

AMENDED IN ASSEMBLY AUGUST 25, 2010

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 *1357.03*, *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*~~ *10199.2*, and *10705* 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 applicant to whom it denies coverage or enrollment, *as specified*, or offers coverage at a rate higher than the standard rate *or standard employee risk 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 60 days prior to the effective date of the change.

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 *in the individual, small group, or large group markets* 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 *certified by an independent actuary, as specified*, and made publicly available, *except as specified*. The bill would ~~would~~ authorize the departments to review these filings *and issue guidance regarding compliance, require the departments to consult with each other regarding specified actions, 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.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), specifies that grandfathered health plans, as defined, are subject only to certain provisions of the act, and specifies that policies sold in the group and individual markets to new entities or individuals on or after March 23, 2010, are not grandfathered plans even if the products sold to those subscribers were offered in the group or individual market before March 23, 2010.

Existing law requires a plan or insurer to fairly and affirmatively offer, market, and sell all of the plan’s contracts or the insurer’s benefit plan designs that are sold to small employers to all small employers in each service area in which the plan or insurer provides or arranges for the provision of health care services.

This bill would deem a plan or insurer to be in compliance with that requirement with respect to a plan contract or benefit plan design that qualifies as a grandfathered health plan under PPACA if certain requirements are met.

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 1357.03 of the Health and Safety Code
- 2 is amended to read:
- 3 1357.03. (a) (1) Upon the effective date of this article, a plan
- 4 shall fairly and affirmatively offer, market, and sell all of the plan’s
- 5 health care service plan contracts that are sold to small employers
- 6 or to associations that include small employers to all small
- 7 employers in each service area in which the plan provides or
- 8 arranges for the provision of health care services. ~~A plan~~
- 9 contracting to participate in the voluntary purchasing pool for small

1 employers provided for under Article 4 (commencing with Section
2 10730) of Chapter 8 of Part 2 of Division 2 of the Insurance Code
3 shall be deemed in compliance with this requirement for a contract
4 offered through the voluntary purchasing pool established under
5 Article 4 (commencing with Section 10730) of Chapter 8 of Part
6 2 of Division 2 of the Insurance Code in those geographic regions
7 in which plans participate in the pool, if the contract is offered
8 exclusively through the pool. Each

9 (2) *Each plan shall make available to each small employer all*
10 *small employer health care service plan contracts that the plan*
11 *offers and sells to small employers or to associations that include*
12 *small employers in this state.* ~~No~~

13 (3) *No plan or solicitor shall induce or otherwise encourage a*
14 *small employer to separate or otherwise exclude an eligible*
15 *employee from a health care service plan contract that is provided*
16 *in connection with the employee's employment or membership in*
17 *a guaranteed association.*

18 (4) *A plan contracting to participate in the voluntary purchasing*
19 *pool for small employers provided for under Article 4 (commencing*
20 *with Section 10730) of Chapter 8 of Part 2 of Division 2 of the*
21 *Insurance Code shall be deemed in compliance with the*
22 *requirements of paragraph (1) for a contract offered through the*
23 *voluntary purchasing pool established under Article 4*
24 *(commencing with Section 10730) of Chapter 8 of Part 2 of*
25 *Division 2 of the Insurance Code in those geographic regions in*
26 *which plans participate in the pool, if the contract is offered*
27 *exclusively through the pool.*

28 (5) (A) *A plan shall be deemed to meet the requirements of*
29 *paragraphs (1) and (2) with respect to a plan contract that qualifies*
30 *as a grandfathered health plan under Section 1251 of PPACA if*
31 *all of the following requirements are met:*

32 (i) *The plan offers to renew the plan contract, unless the plan*
33 *withdraws the plan contract from the small employer market*
34 *pursuant to subdivision (e) of Section 1357.11.*

35 (ii) *The plan provides appropriate notice of the grandfathered*
36 *status of the contract in any materials provided to an enrollee of*
37 *the contract describing the benefits provided under the contract,*
38 *as required under PPACA.*

39 (iii) *The plan makes no changes to the benefits covered under*
40 *the plan contract other than those required by a state or federal*

1 law, regulation, rule, or guidance and those permitted to be made
2 to a grandfathered health plan under PPACA.

3 (B) For purposes of this paragraph, “PPACA” means the
4 federal Patient Protection and Affordable Care Act (Public Law
5 111-148), as amended by the federal Health Care and Education
6 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
7 regulations, or guidance issued thereunder. For purposes of this
8 paragraph, a “grandfathered health plan” shall have the meaning
9 set forth in Section 1251 of PPACA.

10 (b) Every plan shall file with the director the reasonable
11 employee participation requirements and employer contribution
12 requirements that will be applied in offering its plan contracts.
13 Participation requirements shall be applied uniformly among all
14 small employer groups, except that a plan may vary application
15 of minimum employee participation requirements by the size of
16 the small employer group and whether the employer contributes
17 100 percent of the eligible employee’s premium. Employer
18 contribution requirements shall not vary by employer size. A health
19 care service plan shall not establish a participation requirement
20 that (1) requires a person who meets the definition of a dependent
21 in subdivision (a) of Section 1357 to enroll as a dependent if he
22 or she is otherwise eligible for coverage and wishes to enroll as
23 an eligible employee and (2) allows a plan to reject an otherwise
24 eligible small employer because of the number of persons that
25 waive coverage due to coverage through another employer.
26 Members of an association eligible for health coverage under
27 subdivision (o) of Section 1357, but not electing any health
28 coverage through the association, shall not be counted as eligible
29 employees for purposes of determining whether the guaranteed
30 association meets a plan’s reasonable participation standards.

31 (c) The plan shall not reject an application from a small
32 employer for a health care service plan contract if all of the
33 following are met:

34 (1) The small employer, as defined by paragraph (1) of
35 subdivision (l) of Section 1357, offers health benefits to 100
36 percent of its eligible employees, as defined by paragraph (1) of
37 subdivision (b) of Section 1357. Employees who waive coverage
38 on the grounds that they have other group coverage shall not be
39 counted as eligible employees.

1 (2) The small employer agrees to make the required premium
2 payments.

3 (3) The small employer agrees to inform the small employers'
4 employees of the availability of coverage and the provision that
5 those not electing coverage must wait one year to obtain coverage
6 through the group if they later decide they would like to have
7 coverage.

8 (4) The employees and their dependents who are to be covered
9 by the plan contract work or reside in the service area in which
10 the plan provides or otherwise arranges for the provision of health
11 care services.

12 (d) No plan or solicitor shall, directly or indirectly, engage in
13 the following activities:

14 (1) Encourage or direct small employers to refrain from filing
15 an application for coverage with a plan because of the health status,
16 claims experience, industry, occupation of the small employer, or
17 geographic location provided that it is within the plan's approved
18 service area.

19 (2) Encourage or direct small employers to seek coverage from
20 another plan or the voluntary purchasing pool established under
21 Article 4 (commencing with Section 10730) of Chapter 8 of Part
22 2 of Division 2 of the Insurance Code because of the health status,
23 claims experience, industry, occupation of the small employer, or
24 geographic location provided that it is within the plan's approved
25 service area.

26 (e) A plan shall not, directly or indirectly, enter into any contract,
27 agreement, or arrangement with a solicitor that provides for or
28 results in the compensation paid to a solicitor for the sale of a
29 health care service plan contract to be varied because of the health
30 status, claims experience, industry, occupation, or geographic
31 location of the small employer. This subdivision does not apply
32 to a compensation arrangement that provides compensation to a
33 solicitor on the basis of percentage of premium, provided that the
34 percentage shall not vary because of the health status, claims
35 experience, industry, occupation, or geographic area of the small
36 employer.

37 (f) A policy or contract that covers two or more employees shall
38 not establish rules for eligibility, including continued eligibility,
39 of an individual, or dependent of an individual, to enroll under the

1 terms of the plan based on any of the following health status-related
2 factors:

- 3 (1) Health status.
- 4 (2) Medical condition, including physical and mental illnesses.
- 5 (3) Claims experience.
- 6 (4) Receipt of health care.
- 7 (5) Medical history.
- 8 (6) Genetic information.
- 9 (7) Evidence of insurability, including conditions arising out of
10 acts of domestic violence.
- 11 (8) Disability.
- 12 (g) A plan shall comply with the requirements of Section 1374.3.

13 ~~SECTION 1.~~

14 *SEC. 2.* Section 1374.21 of the Health and Safety Code is
15 amended to read:

16 1374.21. (a) No change in premium rates or changes in
17 coverage stated in a group health care service plan contract shall
18 become effective unless the plan has delivered in writing a notice
19 indicating the change or changes at least 60 days prior to the
20 contract renewal effective date.

21 (b) A health care service plan that declines to offer coverage to
22 or denies enrollment for a *large* group applying for coverage or
23 that offers *small* group coverage at a rate that is higher than the
24 standard *employee risk* rate, shall, at the time of the denial or offer
25 of coverage, provide the applicant with the specific reason or
26 reasons for the decision in writing, in clear, easily understandable
27 language.

28 ~~SEC. 2.~~

29 *SEC. 3.* Section 1374.22 of the Health and Safety Code is
30 amended to read:

31 1374.22. (a) The written notice described in subdivision (a)
32 of Section 1374.21 shall be delivered by mail at the last known
33 address at least 60 days prior to the renewal effective date to the
34 group contract holder.

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

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

4 ~~SEC. 3.~~

5 *SEC. 4.* Article 6.2 (commencing with Section 1385.01) is
 6 added to Chapter 2.2 of Division 2 of the Health and Safety Code,
 7 to read:

8

9

Article 6.2. Review of Rate Increases

10

11 1385.01. For purposes of this article, the following definitions
 12 shall apply:

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

16 (b) “Small group health care service plan contract” means a
 17 group health care service plan contract issued to a small employer,
 18 as defined in Section 1357.

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

24 (d) “Unreasonable rate increase” has the same meaning as that
 25 term is defined in PPACA.

26 1385.02. This article shall apply to health care service plan
 27 contracts offered in the individual or group market in California.
 28 However, this article shall not apply to a specialized health care
 29 service plan contract; a Medicare supplement contract subject to
 30 Article 3.5 (commencing with Section 1358.1); a health care
 31 service plan contract offered in the Medi-Cal program (Chapter 7
 32 (commencing with Section 14000) of Part 3 of Division 9 of the
 33 Welfare and Institutions Code); a health care service plan contract
 34 offered in the Healthy Families Program (Part 6.2 (commencing
 35 with Section 12693) of Division 2 of the Insurance Code), the
 36 Access for Infants and Mothers Program (Part 6.3 (commencing
 37 with Section 12695) of Division 2 of the Insurance Code), the
 38 California Major Risk Medical Insurance Program (Part 6.5
 39 (commencing with Section 12700) of Division 2 of the Insurance
 40 Code), or the Federal Temporary High Risk Pool (Part 6.6

1 (commencing with Section 12739.5) of Division 2 of the Insurance
2 Code); a health care service plan conversion contract offered
3 pursuant to Section 1373.6; or a health care service plan contract
4 offered to a federally eligible defined individual under Article 4.6
5 (commencing with Section 1366.35) or Article 10.5 (commencing
6 with Section 1399.801).

7 ~~1385.04.~~

8 *1385.03.* (a) (1) All health care service plans shall file with
9 the department all required rate information for individual and
10 small group health care service plan contracts at least 60 days prior
11 to implementing any rate change.

12 ~~(2) For large group health care service plan contracts, all health~~
13 ~~plans shall file with the department all required rate information~~
14 ~~for unreasonable rate increases prior to implementing any such~~
15 ~~rate change.~~

16 *(2) For individual health care service plan contracts, the filing*
17 *shall be concurrent with the notice required under Section 1389.25.*

18 *(3) For small group health care service plan contracts, the filing*
19 *shall be concurrent with the notice required under subdivision (a)*
20 *of Section 1374.21.*

21 (b) A plan shall disclose to the department all of the following
22 for each *individual and small group* rate filing:

23 (1) Company name and contact information.

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

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

26 (4) Product type, *such as a preferred provider organization or*
27 *health maintenance organization.*

28 (5) Segment type.

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

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

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

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

33 (10) Annual rate.

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

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

36 (13) Average rate increase initially requested.

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

39 (15) Average rate of increase.

40 (16) Effective date of rate increase.

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

3 (18) The plan's overall annual medical trend factor assumptions
4 in each rate filing for all benefits and ~~disaggregated by~~ *by*
5 *aggregate* benefit category, including hospital inpatient, hospital
6 outpatient, physician services, prescription drugs and other
7 ancillary services, ~~laboratory, and radiology.~~ *A plan shall provide*
8 ~~additional data that demonstrates year-to-year cost increases in~~
9 ~~specific benefit categories. A health plan shall also provide~~
10 ~~information on aggregate annual cost increases for specific~~
11 ~~hospitals and for specific medical groups within a plan network.~~
12 *laboratory, and radiology. A plan may provide aggregated*
13 *additional data that demonstrates or reasonably estimates*
14 *year-to-year cost increases in specific benefit categories in major*
15 *geographic regions of the state. For purposes of this paragraph,*
16 *“major geographic region” shall be defined by the department*
17 *and shall include no more than nine regions. A health plan that*
18 *exclusively contracts with no more than two medical groups in the*
19 *state to provide or arrange for professional medical services for*
20 *the enrollees of the plan shall instead disclose the amount of its*
21 *actual trend experience for the prior contract year by aggregate*
22 *benefit category, using benefit categories that are, to the maximum*
23 *extent possible, the same or similar to those used by other plans.*

24 (19) The amount of the projected trend attributable to the use
25 of services, price inflation, or fees and risk for annual plan contract
26 trends by aggregate benefit category, such as hospital inpatient,
27 hospital outpatient, physician services, prescription drugs and other
28 ancillary services, laboratory, and radiology. *A health plan that*
29 *exclusively contracts with no more than two medical groups in the*
30 *state to provide or arrange for professional medical services for*
31 *the enrollees of the plan shall instead disclose the amount of its*
32 *actual trend experience for the prior contract year by aggregate*
33 *benefit category, using benefit categories that are, to the maximum*
34 *extent possible, the same or similar to those used by other plans.*

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

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

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

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

5 ~~(24)~~

6 (23) The certification described in subdivision ~~(e)~~ (b) of Section
7 1385.06.

8 (24) *Any changes in administrative costs.*

9 (25) *Any other information required for rate review under*
10 *PPACA.*

11 (c) A health care service plan subject to subdivision (a) shall
12 also disclose the following aggregate data for all rate filings
13 *submitted under this section* in the individual, ~~small group, and~~
14 ~~large and small group~~ health plan markets:

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

17 (A) Plan year.

18 (B) Segment type.

19 (C) Product type.

20 (D) Number of subscribers.

21 (E) Number of covered lives affected.

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

23 (A) Plan year.

24 (B) Segment type.

25 (C) Product type.

26 (3) Any cost containment and quality improvement efforts since
27 the plan's last rate filing for the same category of health benefit
28 plan. ~~The~~ *To the extent possible, the* plan shall describe any
29 significant new health care cost containment and quality
30 improvement efforts and provide an estimate of potential savings
31 together with an estimated cost or savings for the projection period.

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

38 (e) A plan shall submit any other information required *under*
39 *PPACA. A plan shall also submit any other information required*

1 *pursuant to any regulation adopted by the department to comply*
2 *with this article.*

3 ~~1385.06. (a) A filing submitted under this article shall be~~
4 ~~consistent with applicable state and federal laws, rules, and~~
5 ~~regulations, including, but not limited to, the applicable provisions~~
6 ~~of law governing health care service plan contracts, medical loss~~
7 ~~ratios, rating rules, health benefit designs, and health benefit~~
8 ~~standards.~~

9 *1385.04. (a) For large group health care service plan*
10 *contracts, all health plans shall file with the department at least*
11 *60 days prior to implementing any rate change all required rate*
12 *information for unreasonable rate increases. This filing shall be*
13 *concurrent with the written notice described in subdivision (a) of*
14 *Section 1374.21.*

15 *(b) For large group rate filings, health plans shall submit all*
16 *information that is required by PPACA. A plan shall also submit*
17 *any other information required pursuant to any regulation adopted*
18 *by the department to comply with this article.*

19 *(c) A health care service plan subject to subdivision (a) shall*
20 *also disclose the following aggregate data for all rate filings*
21 *submitted under this section in the large group health plan market:*

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

24 *(A) Plan year.*

25 *(B) Segment type.*

26 *(C) Product type.*

27 *(D) Number of subscribers.*

28 *(E) Number of covered lives affected.*

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

30 *(A) Plan year.*

31 *(B) Segment type.*

32 *(C) Product type.*

33 *(3) Any cost containment and quality improvement efforts since*
34 *the plan's last rate filing for the same category of health benefit*
35 *plan. To the extent possible, the plan shall describe any significant*
36 *new health care cost containment and quality improvement efforts*
37 *and provide an estimate of potential savings together with an*
38 *estimated cost or savings for the projection period.*

39 *(d) The department may require all health care service plans*
40 *to submit all rate filings to the National Association of Insurance*

1 *Commissioners' System for Electronic Rate and Form Filing*
2 *(SERFF). Submission of the required rate filings to SERFF shall*
3 *be deemed to be filing with the department for purposes of*
4 *compliance with this section.*

5 *1385.05. Notwithstanding any provision in a contract between*
6 *a health care service plan and a provider, the department may*
7 *request from a health care service plan any information required*
8 *under this article or PPACA.*

9 ~~(b)~~

10 *1385.06. (a) A filing submitted under this article shall be*
11 *actuarially sound.*

12 *(b) (1) The plan shall contract with an independent actuary or*
13 *actuaries consistent with this section.*

14 ~~(e) (1)~~

15 *(2) A filing submitted under this article shall include a*
16 *certification by an independent actuary or actuarial firm that the*
17 *rate increase is reasonable or unreasonable and, if unreasonable,*
18 *that the justification for the increase is based on accurate and sound*
19 *actuarial assumptions and methodologies. Unless PPACA requires*
20 *a certification of actuarial soundness for each large group*
21 *contract, a filing submitted under Section 1385.04 shall include*
22 *a certification by an independent actuary, as described in this*
23 *section, that the aggregate or average rate increase is based on*
24 *accurate and sound actuarial assumptions and methodologies.*

25 ~~(2)~~

26 *(3) The actuary or actuarial firm acting under paragraph ~~(1)~~ (2)*
27 *shall not be an affiliate or a subsidiary of, nor in any way owned*
28 *or controlled by, a health care service plan or a trade association*
29 *of health care service plans. A board member, director, officer, or*
30 *employee of the actuary or actuarial firm shall not serve as a board*
31 *member, director, or employee of a health care service plan. A*
32 *board member, director, or officer of a health care service plan or*
33 *a trade association of health care service plans shall not serve as*
34 *a board member, director, officer, or employee of the actuary or*
35 *actuarial firm.*

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

1 (c) *Nothing in this article shall be construed to permit the*
2 *director to establish the rates charged subscribers and enrollees*
3 *for covered health care services.*

4 1385.07. (a) Notwithstanding Chapter 3.5 (commencing with
5 Section 6250) of Division 7 of Title 1 of the Government Code,
6 all information submitted under this article shall be made publicly
7 available *by the department* except as provided in subdivision (b).

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

13 (b) *The contracted rates between a health care service plan and*
14 *a provider shall be deemed confidential information that shall not*
15 *be made public by the department and are exempt from disclosure*
16 *under the California Public Records Act (Chapter 3.5 (commencing*
17 *with Section 6250) of Division 7 of Title 1 of the Government*
18 *Code). The contracted rates between a health care service plan*
19 *and a large group shall be deemed confidential information that*
20 *shall not be made public by the department and are exempt from*
21 *disclosure under the California Public Records Act (Chapter 3.5*
22 *(commencing with Section 6250) of Division 7 of Title 1 of the*
23 *Government Code).*

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

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

32 (d) *In addition, the department and the health care service plan*
33 *shall, at a minimum, make the following information readily*
34 *available to the public on their Internet Web sites, in plain*
35 *language and in a manner and format specified by the department,*
36 *except as provided in subdivision (b). The information shall be*
37 *made public for 60 days prior to the implementation of the rate*
38 *increase. This period may be extended by the department if needed*
39 *to complete its review consistent with this article. The information*
40 *shall include:*

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

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

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

10 (4) The amount of the projected trend attributable to the use of
11 services, price inflation, or fees and risk for annual plan contract
12 trends by aggregate benefit category, such as hospital inpatient,
13 hospital outpatient, physician services, prescription drugs and other
14 ancillary services, laboratory, and radiology. *A health plan that*
15 *exclusively contracts with no more than two medical groups in the*
16 *state to provide or arrange for professional medical services for*
17 *the enrollees of the plan shall instead disclose the amount of its*
18 *actual trend experience for the prior contract year by aggregate*
19 *benefit category, using benefit categories that are, to the maximum*
20 *extent possible, the same or similar to those used by other plans.*

21 1385.08. (a) On or before July 1, ~~2011~~ 2012, the director may
22 issue guidance to health care service plans regarding compliance
23 with this article. This guidance shall not be subject to the
24 Administrative Procedure Act (Chapter 3.5 (commencing with
25 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
26 Code).

27 ~~(b) The department may adopt regulations to implement this~~
28 ~~article in accordance with Chapter 3.5 (commencing with Section~~
29 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code.~~

30 ~~(e)~~

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

36 1385.11. (a) Whenever it appears to the department that any
37 person has engaged, or is about to engage, in any act or practice
38 constituting a violation of this article, including the filing of
39 inaccurate or unjustified rates or inaccurate or unjustified rate

1 information, the department may review the rate filing to ensure
 2 compliance with the law.

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

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

9 ~~(d)~~

10 (b) The department may review other filings.

11 ~~(e)~~

12 (c) The department shall ~~consider~~ *accept and post to its Internet*
 13 *Web site* any public comment on a rate increase submitted to the
 14 department during the 60-day period described in subdivision (d)
 15 of Section 1385.07.

16 ~~(f)~~

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

24 ~~(g) After conducting a review under this section, the department~~

25 (e) *The department* shall post on its Internet Web site any
 26 *changes submitted by the plan* to the proposed rate increase,
 27 including any documentation *submitted by the plan* supporting
 28 those changes.

29 ~~(h)~~

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

33 ~~(i)~~

34 (g) Nothing in this article shall be construed to impair or impede
 35 the department’s authority to administer or enforce any other
 36 provision of this chapter.

37 1385.13. The department shall do all of the following in a
 38 manner consistent with applicable federal laws, rules, and
 39 regulations:

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

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

8 (e)

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

19 ~~SEC. 4.~~

20 *SEC. 5.* Section 1389.25 of the Health and Safety Code is
21 amended to read:

22 1389.25. (a) (1) This section shall apply only to a full service
23 health care service plan offering health coverage in the individual
24 market in California and shall not apply to a specialized health
25 care service plan, a health care service plan contract in the
26 Medi-Cal program (Chapter 7 (commencing with Section 14000)
27 of Part 3 of Division 9 of the Welfare and Institutions Code), a
28 health care service plan conversion contract offered pursuant to
29 Section 1373.6, a health care service plan contract in the Healthy
30 Families Program (Part 6.2 (commencing with Section 12693) of
31 Division 2 of the Insurance Code), or a health care service plan
32 contract offered to a federally eligible defined individual under
33 Article 4.6 (commencing with Section 1366.35).

34 (2) A local initiative, as defined in subdivision (v) of Section
35 53810 of Title 22 of the California Code of Regulations, that is
36 awarded a contract by the State Department of Health Care Services
37 pursuant to subdivision (b) of Section 53800 of Title 22 of the
38 California Code of Regulations, shall not be subject to this section
39 unless the plan offers coverage in the individual market to persons
40 not covered by Medi-Cal or the Healthy Families Program.

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

8 (2) No change in the premium rate or coverage for an individual
9 plan contract shall become effective unless the plan has delivered
10 a written notice of the change at least 60 days prior to the effective
11 date of the contract renewal or the date on which the rate or
12 coverage changes. A notice of an increase in the premium rate
13 shall include the reasons for the rate increase.

14 (3) The written notice required pursuant to paragraph (2) shall
15 be delivered to the individual contractholder at his or her last
16 address known to the plan, at least 60 days prior to the effective
17 date of the change. The notice shall state in italics and in 12-point
18 type the actual dollar amount of the premium rate increase and the
19 specific percentage by which the current premium will be
20 increased. The notice shall describe in plain, understandable
21 English any changes in the plan design or any changes in benefits,
22 including a reduction in benefits or changes to waivers, exclusions,
23 or conditions, and highlight this information by printing it in italics.
24 The notice shall specify in a minimum of 10-point bold typeface,
25 the reason for a premium rate change or a change to the plan design
26 or benefits.

27 (4) If a plan rejects an applicant or the dependents of an
28 applicant for coverage or offers individual coverage at a rate that
29 is higher than the standard rate, the plan shall inform the applicant
30 about the state's high-risk health insurance pool, the California
31 Major Risk Medical Insurance Program (MRMIP) (Part 6.5
32 (commencing with Section 12700) of Division 2 of the Insurance
33 Code), and the federal temporary high risk pool established
34 pursuant to Part 6.6 (commencing with Section 12739.5) of
35 Division 2 of the Insurance Code. The information provided to the
36 applicant by the plan shall be in accordance with standards
37 developed by the department, in consultation with the Managed
38 Risk Medical Insurance Board, and shall specifically include the
39 toll-free telephone number and Internet Web site address for
40 MRMIP and the federal temporary high risk pool. The requirement

1 to notify applicants of the availability of MRMIP and the federal
2 temporary high risk pool shall not apply when a health plan rejects
3 an applicant for Medicare supplement coverage.

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

9 ~~SEC. 5.~~

10 *SEC. 6.* Section 10113.9 of the Insurance Code is amended to
11 read:

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

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

24 (2) No change in the premium rate or coverage for an individual
25 health insurance policy shall become effective unless the insurer
26 has delivered a written notice of the change at least 60 days prior
27 to the effective date of the policy renewal or the date on which the
28 rate or coverage changes. A notice of an increase in the premium
29 rate shall include the reasons for the rate increase.

30 (3) The written notice required pursuant to paragraph (2) shall
31 be delivered to the individual policyholder at his or her last address
32 known to the insurer, at least 60 days prior to the effective date of
33 the change. The notice shall state in italics and in 12-point type
34 the actual dollar amount of the premium increase and the specific
35 percentage by which the current premium will be increased. The
36 notice shall describe in plain, understandable English any changes
37 in the policy or any changes in benefits, including a reduction in
38 benefits or changes to waivers, exclusions, or conditions, and
39 highlight this information by printing it in italics. The notice shall

1 specify in a minimum of 10-point bold typeface, the reason for a
 2 premium rate change or a change in coverage or benefits.

3 (4) If an insurer rejects an applicant or the dependents of an
 4 applicant for coverage or offers individual coverage at a rate that
 5 is higher than the standard rate, the insurer shall inform the
 6 applicant about the state’s high-risk health insurance pool, the
 7 California Major Risk Medical Insurance Program (MRMIP) (Part
 8 6.5 (commencing with Section 12700)), and the federal temporary
 9 high risk pool established pursuant to Part 6.6 (commencing with
 10 Section 12739.5). The information provided to the applicant by
 11 the insurer shall be in accordance with standards developed by the
 12 department, in consultation with the Managed Risk Medical
 13 Insurance Board, and shall specifically include the toll-free
 14 telephone number and Internet Web site address for MRMIP and
 15 the federal temporary high risk pool. The requirement to notify
 16 applicants of the availability of MRMIP and the federal temporary
 17 high risk pool shall not apply when a health plan rejects an
 18 applicant for Medicare supplement coverage.

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

24 ~~SEC. 6.~~

25 SEC. 7. Article 4.5 (commencing with Section 10181) is added
 26 to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

27

28 Article 4.5. Review of Rate Increases

29

30 10181. For purposes of this article, the following definitions
 31 shall apply:

32 (a) “Large group health insurance policy” means a group health
 33 insurance policy other than a policy issued to a small employer,
 34 as defined in Section 10700.

35 (b) “Small group health insurance policy” means a group health
 36 insurance policy issued to a small employer, as defined in Section
 37 10700.

38 (c) “PPACA” means Section 2794 of the federal Public Health
 39 Service Act (42 U.S.C. Sec. 300gg-14), as amended by the federal
 40 Patient Protection and Affordable Care Act (P. L. 111-48), and

1 any subsequent rules or regulations, regulations, or guidance issued
2 pursuant to that law.

3 (d) “Unreasonable rate increase” has the same meaning as that
4 term is defined in PPACA.

5 10181.2. This article shall apply to health insurance policies
6 offered in the individual or group market in California. However,
7 this article shall not apply to a specialized health insurance policy;
8 a Medicare supplement policy subject to Article 6 (commencing
9 with Section 10192.05); a health insurance policy offered in the
10 Medi-Cal program (Chapter 7 (commencing with Section 14000)
11 of Part 3 of Division 9 of the Welfare and Institutions Code); a
12 health insurance policy offered in the Healthy Families Program
13 (Part 6.2 (commencing with Section 12693)), the Access for Infants
14 and Mothers Program (Part 6.3 (commencing with Section 12695)),
15 the California Major Risk Medical Insurance Program (Part 6.5
16 (commencing with Section 12700)), or the Federal Temporary
17 High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a
18 health insurance conversion policy offered pursuant to Section
19 12682.1; or a health insurance policy offered to a federally eligible
20 defined individual under Chapter 9.5 (commencing with Section
21 10900).

22 ~~10181.4.~~

23 10181.3. (a) (1) All health insurers shall file with the
24 department all required rate information for individual and small
25 group health insurance policies at least 60 days prior to
26 implementing any rate change.

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

31 *(2) For individual health insurance policies, the filing shall be*
32 *concurrent with the notice required under Section 10113.9.*

33 *(3) For small group health insurance policies, the filing shall*
34 *be concurrent with the notice required under Section 10199.1.*

35 (b) An insurer shall disclose to the department all of the
36 following for each *individual and small group* rate filing:

- 37 (1) Company name and contact information.
- 38 (2) Number of policy forms covered by the filing.
- 39 (3) Policy form numbers covered by the filing.

- 1 (4) Product type, *such as indemnity or preferred provider*
- 2 *organization.*
- 3 (5) Segment type.
- 4 (6) Type of insurer involved, such as for profit or not for profit.
- 5 (7) Whether the products are opened or closed.
- 6 (8) Enrollment in each policy and rating form.
- 7 (9) Insured months in each policy form.
- 8 (10) Annual rate.
- 9 (11) Total earned premiums in each policy form.
- 10 (12) Total incurred claims in each policy form.
- 11 (13) Average rate increase initially requested.
- 12 (14) Review category: initial filing for new product, filing for
- 13 *existing product, or resubmission.*
- 14 (15) Average rate of increase.
- 15 (16) Effective date of rate increase.
- 16 (17) Number of policyholders or insureds affected by each
- 17 *policy form.*
- 18 (18) The insurer's overall annual medical trend factor
- 19 *assumptions in each rate filing for all benefits and*~~disaggregated~~
- 20 ~~by~~ *by aggregate* benefit category, including hospital inpatient,
- 21 hospital outpatient, physician services, prescription drugs and other
- 22 ancillary services, laboratory, and radiology. An insurer ~~shall~~
- 23 ~~provide additional data that demonstrates year-to-year cost~~
- 24 ~~increases in specific benefit categories. An insurer shall also~~
- 25 ~~provide information on aggregate annual cost increases for specific~~
- 26 ~~hospitals and for specific medical groups within a network.~~ *may*
- 27 *provide aggregated additional data that demonstrates or*
- 28 *reasonably estimates year-to-year cost increases in specific benefit*
- 29 *categories in major geographic regions of the state. For purposes*
- 30 *of this paragraph, "major geographic region" shall be defined by*
- 31 *the department and shall include no more than nine regions.*
- 32 (19) The amount of the projected trend attributable to the use
- 33 of services, price inflation, or fees and risk for annual policy trends
- 34 by aggregate benefit category, such as hospital inpatient, hospital
- 35 outpatient, physician services, prescription drugs and other
- 36 ancillary services, laboratory, and radiology.
- 37 (20) A comparison of claims cost and rate of changes over time.
- 38 (21) Any changes in insured cost-sharing over the prior year
- 39 associated with the submitted rate filing.

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

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

7 ~~(24)~~

8 (23) The certification described in subdivision ~~(e)~~ (b) of Section
9 10181.6.

10 (24) *Any changes in administrative costs.*

11 (25) *Any other information required for rate review under*
12 *PPACA.*

13 (c) An insurer subject to subdivision (a) shall also disclose the
14 following aggregate data for all rate filings *submitted under this*
15 *section* in the individual, ~~small group, and large~~ *and small* group
16 health insurance markets:

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

19 (A) Plan year.

20 (B) Segment type.

21 (C) Product type.

22 (D) Number of policyholders

23 (E) Number of covered lives affected.

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

26 (A) Plan year.

27 (B) Segment type.

28 (C) Product type.

29 (3) Any cost containment and quality improvement efforts since
30 the insurer's last rate filing for the same category of health benefit
31 plan. ~~The~~ *To the extent possible, the* insurer shall describe any
32 significant new health care cost containment and quality
33 improvement efforts and provide an estimate of potential savings
34 together with an estimated cost or savings for the projection period.

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

1 (e) A health insurer shall submit any other information required
2 *under PPACA. A health insurer shall also submit any other*
3 *information required pursuant to any regulation adopted by the*
4 *department to comply with this article.*

5 ~~10181.6. (a) A filing submitted under this article shall be~~
6 ~~consistent with applicable state and federal laws, rules, and~~
7 ~~regulations, including, but not limited to, the provisions of law~~
8 ~~governing health insurance policies, medical loss ratios, rating~~
9 ~~rules, health benefit designs, and health benefit standards.~~

10 *10181.4. (a) For large group health insurance policies, all*
11 *health insurers shall file with the department at least 60 days prior*
12 *to implementing any rate change all required rate information for*
13 *unreasonable rate increases. This filing shall be concurrent with*
14 *the written notice described in Section 10199.1.*

15 *(b) For large group rate filings, health insurers shall submit*
16 *all information that is required by PPACA. A health insurer shall*
17 *also submit any other information required pursuant to any*
18 *regulation adopted by the department to comply with this article.*

19 *(c) A health insurer subject to subdivision (a) shall also disclose*
20 *the following aggregate data for all rate filings submitted under*
21 *this section in the large group health insurance market:*

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

24 *(A) Plan year.*

25 *(B) Segment type.*

26 *(C) Product type.*

27 *(D) Number of insureds.*

28 *(E) Number of covered lives affected*

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

31 *(A) Plan year.*

32 *(B) Segment type.*

33 *(C) Product type.*

34 *(3) Any cost containment and quality improvement efforts since*
35 *the health insurer's last rate filing for the same category of health*
36 *insurance policy. To the extent possible, the health insurer shall*
37 *describe any significant new health care cost containment and*
38 *quality improvement efforts and provide an estimate of potential*
39 *savings together with an estimated cost or savings for the*
40 *projection period.*

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

7 10181.5. Notwithstanding any provision in a contract between
8 a health insurer and a provider, the department may request from
9 a health insurer any information required under this article or
10 PPACA.

11 ~~(b)~~
12 10181.6. (a) A filing submitted under this article shall be
13 actuarially sound.

14 (b) (1) The health insurer shall contract with an independent
15 actuary or actuaries consistent with this section.

16 ~~(e)-(1)~~
17 (2) A filing submitted under this article shall include a
18 certification by an independent actuary or actuarial firm that the
19 rate increase is reasonable or unreasonable and, if unreasonable,
20 that the justification for the increase is based on accurate and sound
21 actuarial assumptions and methodologies. Unless PPACA requires
22 a certification of actuarial soundness for each large group health
23 insurance policy, a filing submitted under Section 10181.4 shall
24 include a certification by an independent actuary, as described in
25 this section, that the aggregate or average rate increase is based
26 on accurate and sound actuarial assumptions and methodologies.

27 ~~(2)~~
28 (3) The actuary or actuarial firm acting under paragraph~~(1)~~ (2)
29 shall not be an affiliate or a subsidiary of, nor in any way owned
30 or controlled by, a health insurer or a trade association of health
31 insurers. A board member, director, officer, or employee of the
32 actuary or actuarial firm shall not serve as a board member,
33 director, or employee of a health insurer. A board member, director,
34 or officer of a health insurer or a trade association of health insurers
35 shall not serve as a board member, director, officer, or employee
36 of the actuary or actuarial firm.

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

1 (c) *Nothing in this article shall be construed to permit the*
2 *commissioner to establish the rates charged insureds and*
3 *policyholders for covered health care services.*

4 10181.7. (a) Notwithstanding Chapter 3.5 (commencing with
5 Section 6250) of Division 7 of Title 1 of the Government Code,
6 all information submitted under this article shall be made publicly
7 available *by the department* except as provided in subdivision (b).

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

13 (b) *Any contracted rates between a health insurer and a provider*
14 *shall be deemed confidential information that shall not be made*
15 *public by the department and are exempt from disclosure under*
16 *the California Public Records Act (Chapter 3.5 (commencing with*
17 *Section 6250) of Division 7 of Title 1 of the Government Code).*
18 *The contracted rates between a health insurer and a large group*
19 *shall be deemed confidential information that shall not be made*
20 *public by the department and are exempt from disclosure under*
21 *the California Public Records Act (Chapter 3.5 (commencing with*
22 *Section 6250) of Division 7 of Title 1 of the Government Code).*

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

26 ~~(d) In addition, the health insurer shall file the following~~
27 ~~information in a manner and format specified by the department.~~
28 ~~The information shall be in plain language and shall be made~~
29 ~~readily available to the public on the Internet Web site of the~~
30 ~~department and the insurer, except as provided in subdivision (b).~~

31 (d) *In addition, the department and the health insurer shall, at*
32 *a minimum, make the following information readily available to*
33 *the public on their Internet Web sites, in plain language and in a*
34 *manner and format specified by the department, except as provided*
35 *in subdivision (b).* The information shall be made public for 60
36 days prior to the implementation of the rate increase. ~~This period~~
37 ~~may be extended by the department if needed to complete its~~
38 ~~review consistent with this article.~~ The information shall include:

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

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

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

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

15 10181.9. (a) On or before July 1, ~~2011~~ 2012, the commissioner
16 may issue guidance to health insurers regarding compliance with
17 this article. This guidance shall not be subject to the Administrative
18 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
19 Part 1 of Division 3 of Title 2 of the Government Code).

20 ~~(b) The department may adopt regulations to implement this~~
21 ~~article in accordance with Chapter 3.5 (commencing with Section~~
22 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code.~~

23 (e)

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

30 10181.11. (a) Whenever it appears to the department that any
31 person has engaged, or is about to engage, in any act or practice
32 constituting a violation of this article, including the filing of
33 inaccurate or unjustified rates or inaccurate or unjustified rate
34 information, the department may review rate filing to ensure
35 compliance with the law.

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

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

1 ~~(d)~~

2 (b) The department may review other filings.

3 ~~(e)~~

4 (c) The department shall ~~consider~~ *accept and post to its Internet*
5 *Web site* any public comment on a rate increase submitted to the
6 department during the 60-day period described in subdivision (d)
7 of Section 10181.7.

8 ~~(f)~~

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

16 ~~(g) After conducting a review under this section, the department~~

17 (e) *The department* shall post on its Internet Web site any
18 *changes submitted by the insurer* to the proposed rate increase,
19 including any documentation *submitted by the insurer* supporting
20 those changes.

21 ~~(h)~~

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

25 ~~(i)~~

26 (g) Nothing in this article shall be construed to impair or impede
27 the department’s authority to administer or enforce any other
28 provision of this code.

29 10181.13. The department shall do all of the following in a
30 manner consistent with applicable federal laws, rules, and
31 regulations:

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

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

39 ~~(e)~~

1 (b) Commencing with the creation of the Exchange, provide to
2 the Exchange such information as may be necessary to allow
3 compliance with federal law, rules, regulations, and guidance. ~~The~~
4 ~~director shall develop an interagency agreement with the Exchange~~
5 ~~to facilitate the reporting of information regarding rate filings that~~
6 ~~is consistent with the responsibilities of the Exchange. As used in~~
7 ~~this subdivision, the “Exchange” means the American Health~~
8 ~~Benefit Exchange established in California pursuant to Section~~
9 ~~1311 of the federal Patient Protection and Affordable Care Act~~
10 ~~(Public Law 111-148).~~

11 SEC. 7.

12 SEC. 8. Section 10199.1 of the Insurance Code is amended to
13 read:

14 10199.1. (a) No insurer or nonprofit hospital service plan or
15 administrator acting on its behalf shall terminate a group master
16 policy or contract providing hospital, medical, or surgical benefits,
17 increase premiums or charges therefor, reduce or eliminate benefits
18 thereunder, or restrict eligibility for coverage thereunder without
19 providing prior notice of that action. No such action shall become
20 effective unless written notice of the action was delivered by mail
21 to the last known address of the appropriate insurance producer
22 and the appropriate administrator, if any, at least 45 days prior to
23 the effective date of the action and to the last known address of
24 the group policyholder or group contractholder at least 60 days
25 prior to the effective date of the action. If nonemployee certificate
26 holders or employees of more than one employer are covered under
27 the policy or contract, written notice shall also be delivered by
28 mail to the last known address of each nonemployee certificate
29 holder or affected employer or, if the action does not affect all
30 employees and dependents of one or more employers, to the last
31 known address of each affected employee certificate holder, at
32 least 60 days prior to the effective date of the action.

33 (b) No holder of a master group policy or a master group
34 nonprofit hospital service plan contract or administrator acting on
35 its behalf shall terminate the coverage of, increase premiums or
36 charges for, or reduce or eliminate benefits available to, or restrict
37 eligibility for coverage of a covered person, employer unit, or class
38 of certificate holders covered under the policy or contract for
39 hospital, medical, or surgical benefits without first providing prior
40 notice of the action. No such action shall become effective unless

1 written notice was delivered by mail to the last known address of
2 each affected nonemployee certificate holder or employer, or if
3 the action does not affect all employees and dependents of one or
4 more employers, to the last known address of each affected
5 employee certificate holder, at least 60 days prior to the effective
6 date of the action.

7 (c) A health insurer that declines to offer coverage to or denies
8 enrollment for a *large* group applying for coverage or that offers
9 *small* group coverage at a rate that is higher than the standard
10 *employee risk* rate shall, at the time of the denial or offer of
11 coverage, provide the applicant with the specific reason or reasons
12 for the decision in writing, in clear, easily understandable language.

13 ~~SEC. 8.~~

14 *SEC. 9.* Section 10199.2 of the Insurance Code is amended to
15 read:

16 10199.2. (a) The written notice described in subdivisions (a)
17 and (b) of Section 10199.1 shall state in italics and in 12-point
18 type the actual dollar amount and the specific percentage of the
19 premium rate increase. Further, the notice shall describe in plain
20 understandable English and highlighted in italics any changes in
21 the plan design or change in benefits with reduction in benefits,
22 waivers, exclusions, or conditions.

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

26 *SEC. 10.* Section 10705 of the Insurance Code is amended to
27 read:

28 10705. Upon the effective date of this act:

29 (a) No group or individual policy or contract or certificate of
30 group insurance or statement of group coverage providing benefits
31 to employees of small employers as defined in this chapter shall
32 be issued or delivered by a carrier subject to the jurisdiction of the
33 commissioner regardless of the situs of the contract or master
34 policyholder or of the domicile of the carrier nor, except as
35 otherwise provided in Sections 10270.91 and 10270.92, shall a
36 carrier provide coverage subject to this chapter until a copy of the
37 form of the policy, contract, certificate, or statement of coverage
38 is filed with and approved by the commissioner in accordance with
39 Sections 10290 and 10291, and the carrier has complied with the
40 requirements of Section 10717.

1 (b) (1) Each carrier, except a self-funded employer, shall fairly
2 and affirmatively offer, market, and sell all of the carrier’s benefit
3 plan designs that are sold to, offered through, or sponsored by,
4 small employers or associations that include small employers to
5 all small employers in each geographic region in which the carrier
6 makes coverage available or provides benefits. ~~A~~

7 (2) A carrier contracting to participate in the Voluntary Alliance
8 Uniting Employers Purchasing Program shall be deemed to be in
9 compliance with ~~this requirement~~ *paragraph (1)* for a benefit plan
10 design offered through the program in those geographic regions
11 in which the carrier participates in the program and the benefit
12 plan design is offered exclusively through the program.

13 (3) (A) *A carrier shall be deemed to meet the requirements of*
14 *paragraph (1) and subdivision (c) with respect to a benefit plan*
15 *design that qualifies as a grandfathered health plan under Section*
16 *1251 of PPACA if all of the following requirements are met:*

17 (i) *The carrier offers to renew the benefit plan design, unless*
18 *the carrier withdraws the benefit plan design from the small*
19 *employer market pursuant to subdivision (e) of Section 10713.*

20 (ii) *The carrier provides appropriate notice of the grandfathered*
21 *status of the benefit plan design in any materials provided to an*
22 *insured of the design describing the benefits provided under the*
23 *design, as required under PPACA.*

24 (iii) *The carrier makes no changes to the benefits covered under*
25 *the benefit plan design other than those required by a state or*
26 *federal law, regulation, rule, or guidance and those permitted to*
27 *be made to a grandfathered health plan under PPACA.*

28 (B) *For purposes of this paragraph, “PPACA” means the*
29 *federal Patient Protection and Affordable Care Act (Public Law*
30 *111-148), as amended by the federal Health Care and Education*
31 *Reconciliation Act of 2010 (Public Law 111-152), and any rules,*
32 *regulations, or guidance issued thereunder For purposes of this*
33 *paragraph, a “grandfathered health plan” shall have the meaning*
34 *set forth in Section 1251 of PPACA.*

35 ~~(1)~~

36 (4) Nothing in this section shall be construed to require an
37 association, or a trust established and maintained by an association
38 to receive a master insurance policy issued by an admitted insurer
39 and to administer the benefits thereof solely for association
40 members, to offer, market or sell a benefit plan design to those

1 who are not members of the association. However, if the
2 association markets, offers or sells a benefit plan design to those
3 who are not members of the association it is subject to the
4 requirements of this section. This shall apply to an association that
5 otherwise meets the requirements of paragraph~~(5)~~ (8) formed by
6 merger of two or more associations after January 1, 1992, if the
7 predecessor organizations had been in active existence on January
8 1, 1992, and for at least five years prior to that date and met the
9 requirements of paragraph (5).

10 ~~(2)~~

11 (5) A carrier which (A) effective January 1, 1992, and at least
12 20 years prior to that date, markets, offers, or sells benefit plan
13 designs only to all members of one association and (B) does not
14 market, offer or sell any other individual, selected group, or group
15 policy or contract providing medical, hospital and surgical benefits
16 shall not be required to market, offer, or sell to those who are not
17 members of the association. However, if the carrier markets, offers
18 or sells any benefit plan design or any other individual, selected
19 group, or group policy or contract providing medical, hospital and
20 surgical benefits to those who are not members of the association
21 it is subject to the requirements of this section.

22 ~~(3)~~

23 (6) Each carrier that sells health benefit plans to members of
24 one association pursuant to paragraph~~(2)~~ (5) shall submit an annual
25 statement to the commissioner which states that the carrier is selling
26 health benefit plans pursuant to paragraph~~(2)~~ (5) and which, for
27 the one association, lists all the information required by paragraph
28 ~~(4)~~ (7).

29 ~~(4)~~

30 (7) Each carrier that sells health benefit plans to members of
31 any association shall submit an annual statement to the
32 commissioner which lists each association to which the carrier
33 sells health benefit plans, the industry or profession which is served
34 by the association, the association's membership criteria, a list of
35 officers, the state in which the association is organized, and the
36 site of its principal office.

37 ~~(5)~~

38 (8) For purposes of paragraphs~~(1) and (2)~~ (4) and (5), an
39 association is a nonprofit organization comprised of a group of
40 individuals or employers who associate based solely on

1 participation in a specified profession or industry, accepting for
2 membership any individual or small employer meeting its
3 membership criteria, which do not condition membership directly
4 or indirectly on the health or claims history of any person, which
5 uses membership dues solely for and in consideration of the
6 membership and membership benefits, except that the amount of
7 the dues shall not depend on whether the member applies for or
8 purchases insurance offered by the association, which is organized
9 and maintained in good faith for purposes unrelated to insurance,
10 which has been in active existence on January 1, 1992, and at least
11 five years prior to that date, which has a constitution and bylaws,
12 or other analogous governing documents which provide for election
13 of the governing board of the association by its members, which
14 has contracted with one or more carriers to offer one or more health
15 benefit plans to all individual members and small employer
16 members in this state.

17 (c) Each carrier shall make available to each small employer
18 all benefit plan designs that the carrier offers or sells to small
19 employers or to associations that include small employers.
20 Notwithstanding subdivision (d) of Section 10700, for purposes
21 of this subdivision, companies that are affiliated companies or that
22 are eligible to file a consolidated income tax return shall be treated
23 as one carrier.

24 (d) Each carrier shall do all of the following:

25 (1) Prepare a brochure that summarizes all of its benefit plan
26 designs and make this summary available to small employers,
27 agents and brokers upon request. The summary shall include for
28 each benefit plan design information on benefits provided, a generic
29 description of the manner in which services are provided, such as
30 how access to providers is limited, benefit limitations, required
31 copayments and deductibles, standard employee risk rates, an
32 explanation of how creditable coverage is calculated if a preexisting
33 condition or affiliation period is imposed, and a telephone number
34 that can be called for more detailed benefit information. Carriers
35 are required to keep the information contained in the brochure
36 accurate and up to date, and, upon updating the brochure, send
37 copies to agents and brokers representing the carrier. Any entity
38 that provides administrative services only with regard to a benefit
39 plan design written or issued by another carrier shall not be

1 required to prepare a summary brochure which includes that benefit
2 plan design.

3 (2) For each benefit plan design, prepare a more detailed
4 evidence of coverage and make it available to small employers,
5 agents and brokers upon request. The evidence of coverage shall
6 contain all information that a prudent buyer would need to be aware
7 of in making selections of benefit plan designs. An entity that
8 provides administrative services only with regard to a benefit plan
9 design written or issued by another carrier shall not be required to
10 prepare an evidence of coverage for that benefit plan design.

11 (3) Provide to small employers, agents, and brokers, upon
12 request, for any given small employer the sum of the standard
13 employee risk rates and the sum of the risk adjusted standard
14 employee risk rates. When requesting this information, small
15 employers, agents and brokers shall provide the carrier with the
16 information the carrier needs to determine the small employer's
17 risk adjusted employee risk rate.

18 (4) Provide copies of the current summary brochure to all agents
19 or brokers who represent the carrier and, upon updating the
20 brochure, send copies of the updated brochure to agents and brokers
21 representing the carrier for the purpose of selling health benefit
22 plans.

23 (5) Notwithstanding subdivision (d) of Section 10700, for
24 purposes of this subdivision, companies that are affiliated
25 companies or that are eligible to file a consolidated income tax
26 return shall be treated as one carrier.

27 (e) Every agent or broker representing one or more carriers for
28 the purpose of selling health benefit plans to small employers shall
29 do all of the following:

30 (1) When providing information on a health benefit plan to a
31 small employer but making no specific recommendations on
32 particular benefit plan designs:

33 (A) Advise the small employer of the carrier's obligation to sell
34 to any small employer any of the benefit plan designs it offers to
35 small employers and provide them, upon request, with the actual
36 rates that would be charged to that employer for a given benefit
37 plan design.

38 (B) Notify the small employer that the agent or broker will
39 procure rate and benefit information for the small employer on

1 any benefit plan design offered by a carrier for whom the agent or
2 broker sells health benefit plans.

3 (C) Notify the small employer that, upon request, the agent or
4 broker will provide the small employer with the summary brochure
5 required in paragraph (1) of subdivision (d) for any benefit plan
6 design offered by a carrier whom the agent or broker represents.

7 (2) When recommending a particular benefit plan design or
8 designs, advise the small employer that, upon request, the agent
9 will provide the small employer with the brochure required by
10 paragraph (1) of subdivision (d) containing the benefit plan design
11 or designs being recommended by the agent or broker.

12 (3) Prior to filing an application for a small employer for a
13 particular health benefit plan:

14 (A) For each of the benefit plan designs offered by the carrier
15 whose benefit plan design the agent or broker is presenting, provide
16 the small employer with the benefit summary required in paragraph
17 (1) of subdivision (d) and the sum of the standard employee risk
18 rates for that particular employer.

19 (B) Notify the small employer that, upon request, the agent or
20 broker will provide the small employer with an evidence of
21 coverage brochure for each benefit plan design the carrier offers.

22 (C) Notify the small employer that, from July 1, 1993. to July
23 1, 1996, actual rates may be 20 percent higher or lower than the
24 sum of the standard employee risk rates, and from July 1, 1996,
25 and thereafter, actual rates may be 10 percent higher or lower than
26 the sum of the standard employee risk rates depending on how the
27 carrier assesses the risk of the small employer's group.

28 (D) Notify the small employer that, upon request, the agent or
29 broker will submit information to the carrier to ascertain the small
30 employer's sum of the risk adjusted standard employee risk rate
31 for any benefit plan design the carrier offers.

32 (E) Obtain a signed statement from the small employer
33 acknowledging that the small employer has received the disclosures
34 required by ~~this paragraph (3) of subdivision (e) and by Section~~
35 10716.

36 (f) No carrier, agent, or broker shall induce or otherwise
37 encourage a small employer to separate or otherwise exclude an
38 eligible employee from a health benefit plan which, in the case of
39 an eligible employee meeting the definition in paragraph (1) of
40 subdivision (f) of Section 10700, is provided in connection with

1 the employee’s employment or which, in the case of an eligible
2 employee as defined in paragraph (2) of subdivision (f) of Section
3 17000, is provided in connection with a guaranteed association.

4 (g) No carrier shall reject an application from a small employer
5 for a benefit plan design provided:

6 (1) The small employer as defined by paragraph (1) of
7 subdivision (w) of Section 10700 offers health benefits to 100
8 percent of its eligible employees as defined in paragraph (1) of
9 subdivision (f) of Section 10700. Employees who waive coverage
10 on the grounds that they have other group coverage shall not be
11 counted as eligible employees.

12 (2) The small employer agrees to make the required premium
13 payments.

14 (h) No carrier or agent or broker shall, directly or indirectly,
15 engage in the following activities:

16 (1) Encourage or direct small employers to refrain from filing
17 an application for coverage with a carrier because of the health
18 status, claims experience, industry, occupation, or geographic
19 location within the carrier’s approved service area of the small
20 employer or the small employer’s employees.

21 (2) Encourage or direct small employers to seek coverage from
22 another carrier or the program because of the health status, claims
23 experience, industry, occupation, or geographic location within
24 the carrier’s approved service area of the small employer or the
25 small employer’s employees.

26 (i) No carrier shall, directly or indirectly, enter into any contract,
27 agreement, or arrangement with an agent or broker that provides
28 for or results in the compensation paid to an agent or broker for a
29 health benefit plan to be varied because of the health status, claims
30 experience, industry, occupation, or geographic location of the
31 small employer or the small employer’s employees. This
32 subdivision shall not apply with respect to a compensation
33 arrangement that provides compensation to an agent or broker on
34 the basis of percentage of premium, provided that the percentage
35 shall not vary because of the health status, claims experience,
36 industry, occupation, or geographic area of the small employer.

37 (j) Except in the case of a late insured, or for satisfaction of a
38 preexisting condition clause in the case of initial coverage of an
39 eligible employee, a disability insurer may not exclude any eligible
40 employee or dependent who would otherwise be entitled to health

1 care services on the basis of any of the following: the health status,
2 the medical condition, including both physical and mental illnesses,
3 the claims experience, the medical history, the genetic information,
4 or the disability or evidence of insurability, including conditions
5 arising out of acts of domestic violence of that employee or
6 dependent. No health benefit plan may limit or exclude coverage
7 for a specific eligible employee or dependent by type of illness,
8 treatment, medical condition, or accident, except for preexisting
9 conditions as permitted by Section 10198.7 or 10708.

10 (k) If a carrier enters into a contract, agreement, or other
11 arrangement with a third-party administrator or other entity to
12 provide administrative, marketing, or other services related to the
13 offering of health benefit plans to small employers in this state,
14 the third-party administrator shall be subject to this chapter.

15 (l) (1) With respect to the obligation to provide coverage newly
16 issued under subdivision (d), the carrier may cease enrolling new
17 small employer groups and new eligible employees as defined by
18 paragraph (2) of subdivision (f) of Section 10700 if it certifies to
19 the commissioner that the number of eligible employees and
20 dependents, of the employers newly enrolled or insured during the
21 current calendar year by the carrier equals or exceeds: (A) in the
22 case of a carrier that administers any self-funded health benefits
23 arrangement in California, 10 percent of the total number of eligible
24 employees, or eligible employees and dependents, respectively,
25 enrolled or insured in California by that carrier as of December
26 31 of the preceding year, or (B) in the case of a carrier that does
27 not administer any self-funded health benefit arrangements in
28 California, 8 percent of the total number of eligible employees, or
29 eligible employees and dependents, respectively, enrolled or
30 insured by the carrier in California as of December 31 of the
31 preceding year.

32 (2) Certification shall be deemed approved if not disapproved
33 within 45 days after submission to the commissioner. If that
34 certification is approved, the small employer carrier shall not offer
35 coverage to any small employers under any health benefit plans
36 during the remainder of the current year. If the certification is not
37 approved, the carrier shall continue to issue coverage as required
38 by subdivision (d) and be subject to administrative penalties as
39 established in Section 10718.

1 ~~SEC. 9.~~

2 *SEC. 11.* No reimbursement is required by this act pursuant to
3 Section 6 of Article XIII B of the California Constitution because
4 the only costs that may be incurred by a local agency or school
5 district will be incurred because this act creates a new crime or
6 infraction, eliminates a crime or infraction, or changes the penalty
7 for a crime or infraction, within the meaning of Section 17556 of
8 the Government Code, or changes the definition of a crime within
9 the meaning of Section 6 of Article XIII B of the California
10 Constitution.

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