensure consistency in consumer protection.

13    (c) The joint working group shall review and examine all of the  
14    following processes in each department:

15    (1) Grievance and consumer complaint processes, including,  
16    but not limited to, outreach, standard complaints, including  
17    coverage and medical necessity complaints, independent medical  
18    review, and information developed for consumer use.

19    (2) The processes used to ensure enforcement of the law,  
20    including, but not limited to, the medical survey and audit process  
21    in the Health and Safety Code and market conduct exams in the  
22    Insurance Code.

23    (3) The processes for regulating the timely payment of claims.

24    (4) *Review of rates in the individual and group markets*  
25    *consistent with federal law.*

26    (d) The joint working group shall report its findings to the  
27    Insurance Commissioner and the Director of the Department of  
28    Managed Health Care for review and approval. The commissioner  
29    and the director shall submit the approved final report under  
30    signature to the Legislature by January 1 of every year for five  
31    years.

32    *SEC. 14. Section 12969.1 is added to the Insurance Code, to*  
33    *read:*

34    12969.1. (a) *A health insurer that issues, renews, or amends*  
35    *health insurance policies shall be subject to this section. On or*  
36    *before June 1, 2011, and for each rate filing thereafter, an insurer*  
37    *shall disclose to the commissioner all of the following for each*  
38    *rate filing in the individual, small employer, and large group policy*  
39    *markets:*

40    (1) *Company name and contact information.*

- 1 (2) *Number of policy forms covered by the filing.*
- 2 (3) *Policy form numbers covered by the filing.*
- 3 (4) *Product type.*
- 4 (5) *Market segment.*
- 5 (6) *Type of insurer.*
- 6 (7) *Whether the products are opened or closed.*
- 7 (8) *Enrollment in each policy and rating form.*
- 8 (9) *Member months in each policy form.*
- 9 (10) *Annual rate.*
- 10 (11) *Total earned premiums in each policy form.*
- 11 (12) *Total incurred claims in each policy form.*
- 12 (13) *Average rate increase initially requested.*
- 13 (14) *Rate of review category, including approved as originally*
- 14 *submitted, initially rejected, or resubmitted with modifications,*
- 15 *and initially rejected and not resubmitted or initially rejected and*
- 16 *challenged.*
- 17 (15) *Average rate of increase approved.*
- 18 (16) *Effective date of rate increase.*
- 19 (17) *Number of policyholders or insureds affected by each policy*
- 20 *form.*
- 21 (18) *Overall annual medical trend factor assumptions in each*
- 22 *rate filing for all benefits and disaggregated by benefit category,*
- 23 *including hospital inpatient, hospital outpatient, physician services,*
- 24 *prescription drugs, and other ancillary services, laboratory, and*
- 25 *radiology.*
- 26 (19) *The amount of the projected trend attributable to the use,*
- 27 *price inflation, or fees and risk for annual insurance trends by*
- 28 *benefit category, such as hospital inpatient, hospital outpatient,*
- 29 *physician services, prescription drugs and other ancillary services,*
- 30 *laboratory, and radiology.*
- 31 (20) *A comparison of claims cost and rate of changes over time.*
- 32 (21) *Any changes in the cost sharing of insureds over the prior*
- 33 *year associated with the submitted rate filing.*
- 34 (22) *Any changes in insured benefits over the prior year*
- 35 *associated with the submitted rate filing.*
- 36 (23) *The number and a summary the nature of consumer*
- 37 *inquiries and complaints related to health insurance rates that*
- 38 *have been received for the past two policy years.*

1 (b) A health insurer subject to subdivision (a) shall also disclose  
2 the following required aggregate data for rate filings in the  
3 individual, small employer, and large group policy markets:

4 (1) Number and percentage of rate filings reviewed by the  
5 following:

6 (A) Policy year.

7 (B) Segment type.

8 (C) Product type.

9 (D) Number of policyholders.

10 (E) Number of covered lives affected.

11 (2) The average rate increase by the following:

12 (A) Policy year.

13 (B) Segment type.

14 (C) Product type.

15 (c) For purposes of this section, “large group policy” means a  
16 group health insurance policy other than a policy issued to a small  
17 employer, as defined in Section 10700.

18 (d) This section shall not apply to specialized health insurance.

19 SEC. 15. Section 12969.2 is added to the Insurance Code, to  
20 read:

21 12969.2. (a) Each rate filing described in Section 12969.1,  
22 including all supporting material, shall be publicly available on  
23 the department’s Internet Web site. All submissions to the  
24 commissioner shall be made electronically in order to facilitate  
25 review by the commissioner and the public. Each rate filing shall  
26 include a summary of rate changes offered in plain language for  
27 consumers.

28 (b) The commissioner shall post to its public Internet Web site  
29 information about the rate filing and justification in an easy to  
30 understand language for the public.

31 (c) Health insurers shall post all proposed rate increases,  
32 including all accompanying documentation on their Internet Web  
33 site.

34 SEC. 16. Section 12969.3 is added to the Insurance Code, to  
35 read:

36 12969.3. (a) The commissioner shall review each rate filing  
37 described in Section 12969.1 for consistency with applicable state  
38 law and regulations as well as federal law, regulations, rules, or  
39 other guidance.

1 (b) The commissioner shall also review each rate filing to  
2 determine that it is actuarially sound.

3 (c) The commissioner shall consider public comment on the  
4 rate filing for no less than 60 days and respond pursuant to  
5 Chapter 3.5 (commencing with Section 11340) of Part 1 of Division  
6 3 of Title 2 of the Government Code.

7 (d) The commissioner shall conduct a public hearing on the  
8 rate filing on any of the following grounds:

9 (1) A consumer or consumer advocacy organization requests a  
10 hearing within 45 days of the rate filing. If the commissioner grants  
11 a hearing, it shall issue written findings in support of that decision.

12 (2) The commissioner determines for any reason to hold a  
13 hearing.

14 (3) The commissioner finds that the rate filing does not comply  
15 with the provisions of this section.

16 (e) After completing a review pursuant to this section, the  
17 commissioner shall post to its Internet Web site any changes to  
18 the rates and the reason for those changes, including any  
19 documentation to support those changes.

20 SEC. 17. Section 12969.4 is added to the Insurance Code, to  
21 read:

22 12969.4. (a) Consistent with federal law, rules, and guidance,  
23 the commissioner shall do all of the following:

24 (1) Provide data to the United States Secretary of Health and  
25 Human Services on health insurance rate trends in premium rating  
26 areas.

27 (2) Provide to the United States Secretary of Health and Human  
28 Services the number and summarize the nature of consumer  
29 inquiries and complaints related to health insurance rates that  
30 have been received for the past two plan years.

31 (b) Commencing with the creation of the Exchange, provide to  
32 the Exchange such information as may be necessary to allow  
33 compliance with federal law, rules, and guidance. The  
34 commissioner shall develop an interagency agreement with the  
35 Exchange to facilitate the reporting of information regarding rate  
36 filings that is consistent with the responsibilities of the Exchange.  
37 As used in this subdivision, the "Exchange" means the American  
38 Health Benefit Exchange established in California pursuant to  
39 Section 1311 of the federal Patient Protection and Affordable Care  
40 Act (Public Law 111-148).

1     *SEC. 18. Section 12969.5 is added to the Insurance Code, to*  
2 *read:*

3     *12969.5. (a) The commissioner shall apply for grant funding*  
4 *from the federal government for the purposes of rate review*  
5 *consistent with the requirements of federal law, rules, and*  
6 *guidance.*

7     *(b) Additional costs and expenses associated with rate reviews*  
8 *shall be supported by fees established by the commissioner.*

9     ~~SEC. 9.~~

10     *SEC. 19. No reimbursement is required by this act pursuant*  
11 *to Section 6 of Article XIII B of the California Constitution because*  
12 *the only costs that may be incurred by a local agency or school*  
13 *district will be incurred because this act creates a new crime or*  
14 *infraction, eliminates a crime or infraction, or changes the penalty*  
15 *for a crime or infraction, within the meaning of Section 17556 of*  
16 *the Government Code, or changes the definition of a crime within*  
17 *the meaning of Section 6 of Article XIII B of the California*  
18 *Constitution.*