AMENDED IN ASSEMBLY AUGUST 18, 2010

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

Introduced by Senator Leno
(Coauthor: Senator Pavley)

February 18, 2010

~~An act to amend Sections 1342, 1342.4, 1367, and 1389.25 of, to add Sections 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 Sections 10113.9 and 12923.5 of, to add Sections 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.~~ *An act to amend Sections 1374.21, 1374.22, and 1389.25 of, and to add Article 6.2 (commencing with Section 1385.01) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 10113.9, 10199.1, and 10199.2 of, and to add Article 4.5 (commencing with Section 10181) to Chapter 1 of Part 2 of Division 2 of, the Insurance Code, relating to health care coverage.*

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 *or group* market from changing the premium rate or coverage without providing specified notice *to the policyholder or subscriber* at least 30 days prior to the effective date of the change.

This bill would require a health care service plan *that offers coverage in the group market* and a health insurer that offers health care coverage in the individual or group market to provide an ~~individual or group~~ *applicant* 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~~ *60* 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 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 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 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, including accompanying documentation regarding rate changes. The bill would 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.~~

Existing law, the federal Patient Protection and Affordable Care Act, requires the United States Secretary of Health and Human Services to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage in which health insurance issuers submit to the secretary and the relevant state a justification for an unreasonable premium increase prior to implementation of the increase. The act requires the secretary to carry out a program to award grants to states during the 5-year period beginning with fiscal year 2010 to assist states in carrying out this process, as specified.

This bill would require a health care service plan or health insurer to file rate information with the Department of Managed Health Care or the Department of Insurance, as specified, and would require that the information be made publicly available, as specified. The bill would would authorize the departments to review these filings and conduct a public hearing under specified circumstances and would require the departments to post certain findings on their Internet Web sites. The bill would enact other related provisions.

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 1374.21 of the Health and Safety Code is amended to read:

1374.21. *(a)* No change in premium rates or changes in coverage stated in a group health care service plan contract shall become effective unless the plan has delivered in writing a notice indicating the change or changes at least ~~30~~ *60* days prior to the contract renewal effective date.

(b) A health care service plan that declines to offer coverage to or denies enrollment for a group applying for coverage or that offers 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 applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

SEC. 2. Section 1374.22 of the Health and Safety Code is amended to read:

1374.22. (a) The written notice *described in subdivision (a) of Section 1374.21* shall be delivered by mail at the last known address at least ~~30~~ *60* days prior to the renewal effective date to the group contract holder.

(b) The written notice shall state in italics ~~either~~ *and in 12-point type* the actual dollar amount ~~or a~~ *and the* specific percentage of the premium rate increase. Further, the notice shall describe in plain understandable English and highlighted in italics any changes in the plan design or change in benefits with reduction in benefits, waivers, exclusions, or conditions.

(c) The written notice shall specify in *a minimum of* 10-point bold typeface the reason or reasons for premium rate changes, plan design, or plan benefit changes.

SEC. 3. Article 6.2 (commencing with Section 1385.01) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 6.2. Review of Rate Increases

1385.01. For purposes of this article, the following definitions shall apply:

(a) "Large group health care service plan contract" means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357.

(b) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357.

(c) "PPACA" means Section 2794 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-14), as amended by the federal Patient Protection and Affordable Care Act (P. L. 111-48), and any subsequent rules or regulations issued under that section.

(d) "Unreasonable rate increase" has the same meaning as that term is defined in PPACA.

1385.02. This article shall apply to health care service plan contracts offered in the individual or group market in California. However, this article shall not apply to a specialized health care service plan contract; a Medicare supplement contract subject to Article 3.5 (commencing with Section 1358.1); a health care service plan contract offered 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 contract offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code); a health care service plan conversion contract offered pursuant to Section 1373.6; or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article 10.5 (commencing with Section 1399.801).

1385.04. (a) (1) All health care service plans shall file with the department all required rate information for individual and small group health care service plan contracts at least 60 days prior to implementing any rate change.

(2) For large group health care service plan contracts, all health plans shall file with the department all required rate information

for unreasonable rate increases prior to implementing any such rate change.

(b) A plan shall disclose to the department all of the following for each rate filing:

(1) Company name and contact information.

(2) Number of plan contract forms covered by the filing.

(3) Plan contract form numbers covered by the filing.

(4) Product type.

(5) Segment type.

(6) Type of plan involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each plan contract and rating form.

(9) Enrollee months in each plan contract form.

(10) Annual rate.

(11) Total earned premiums in each plan contract form.

(12) Total incurred claims in each plan contract form.

(13) Average rate increase initially requested.

(14) Review category: initial filing for new product, filing for existing product, or resubmission.

(15) Average rate of increase.

(16) Effective date of rate increase.

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

(18) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and disaggregated by benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A plan shall provide additional data that demonstrates year-to-year cost increases in specific benefit categories. A health plan shall also provide information on aggregate annual cost increases for specific hospitals and for specific medical groups within a plan network.

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

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

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

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

(23) The number of consumer inquiries and complaints related to the plan's rates that have been received by the plan during the preceding two plan years. The plan shall also summarize the nature of those inquiries and complaints.

(24) The certification described in subdivision (c) of Section 1385.06.

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings in the individual, small group, and large group health plan markets:

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

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. The plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(e) A plan shall submit any other information required by the department to comply with this article.

1385.06. (a) A filing submitted under this article shall be consistent with applicable state and federal laws, rules, and regulations, including, but not limited to, the applicable provisions of law governing health care service plan contracts, medical loss

ratios, rating rules, health benefit designs, and health benefit standards.

(b) A filing submitted under this article shall be actuarially sound.

(c) (1) A filing submitted under this article shall include a certification by an independent actuary or actuarial firm that the rate increase is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions.

(2) The actuary or actuarial firm acting under paragraph (1) shall not be an affiliate or a subsidiary of, nor in any way owned or controlled by, a health care service plan or a trade association of health care service plans. A board member, director, officer, or employee of the actuary or actuarial firm shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health care service plan or a trade association of health care service plans shall not serve as a board member, director, officer, or employee of the actuary or actuarial firm.

(d) Nothing in this section shall be construed to preclude the department from reviewing a proposed rate increase for actuarial soundness or consistency with applicable state or federal laws, rules, or regulations.

1385.07. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available except as provided in subdivision (b).

(b) The contracted rates between a health care service plan and an individual provider, including, but not limited to, a health professional, medical group, hospital, or hospital system, shall be deemed confidential information that shall not be divulged by the department.

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the health care service plan shall file the following information in a manner and format specified by the department. The information shall be in plain language and shall be made readily available to the public on the Internet Web site of the department and the plan, except as provided in subdivision

(b). The information shall be made public for 60 days prior to the implementation of the rate increase. This period may be extended by the department if needed to complete its review consistent with this article. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health plan's actual costs, disaggregated by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

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

1385.08. (a) On or before July 1, 2011, the director may issue guidance to health care service plans regarding compliance with this article. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) The department may adopt regulations to implement this article in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) The department shall consult with the Department of Insurance in issuing guidance under subdivision (a), in adopting regulations under subdivision (b), in posting information on its Internet Web site under this article, and in taking any other action for the purpose of implementing this article.

1385.11. (a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, including the filing of inaccurate or unjustified rates or inaccurate or unjustified rate information, the department may review the rate filing to ensure compliance with the law.

(b) The department shall, at a minimum, review for consistency with Section 1385.06 any unreasonable rate increase.

(c) The department shall also review a proposed rate increase if the plan proposing the increase is found by the department to have a pattern of filing inaccurate, unjustified, or unreasonable rate increases.

(d) The department may review other filings.

(e) The department shall consider any public comment on a rate increase submitted to the department during the 60-day period described in subdivision (d) of Section 1385.07.

(f) The department shall report to the Legislature at least quarterly on all rate filings that are unreasonable, not actuarially sound, or otherwise not consistent with applicable state or federal laws or regulations, including, but not limited to, those governing health care service plan contracts, medical loss ratio, rating rules, benefit designs, and benefit standards.

(g) After conducting a review under this section, the department shall post on its Internet Web site any changes to the proposed rate increase, including any documentation supporting those changes.

(h) If the department finds that an unreasonable rate increase is not justified or that a rate filing contains inaccurate information, the department shall post its finding on its Internet Web site.

(i) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this chapter.

1385.13. The department shall do all of the following in a manner consistent with applicable federal laws, rules, and regulations:

(a) Provide data to the United States Secretary of Health and Human Services on health care service plan rate trends in premium rating areas.

(b) Provide to the United States Secretary of Health and Human Services the number of, and a summary of the nature of, inquiries and complaints related to health care service plan rates that have been received for the past two plan years.

(c) Commencing with the creation of the Exchange, provide to the Exchange such information as may be necessary to allow compliance with federal law, rules, regulations, and guidance. The director shall develop an interagency agreement with the Exchange to facilitate the reporting of information regarding rate filings that is consistent with the responsibilities of the Exchange.

As used in this subdivision, the "Exchange" means the American Health Benefit Exchange established in California pursuant to Section 1311 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 4. 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 ~~at the time of the denial or offer of coverage~~ *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~~ *60* 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~~ *60* days prior to the effective date of the change. The notice shall state in italics ~~either~~ *and in 12-point type* the actual dollar amount of the premium rate increase ~~or~~ *and* 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 (MRMIP) (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code. The information provided to the applicant by the plan shall be in accordance with standards developed by the department, in consultation with the Managed Risk Medical Insurance Board, and shall specifically include the toll-free telephone number and Internet Web site address for MRMIP and the federal temporary high risk pool. The requirement to notify applicants of the availability of MRMIP and the federal temporary high risk pool 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. 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 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 to 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 applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

~~(b)~~

(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~~ *60* 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.

~~(c)~~

(3) The written notice required pursuant to ~~subdivision (b)~~ *paragraph (2)* shall be delivered to the individual policyholder at his or her last address known to the insurer, at least ~~30~~ *60* days prior to the effective date of the change. The notice shall state in italics ~~either~~ *and in 12-point type* the actual dollar amount of the premium increase ~~or~~ *and* the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

~~(d)~~

(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 (MRMIP) (Part 6.5 (commencing with Section 12700)), and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5). The information provided to the applicant by the insurer shall be in accordance with standards developed by the

department, in consultation with the Managed Risk Medical Insurance Board, and shall specifically include the toll-free telephone number and Internet Web site address for MRMIP and the federal temporary high risk pool. The requirement to notify applicants of the availability of MRMIP and the federal temporary high risk pool 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 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. Article 4.5 (commencing with Section 10181) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 4.5. Review of Rate Increases

10181. For purposes of this article, the following definitions shall apply:

(a) "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.

(b) "Small group health insurance policy" means a group health insurance policy issued to a small employer, as defined in Section 10700.

(c) "PPACA" means Section 2794 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-14), as amended by the federal Patient Protection and Affordable Care Act (P. L. 111-48), and any subsequent rules or regulations issued pursuant to that law.

(d) "Unreasonable rate increase" has the same meaning as that term is defined in PPACA.

10181.2. This article shall apply to health insurance policies offered in the individual or group market in California. However, this article shall not apply to a specialized health insurance policy; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered 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 insurance policy offered in the Healthy Families Program

(Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

10181.4. (a) (1) All health insurers shall file with the department all required rate information for individual and small group health insurance policies at least 60 days prior to implementing any rate change.

(2) For large group health insurance policies, all health insurers shall file with the department all required rate information for unreasonable rate increases prior to implementing any such rate change.

(b) An insurer shall disclose to the department all of the following for each rate filing:

(1) Company name and contact information.

(2) Number of policy forms covered by the filing.

(3) Policy form numbers covered by the filing.

(4) Product type.

(5) Segment type.

(6) Type of insurer involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each policy and rating form.

(9) Insured months in each policy form.

(10) Annual rate.

(11) Total earned premiums in each policy form.

(12) Total incurred claims in each policy form.

(13) Average rate increase initially requested.

(14) Review category: initial filing for new product, filing for existing product, or resubmission.

(15) Average rate of increase.

(16) Effective date of rate increase.

(17) Number of policyholders or insureds affected by each policy form.

(18) The insurer's overall annual medical trend factor assumptions in each rate filing for all benefits and disaggregated

by benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. An insurer shall provide additional data that demonstrates year-to-year cost increases in specific benefit categories. An insurer shall also provide information on aggregate annual cost increases for specific hospitals and for specific medical groups within a network.

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

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

(21) Any changes in insured cost-sharing over the prior year associated with the submitted rate filing.

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

(23) The number of consumer inquiries and complaints related to the insurer's rates that have been received by the insurer during the preceding two plan years. The insurer shall also summarize the nature of those inquiries and complaints.

(24) The certification described in subdivision (c) of Section 10181.6.

(c) An insurer subject to subdivision (a) shall also disclose the following aggregate data for all rate filings in the individual, small group, and large group health insurance markets:

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

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of policyholders

(E) Number of covered lives affected.

(2) The insurer's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the insurer's last rate filing for the same category of health benefit

plan. The insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health insurers to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(e) A health insurer shall submit any other information required by the department to comply with this article.

10181.6. (a) A filing submitted under this article shall be consistent with applicable state and federal laws, rules, and regulations, including, but not limited to, the provisions of law governing health insurance policies, medical loss ratios, rating rules, health benefit designs, and health benefit standards.

(b) A filing submitted under this article shall be actuarially sound.

(c) (1) A filing submitted under this article shall include a certification by an independent actuary or actuarial firm that the rate increase is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions.

(2) The actuary or actuarial firm acting under paragraph (1) shall not be an affiliate or a subsidiary of, nor in any way owned or controlled by, a health insurer or a trade association of health insurers. A board member, director, officer, or employee of the actuary or actuarial firm shall not serve as a board member, director, or employee of a health insurer. A board member, director, or officer of a health insurer or a trade association of health insurers shall not serve as a board member, director, officer, or employee of the actuary or actuarial firm.

(d) Nothing in this section shall be construed to preclude the department from reviewing a proposed rate increase for actuarial soundness or consistency with applicable state or federal laws, rules, or regulations.

10181.7. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all

information submitted under this article shall be made publicly available except as provided in subdivision (b).

(b) The contracted rates between a health insurer and an individual provider, including, but not limited to, a health professional, medical group, hospital, or hospital system, shall be deemed confidential information that shall not be divulged by the department.

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the health insurer shall file the following information in a manner and format specified by the department. The information shall be in plain language and shall be made readily available to the public on the Internet Web site of the department and the insurer, except as provided in subdivision (b). The information shall be made public for 60 days prior to the implementation of the rate increase. This period may be extended by the department if needed to complete its review consistent with this article. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) An insurer's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) An insurer's actual costs, disaggregated by aggregate benefit category to include, hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual policy trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

10181.9. (a) On or before July 1, 2011, the commissioner may issue guidance to health insurers regarding compliance with this article. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) The department may adopt regulations to implement this article in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) The department shall consult with the Department of Managed Health Care in issuing guidance under subdivision (a), in adopting regulations under subdivision (b), in posting information on its Internet Web site under this article, and in taking any other action for the purpose of implementing this article.

10181.11. (a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, including the filing of inaccurate or unjustified rates or inaccurate or unjustified rate information, the department may review rate filing to ensure compliance with the law.

(b) The department shall, at a minimum, review for consistency with Section 10181.6 any unreasonable rate increase.

(c) The department shall also review a rate increase if the insurer proposing the increase is found by the department to have a pattern of filing inaccurate, unjustified, or unreasonable rate increases.

(d) The department may review other filings.

(e) The department shall consider any public comment on a rate increase submitted to the department during the 60-day period described in subdivision (d) of Section 10181.7.

(f) The department shall report to the Legislature at least quarterly on all rate filings that are unreasonable, not actuarially sound, or otherwise not consistent with applicable state or federal laws or regulations, including, but not limited to, those governing health insurance policies, medical loss ratio, rating rules, benefit designs, and benefit standards.

(g) After conducting a review under this section, the department shall post on its Internet Web site any changes to the proposed rate increase, including any documentation supporting those changes.

(h) If the department finds that an unreasonable rate increase is not justified or that a rate filing contains inaccurate information, the department shall post its finding on its Internet Web site.

(i) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this code.

10181.13. The department shall do all of the following in a manner consistent with applicable federal laws, rules, and regulations:

(a) Provide data to the United States Secretary of Health and Human Services on health insurer rate trends in premium rating areas.

(b) Provide to the United States Secretary of Health and Human Services the number of, and a summary of the nature of, inquiries and complaints related to health insurer rates that have been received for the past two plan years.

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

SEC. 7. Section 10199.1 of the Insurance Code is amended to read:

10199.1. (a) No insurer or nonprofit hospital service plan or administrator acting on its behalf shall terminate a group master policy or contract providing hospital, medical, or surgical benefits, increase premiums or charges therefor, reduce or eliminate benefits thereunder, or restrict eligibility for coverage thereunder without providing prior notice of that action. No such action shall become effective unless written notice of the action was delivered by mail to the last known address of the appropriate insurance producer and the appropriate administrator, if any, at least 45 days prior to the effective date of the action and to the last known address of the group policyholder or group contractholder at least ~~30~~ *60* days prior to the effective date of the action. If nonemployee certificate holders or employees of more than one employer are covered under the policy or contract, written notice shall also be delivered by mail to the last known address of each nonemployee certificate holder or affected employer or, if the action does not affect all employees and dependents of one or more employers, to the last

known address of each affected employee certificate holder, at least ~~30~~ *60* days prior to the effective date of the action.

(b) No holder of a master group policy or a master group nonprofit hospital service plan contract or administrator acting on its behalf shall terminate the coverage of, increase premiums or charges for, or reduce or eliminate benefits available to, or restrict eligibility for coverage of a covered person, employer unit, or class of certificate holders covered under the policy or contract for hospital, medical, or surgical benefits without first providing prior notice of the action. No such action shall become effective unless written notice was delivered by mail to the last known address of each affected nonemployee certificate holder or employer, or if the action does not affect all employees and dependents of one or more employers, to the last known address of each affected employee certificate holder, at least ~~30~~ *60* days prior to the effective date of the action.

(c) A health insurer that declines to offer coverage to or denies enrollment for a group applying for coverage or that offers 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 applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

SEC. 8. Section 10199.2 of the Insurance Code is amended to read:

10199.2. (a) The written notice *described in subdivisions (a) and (b) of Section 10199.1* shall state in italics ~~either~~ *and in 12-point type* the actual dollar amount ~~or a~~ *and the* specific percentage of the premium rate increase. Further, the notice shall describe in plain understandable English and highlighted in italics any changes in the plan design or change in benefits with reduction in benefits, waivers, exclusions, or conditions.

(b) The written notice shall specify *in a minimum of 10-point bold typeface* the reason or reasons for premium rate changes, plan design, or plan benefit changes.

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.

~~SECTION 1. Section 1342 of the Health and Safety Code is amended to read:~~

~~1342. It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:~~

~~(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.~~

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

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

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

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

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

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

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

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

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

~~1342.4. (a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who~~

~~enforces their patient rights and consistency in the regulations of these departments.~~

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

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

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

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

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

~~(4) Rates in the individual and group markets consistent with federal law.~~

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

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

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

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

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

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

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

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

~~(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.~~

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

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

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

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

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

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

~~(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.~~

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

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

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

~~SEC. 4. 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 or group 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 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 or a group applying for coverage or that offers coverage at a rate that is higher than the standard rate, shall, at the time of the denial or offer of coverage, provide the 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 a plan contract shall become effective unless the plan has delivered a written notice of the change at least 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 contractholder at his or her last address known to the plan, at least 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 individual applicant or the dependents of an individual applicant for individual 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 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. 5. Section 1389.26 is added to the Health and Safety Code, to read:~~

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

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

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

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

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

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

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

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

~~SEC. 6. Section 1389.90 is added to the Health and Safety Code, to read:~~

~~1389.90. (a) A full service health care service plan that issues, renews, or amends health care service plan contracts shall be subject to this section. On or before June 1, 2011, and for each rate filing thereafter, a plan shall disclose to the department all of the following for each rate filing in the individual, small employer, and large group health plan markets:~~

~~(1) Company name and contact information.~~

~~(2) Number of plan contract forms covered by the filing.~~

~~(3) Plan contract form numbers covered by the filing.~~

~~(4) Product type.~~

~~(5) Market segment.~~

~~(6) Type of plan, such as for profit or not for profit.~~

~~(7) Whether the products are opened or closed.~~

~~(8) Enrollment in each plan contract and rating form.~~

~~(9) Enrollee months in each plan contract form.~~

~~(10) Annual rate.~~

~~(11) Total earned premiums in each plan contract form.~~

~~(12) Total incurred claims in each plan contract form.~~

~~(13) Average rate increase initially requested.~~

~~(14) Rate of review category, including approved as originally submitted, initially rejected, or resubmitted with modifications, and initially rejected and not resubmitted or initially rejected and challenged.~~

~~(15) Average rate of increase approved.~~

~~(16) Effective date of rate increase.~~

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

~~(18) Overall annual medical trend factor assumptions in each rate filing for all benefits and disaggregated by benefit category,~~

~~including hospital inpatient, hospital outpatient, physician services, prescription drugs, and other ancillary services, laboratory, and radiology.~~

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

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

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

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

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

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

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

~~(A) Plan year.~~

~~(B) Segment type.~~

~~(C) Product type.~~

~~(D) Number of subscribers.~~

~~(E) Number of covered lives affected.~~

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

~~(A) Plan year.~~

~~(B) Segment type.~~

~~(C) Product type.~~

~~(c) For purposes of this section, "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.~~

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

~~1389.91. (a) Each rate filing described in Section 1389.90, including all supporting material, shall be publicly available on the department's Internet Web site. All submissions to the~~

~~department shall be made electronically in order to facilitate review by the department and the public. Each rate filing shall include a summary of rate changes offered in plain language for consumers.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(2) Provide to the United States Secretary of Health and Human Services the number and summarize the nature of consumer~~

~~inquiries and complaints related to health plan rates that have been received for the past two plan years.~~

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

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

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

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

~~SEC. 11. 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 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 or a group applying for coverage or that offers coverage at a rate that is higher than the standard rate shall, at the time of the denial or offer of coverage, provide the 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 a health insurance policy shall become effective unless the insurer has delivered a written notice of the change at least 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 policyholder at his or her last address known to the insurer, at least 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 individual applicant or the dependents of an individual applicant for individual coverage or offers individual coverage at a rate that is higher than the standard rate, the insurer shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)). The information provided to the applicant by the insurer shall specifically include the program's toll-free telephone number and its Internet Web site address. The requirement to notify applicants of the availability of the California Major Risk Medical Insurance Program shall not apply when a health plan rejects an applicant for Medicare supplement coverage.~~

~~(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 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. 12. Section 10113.91 is added to the Insurance Code, to read:~~

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

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

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

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

~~(b) The commissioner shall post on the department's Internet Web site the following information for each product offered by a health insurer and for all products offered by the insurer:~~

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

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

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

~~SEC. 13. Section 12923.5 of the Insurance Code is amended to read:~~

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

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

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

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

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

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

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

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

~~SEC. 14. Section 12969.1 is added to the Insurance Code, to read:~~

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

~~(1) Company name and contact information.~~

~~(2) Number of policy forms covered by the filing.~~

~~(3) Policy form numbers covered by the filing.~~

~~(4) Product type.~~

~~(5) Market segment.~~

~~(6) Type of insurer.~~

~~(7) Whether the products are opened or closed.~~

~~(8) Enrollment in each policy and rating form.~~

~~(9) Member months in each policy form.~~

~~(10) Annual rate.~~

~~(11) Total earned premiums in each policy form.~~

~~(12) Total incurred claims in each policy form.~~

~~(13) Average rate increase initially requested.~~

~~(14) Rate of review category, including approved as originally submitted, initially rejected, or resubmitted with modifications, and initially rejected and not resubmitted or initially rejected and challenged.~~

~~(15) Average rate of increase approved.~~

~~(16) Effective date of rate increase.~~

~~(17) Number of policyholders or insureds affected by each policy form.~~

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

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

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

~~(21) Any changes in the cost sharing of insureds over the prior year associated with the submitted rate filing.~~

~~(22) Any changes in insured benefits over the prior year associated with the submitted rate filing.~~

~~(23) The number and a summary the nature of consumer inquiries and complaints related to health insurance rates that have been received for the past two policy years.~~

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

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

~~(A) Policy year.~~

~~(B) Segment type.~~

~~(C) Product type.~~

~~(D) Number of policyholders.~~

~~(E) Number of covered lives affected.~~

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

~~(A) Policy year.~~

~~(B) Segment type.~~

~~(C) Product type.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~SEC. 18. Section 12969.5 is added to the Insurance Code, to read:~~

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

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

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

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