Senate Bill No. 1163

Passed the Senate August 31, 2010

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Secretary of the Senate

Passed the Assembly August 30, 2010

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2010, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

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, 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, 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 be made publicly available, except as specified. The bill 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 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.

The people of the State of California do enact as follows:

SECTION 1. Section 1357.03 of the Health and Safety Code is amended to read:

1357.03. (a) (1) Upon the effective date of this article, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to small employers or to associations that include small employers to all small employers in each service area in which the plan provides or arranges for the provision of health care services.

(2) Each plan shall make available to each small employer all small employer health care service plan contracts that the plan offers and sells to small employers or to associations that include small employers in this state.

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

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

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

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

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

(iii) The plan makes no changes to the benefits covered under the plan contract other than those required by a state or federal law, regulation, rule, or guidance and those permitted to be made to a grandfathered health plan under PPACA.

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

(b) Every plan shall file with the director the reasonable employee participation requirements and employer contribution requirements that will be applied in offering its plan contracts. Participation requirements shall be applied uniformly among all small employer groups, except that a plan may vary application of minimum employee participation requirements by the size of the small employer group and whether the employer contributes 100 percent of the eligible employee's premium. Employer contribution requirements shall not vary by employer size. A health care service plan shall not establish a participation requirement that (1) requires a person who meets the definition of a dependent in subdivision (a) of Section 1357 to enroll as a dependent if he or she is otherwise eligible for coverage and wishes to enroll as an eligible employee and (2) allows a plan to reject an otherwise eligible small employer because of the number of persons that waive coverage due to coverage through another employer. Members of an association eligible for health coverage under subdivision (o) of Section 1357, but not electing any health

coverage through the association, shall not be counted as eligible employees for purposes of determining whether the guaranteed association meets a plan's reasonable participation standards.

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

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

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

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

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

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

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

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

(e) A plan shall not, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a

health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer. This subdivision does not apply to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(f) A policy or contract that covers two or more employees shall not establish rules for eligibility, including continued eligibility, of an individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

(g) A plan shall comply with the requirements of Section 1374.3.

SEC. 2. 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 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 large group applying for coverage or that offers small group coverage at a rate that is higher than the standard employee risk 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. 3. 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 60 days prior to the renewal effective date to the group contract holder.

(b) The written notice shall state in italics and in 12-point type the actual dollar amount 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. 4. 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, regulations, or guidance 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).

1385.03. (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 individual health care service plan contracts, the filing shall be concurrent with the notice required under Section 1389.25.

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

(b) A plan shall disclose to the department all of the following for each individual and small group 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, such as a preferred provider organization or health maintenance organization.

(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 by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in major geographic regions of the state. For purposes of this paragraph, "major geographic region" shall be defined by the department and shall include no more than nine regions. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(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. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(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 certification described in subdivision (b) of Section 1385.06.

(24) Any changes in administrative costs.

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

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small 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. To the extent possible, 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 under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

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

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

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

(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. To the extent possible, 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.

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

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

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

(2) 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 and methodologies. Unless PPACA requires a certification of actuarial soundness for each large group contract, a filing submitted under Section 1385.04 shall include a certification by an independent actuary, as described in this section, that the aggregate or average rate increase is based on accurate and sound actuarial assumptions and methodologies.

(3) The actuary or actuarial firm acting under paragraph (2) 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.

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

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 by the department except as provided in subdivision (b).

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

(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 department and the health care service plan shall, at a minimum, make the following information readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the department, except as provided in subdivision (b). The information shall be made public for 60 days prior to the implementation of the rate increase. 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, 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. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

1385.08. (a) On or before July 1, 2012, 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 shall consult with the Department of Insurance in issuing guidance under subdivision (a), in adopting necessary regulations, 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 may review other filings.

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

(d) The department shall report to the Legislature at least quarterly on all unreasonable rate filings.

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

(f) 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.

(g) 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) 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.

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

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of

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

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

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

(2) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has delivered a written notice of the change at least 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 60 days prior to the effective date of the change. The notice shall state in italics and in 12-point type the actual dollar amount of the premium rate increase 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. 6. 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.

(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 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.

(3) The written notice required pursuant to paragraph (2) shall be delivered to the individual policyholder at his or her last address

known to the insurer, at least 60 days prior to the effective date of the change. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase 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.

(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. 7. 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, regulations, or guidance 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).

10181.3. (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 individual health insurance policies, the filing shall be concurrent with the notice required under Section 10113.9.

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

(b) An insurer shall disclose to the department all of the following for each individual and small group 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, such as indemnity or preferred provider organization.
(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 by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. An insurer may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in major geographic regions of the state. For purposes of this paragraph, "major geographic region" shall be defined by the department and shall include no more than nine regions.
(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 certification described in subdivision (b) of Section 10181.6.

(24) Any changes in administrative costs.

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

(c) An insurer subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small 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. To the extent possible, 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 under PPACA. A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

10181.4. (a) For large group health insurance policies, all health insurers shall file with the department at least 60 days prior to implementing any rate change all required rate information for

unreasonable rate increases. This filing shall be concurrent with the written notice described in Section 10199.1.

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

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

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

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of insureds.

(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 health insurer's last rate filing for the same category of health insurance policy. To the extent possible, the health 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.

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

10181.6. (a) A filing submitted under this article shall be actuarially sound.

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

(2) 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 and methodologies. Unless PPACA requires a certification of actuarial soundness for each large group health insurance policy, a filing submitted under Section 10181.4 shall include a certification by an independent actuary, as described in this section, that the aggregate or average rate increase is based on accurate and sound actuarial assumptions and methodologies.

(3) The actuary or actuarial firm acting under paragraph (2) 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.

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

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 by the department except as provided in subdivision (b).

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

(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 department and the health insurer shall, at a minimum, make the following information readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the department, except as provided in subdivision (b). The information shall be made public for 60 days prior to the implementation of the rate increase. 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, 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, 2012, 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 shall consult with the Department of Managed Health Care in issuing guidance under subdivision (a), in adopting necessary regulations, 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 may review other filings.

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

(d) The department shall report to the Legislature at least quarterly on all unreasonable rate filings.

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

(f) 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.

(g) 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) 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.

SEC. 8. 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 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 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 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 large group applying for coverage or that offers small group coverage at a rate that is higher than the standard employee risk 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. 9. 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 and in 12-point type the actual dollar amount 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. 10. Section 10705 of the Insurance Code is amended to read:

10705. Upon the effective date of this act:

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

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

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

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

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

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

(iii) The carrier makes no changes to the benefits covered under the benefit plan design other than those required by a state or

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

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

(4) Nothing in this section shall be construed to require an association, or a trust established and maintained by an association to receive a master insurance policy issued by an admitted insurer and to administer the benefits thereof solely for association members, to offer, market or sell a benefit plan design to those who are not members of the association. However, if the association markets, offers or sells a benefit plan design to those who are not members of the association it is subject to the requirements of this section. This shall apply to an association that otherwise meets the requirements of paragraph (8) formed by merger of two or more associations after January 1, 1992, if the predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and met the requirements of paragraph (5).

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

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

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

(8) For purposes of paragraphs (4) and (5), an association is a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or small employer meeting its membership criteria, which do not condition membership directly or indirectly on the health or claims history of any person, which uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered by the association, which is organized and maintained in good faith for purposes unrelated to insurance, which has been in active existence on January 1, 1992, and at least five years prior to that date, which has a constitution and bylaws, or other analogous governing documents which provide for election of the governing board of the association by its members, which has contracted with one or more carriers to offer one or more health benefit plans to all individual members and small employer members in this state.

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

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

(1) Prepare a brochure that summarizes all of its benefit plan designs and make this summary available to small employers, agents and brokers upon request. The summary shall include for each benefit plan design information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required

copayments and deductibles, standard employee risk rates, an explanation of how creditable coverage is calculated if a preexisting condition or affiliation period is imposed, and a telephone number that can be called for more detailed benefit information. Carriers are required to keep the information contained in the brochure accurate and up to date, and, upon updating the brochure, send copies to agents and brokers representing the carrier. Any entity that provides administrative services only with regard to a benefit plan design written or issued by another carrier shall not be required to prepare a summary brochure which includes that benefit plan design.

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

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

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

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

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

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

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

(B) Notify the small employer that the agent or broker will procure rate and benefit information for the small employer on any benefit plan design offered by a carrier for whom the agent or broker sells health benefit plans.

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

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

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

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

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

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

(D) Notify the small employer that, upon request, the agent or broker will submit information to the carrier to ascertain the small

employer's sum of the risk adjusted standard employee risk rate for any benefit plan design the carrier offers.

(E) Obtain a signed statement from the small employer acknowledging that the small employer has received the disclosures required by this paragraph and Section 10716.

(f) No carrier, agent, or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an eligible employee from a health benefit plan which, in the case of an eligible employee meeting the definition in paragraph (1) of subdivision (f) of Section 10700, is provided in connection with the employee's employment or which, in the case of an eligible employee as defined in paragraph (2) of subdivision (f) of Section 17000, is provided in connection with a guaranteed association.

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

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

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

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

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

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

(i) No carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the

small employer or the small employer's employees. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(j) Except in the case of a late insured, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible employee, a disability insurer may not exclude any eligible employee or dependent who would otherwise be entitled to health care services on the basis of any of the following: the health status, the medical condition, including both physical and mental illnesses, the claims experience, the medical history, the genetic information, or the disability or evidence of insurability, including conditions arising out of acts of domestic violence of that employee or dependent. No health benefit plan may limit or exclude coverage for a specific eligible employee or dependent by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted by Section 10198.7 or 10708.

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

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

insured by the carrier in California as of December 31 of the preceding year.

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

SEC. 11. 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.

Approved _____, 2010

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Governor