

AMENDED IN SENATE MARCH 29, 2016

**SENATE BILL**

**No. 908**

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**Introduced by Senator Hernandez**

January 26, 2016

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An act to amend Sections 1374.21 and 1389.25 of the Health and Safety Code, and to amend Sections 10113.9 and 10199.1 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 908, as amended, Hernandez. Health care coverage: premium rate change: notice: other health coverage.

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 its provisions a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance.

Existing law prohibits, among other things, a change in premium rates for group health care service plan contracts and group health insurance policies from becoming effective unless a written notice is delivered as specified.

This bill would ~~require that~~ *require*, if the Department of Managed Health Care or the Department of Insurance determines that a group rate is unreasonable or not justified, the contractholder or policyholder ~~would~~ *to* be notified by the health care service plan or health insurer in writing of ~~the~~ *that* determination, and ~~would~~ *require* the contractholder or policyholder ~~would~~ *to* be given 60 days to obtain *other* health coverage from the existing coverage provider or another provider. During the 60-day period the contractholder or policyholder would

continue to be covered at the prior rate. ~~The~~ *With respect to small group plan contracts or policies offered through the Exchange, the bill also would exempt these circumstances from the requirement that an enrollment in or change of a health care service plan or health insurer limit enrollment in a small group health care service plan contract or health insurance policy be made during an to specified open, annual, or special enrollment period. periods.*

Existing law prohibits, among other things, a change in premium rates for individual health care service plan contracts and individual health insurance policies from becoming effective unless a written notice is delivered as specified. *Existing law requires health care service plans and health insurers to limit enrollment in individual health benefit plans to specified open enrollment, annual enrollment, and special enrollment periods.* Existing law, subject to certain provisions, requires a health care service plan or health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events for the purposes of a special enrollment period.

This bill would ~~require that~~ *require*, if the Department of Managed Health Care or the Department of Insurance determines that an individual rate is unreasonable or not justified, the contractholder or policyholder ~~would~~ *to be notified by the health care service plan or health insurer in writing of the that determination, and would require, if the open enrollment period has closed for the applicable rate year or there are fewer than 60 days remaining in the open enrollment period for the applicable rate year;* the contractholder or policyholder ~~would~~ *to be given 60 days to obtain other coverage from the existing coverage provider or another provider. During the 60-day period the contractholder or policyholder would continue to be covered at the prior rate. The bill would provide that this notification provided to the contractholder or policyholder constitutes a triggering event for purposes of special enrollment periods in the individual market if the open enrollment period has closed for the applicable rate year or there are fewer than 60 days remaining in the open enrollment period for the applicable rate year.*

This bill would also revise obsolete references and make other technical, nonsubstantive changes.

Because a willful violation of the bill's requirements with respect 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 1374.21 of the Health and Safety Code  
2 is amended to read:

3 1374.21. (a) (1) A change in premium rates or changes in  
4 coverage stated in a group health care service plan contract shall  
5 not become effective unless the plan has delivered in writing a  
6 notice indicating the change or changes at least 60 days prior to  
7 the contract renewal effective date.

8 (2) The notice delivered pursuant to paragraph (1) for large  
9 group health plans shall also include the following information:

10 (A) Whether the rate proposed to be in effect is greater than the  
11 average rate increase for individual market products negotiated by  
12 the California Health Benefit Exchange for the most recent calendar  
13 year for which the rates are final.

14 (B) Whether the rate proposed to be in effect is greater than the  
15 average rate increase negotiated by the Board of Administration  
16 of the Public Employees' Retirement System for the most recent  
17 calendar year for which the rates are final.

18 (C) Whether the rate change includes any portion of the excise  
19 tax paid by the health plan.

20 (b) A health care service plan that declines to offer coverage to  
21 or denies enrollment for a large group applying for coverage shall,  
22 at the time of the denial of coverage, provide the applicant with  
23 the specific reason or reasons for the decision in writing, in clear,  
24 easily understandable language.

25 (c) (1) Notwithstanding subdivision (b) of Section 1357.503,  
26 if the department determines that a rate is unreasonable or not  
27 ~~justified~~, *justified consistent with Article 6.2 (commencing with*  
28 *Section 1385.01)*, the plan shall notify the contractholder of this  
29 determination and shall offer the contractholder coverage of no  
30 less than 60 days in order for the contractholder to obtain other

1 coverage, including coverage from another health care service  
2 plan. During the 60-day period, the prior rate shall remain in effect  
3 to allow the purchaser the opportunity to obtain other coverage.

4 (2) The notification to the contractholder shall state the  
5 following in 14-point type:

6  
7 “The Department of Managed Health Care has determined that  
8 the rate for this product is not reasonable or not justified. All health  
9 coverage offered to employers like you is reviewed to determine  
10 whether the rates are reasonable and justified. ~~You have~~ *For the*  
11 *next 60 days from the date of this notice you have the option to*  
12 *obtain other coverage from this health plan or another health plan.*  
13 ~~During that time, this 60-day period,~~ the prior rate shall remain in  
14 effect. For small ~~group~~ *business* purchasers, *you may* contact  
15 Covered California at [www.coveredca.com](http://www.coveredca.com) for help in obtaining  
16 coverage.”

17  
18 (3) The notice shall also be provided to the solicitor for the  
19 contractholder, if any, so that the solicitor may assist the purchaser  
20 in finding other coverage.

21 SEC. 2. Section 1389.25 of the Health and Safety Code is  
22 amended to read:

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

35 (2) A local initiative, as defined in subdivision (w) of Section  
36 53810 of Title 22 of the California Code of Regulations, that is  
37 awarded a contract by the State Department of Health Care Services  
38 pursuant to subdivision (b) of Section 53800 of Title 22 of the  
39 California Code of Regulations, shall not be subject to this section

1 unless the plan offers coverage in the individual market to persons  
2 not covered by Medi-Cal or the Healthy Families Program.

3 (b) (1) No change in the premium rate or coverage for an  
4 individual plan contract shall become effective unless the plan has  
5 delivered a written notice of the change at least 15 days prior to  
6 the start of the annual enrollment period applicable to the contract  
7 or 60 days prior to the effective date of the contract renewal,  
8 whichever occurs earlier in the calendar year.

9 (2) The written notice required pursuant to paragraph (1) shall  
10 be delivered to the individual contractholder at his or her last  
11 address known to the plan. The notice shall state in italics and in  
12 12-point type the actual dollar amount of the premium rate increase  
13 and the specific percentage by which the current premium will be  
14 increased. The notice shall describe in plain, understandable  
15 English any changes in the plan design or any changes in benefits,  
16 including a reduction in benefits or changes to waivers, exclusions,  
17 or conditions, and highlight this information by printing it in italics.  
18 The notice shall specify in a minimum of 10-point bold typeface,  
19 the reason for a premium rate change or a change to the plan design  
20 or benefits.

21 (c) (1) Notwithstanding subdivision (c) of Section 1399.849,  
22 if the department determines that a rate is unreasonable or not  
23 ~~justified~~, *justified consistent with Article 6.2 (commencing with*  
24 *Section 1385.01)*, the plan shall notify the contractholder of this  
25 determination and, *if the open enrollment period has closed for*  
26 *the applicable rate year or there are fewer than 60 days remaining*  
27 *in the open enrollment period for the applicable rate year*, shall  
28 offer the contractholder coverage of no less than 60 days to obtain  
29 other coverage, including coverage from another health care service  
30 plan. During the 60-day period, the prior rate shall remain in effect  
31 to allow the purchaser the opportunity to obtain other coverage.

32 (2) *If it is prior to the open enrollment period for the applicable*  
33 *rate year, the notification to the contractholder shall state the*  
34 *following in 14-point type:*

35  
36 *“The Department of Managed Health Care has determined that*  
37 *the rate for this product is not reasonable or not justified. All*  
38 *health coverage offered to individuals like you is reviewed to*  
39 *determine whether the rates are reasonable and justified. Open*  
40 *enrollment is from [insert day of month and year] to [insert day*

1 of month and year]. During that time, you have the option to obtain  
 2 other coverage from this health plan or another health plan. You  
 3 may also contact Covered California at [www.coveredca.com](http://www.coveredca.com) for  
 4 help in obtaining coverage. Many Californians are eligible for  
 5 financial assistance from Covered California to help pay for  
 6 coverage.

7  
 8 ~~(2) The~~

9 (3) If there are less than 60 days remaining in the open  
 10 enrollment period for the applicable rate year or after the open  
 11 enrollment period has closed for the applicable rate year, the  
 12 notification to the contractholder shall state the following in  
 13 14-point type:

14  
 15 “The Department of Managed Health Care has determined that  
 16 the rate for this product is not reasonable or not justified. All health  
 17 coverage offered to individuals like you is reviewed to determine  
 18 whether the rates are reasonable and justified. ~~You have~~ For the  
 19 next 60 days from the date of this notice you have the option to  
 20 obtain other coverage from this health plan or another health plan.  
 21 During ~~that time, this 60-day period~~, the prior rate shall remain in  
 22 effect. You may also contact Covered California at  
 23 [www.coveredca.com](http://www.coveredca.com) for help in obtaining coverage. Many  
 24 Californians are eligible for financial assistance from Covered  
 25 California to help pay for coverage.”

26  
 27 ~~(3)~~

28 (4) The notice shall also be provided to the solicitor for the  
 29 contractholder, if any, so that the solicitor may assist the purchaser  
 30 in finding other coverage.

31 ~~(4)~~

32 (5) The notice shall constitute a ~~trigger~~ triggering event for  
 33 purposes of special enrollment, as defined in Section ~~1399.849~~.  
 34 ~~1399.849~~ if the open enrollment period has closed for the  
 35 applicable rate year or there are fewer than 60 days remaining in  
 36 the open enrollment period for the applicable rate year.

37 (d) If a plan rejects a dependent of a subscriber applying to be  
 38 added to the subscriber’s individual grandfathered health plan,  
 39 rejects an applicant for a Medicare supplement plan contract due  
 40 to the applicant having end-stage renal disease, or offers an

1 individual grandfathered health plan to an applicant at a rate that  
2 is higher than the standard rate, the plan shall inform the applicant  
3 about the California Major Risk Medical Insurance Program  
4 (MRMIP) (Chapter 4 (commencing with Section 15870) of Part  
5 3.3 of Division 9 of the Welfare and Institutions Code) and about  
6 the new coverage options and the potential for subsidized coverage  
7 through Covered California. The plan shall direct persons seeking  
8 more information to MRMIP, Covered California, plan or policy  
9 representatives, insurance agents, or an entity paid by Covered  
10 California to assist with health coverage enrollment, such as a  
11 navigator or an assister.

12 (e) A notice provided pursuant to this section is a private and  
13 confidential communication and, at the time of application, the  
14 plan shall give the individual applicant the opportunity to designate  
15 the address for receipt of the written notice in order to protect the  
16 confidentiality of any personal or privileged information.

17 (f) For purposes of this section, the following definitions shall  
18 apply:

19 (1) “Covered California” means the California Health Benefit  
20 Exchange established pursuant to Section 100500 of the  
21 Government Code.

22 (2) “Grandfathered health plan” has the same meaning as that  
23 term is defined in Section 1251 of PPACA.

24 (3) “PPACA” means the federal Patient Protection and  
25 Affordable Care Act (Public Law 111-148), as amended by the  
26 federal Health Care and Education Reconciliation Act of 2010  
27 (Public Law 111-152), and any rules, regulations, or guidance  
28 issued pursuant to that law.

29 SEC. 3. Section 10113.9 of the Insurance Code is amended to  
30 read:

31 10113.9. (a) This section shall not apply to short-term limited  
32 duration health insurance, vision-only, dental-only, or  
33 CHAMPUS-supplement insurance, or to hospital indemnity,  
34 hospital-only, accident-only, or specified disease insurance that  
35 does not pay benefits on a fixed benefit, cash payment only basis.

36 (b) (1) No change in the premium rate or coverage for an  
37 individual health insurance policy shall become effective unless  
38 the insurer has delivered a written notice of the change at least 15  
39 days prior to the start of the annual enrollment period applicable

1 to the policy or 60 days prior to the effective date of the policy  
2 renewal, whichever occurs earlier in the calendar year.

3 (2) The written notice required pursuant to paragraph (1) shall  
4 be delivered to the individual policyholder at his or her last address  
5 known to the insurer. The notice shall state in italics and in 12-point  
6 type the actual dollar amount of the premium increase and the  
7 specific percentage by which the current premium will be  
8 increased. The notice shall describe in plain, understandable  
9 English any changes in the policy or any changes in benefits,  
10 including a reduction in benefits or changes to waivers, exclusions,  
11 or conditions, and highlight this information by printing it in italics.  
12 The notice shall specify in a minimum of 10-point bold typeface,  
13 the reason for a premium rate change or a change in coverage or  
14 benefits.

15 (c) (1) Notwithstanding subdivision (c) of Section 10965.3, if  
16 the department determines that a rate is unreasonable or not  
17 ~~justified~~, *justified consistent with Article 4.5 (commencing with*  
18 *Section 10181)*, the insurer shall notify the policyholder of this  
19 determination and, *if the open enrollment period has closed for*  
20 *the applicable rate year or there are fewer than 60 days remaining*  
21 *in the open enrollment period for the applicable rate year*, shall  
22 offer the policyholder coverage of no less than 60 days in order to  
23 obtain other coverage, including coverage from another health  
24 insurer. During the 60-day period, the prior rate shall remain in  
25 effect to allow the purchaser the opportunity to obtain other  
26 coverage.

27 (2) *If it is prior to the open enrollment period for the applicable*  
28 *rate year, the notification to the policyholder shall state the*  
29 *following in 14-point type:*  
30

31 *“The Department of Insurance has determined that the rate for*  
32 *this product is not reasonable and is not justified. All health*  
33 *coverage offered to individuals like you is reviewed to determine*  
34 *whether the rates are reasonable and justified. Open enrollment*  
35 *is from [insert day of month and year] to [insert day of month and*  
36 *year]. During that time, you have the option to obtain other*  
37 *coverage from this health insurer or another health insurer. You*  
38 *may also contact Covered California at [www.coveredca.com](http://www.coveredca.com) for*  
39 *help in obtaining coverage. Many Californians are eligible for*

1 *financial assistance from Covered California to help pay for*  
2 *coverage.”*

3  
4 ~~(2) The~~

5 *(3) If there are less than 60 days remaining in the open*  
6 *enrollment period for the applicable rate year or after the open*  
7 *enrollment period has closed for the applicable rate year, the*  
8 *notification to the policyholder shall state the following in 14-point*  
9 *type:*

10  
11 “The Department of Insurance has determined that the rate for  
12 this product is not reasonable or not justified. All health coverage  
13 offered to individuals like you is reviewed to determine whether  
14 the rates are reasonable and justified. ~~You have~~ *For the next 60*  
15 *days from the date of this notice you have the option to obtain*  
16 *other coverage from this health insurer or another health insurer.*  
17 *During that time, the 60-day period, the prior rate shall remain in*  
18 *effect. You may also contact Covered California at*  
19 *www.coveredca.com for help in obtaining coverage. Many*  
20 *Californians are eligible for financial assistance from Covered*  
21 *California to help pay for coverage.”*

22  
23 ~~(3)~~

24 *(4) The notice shall also be provided to the ~~solicitor~~ agent of*  
25 *record for the policyholder, if any, so that the ~~solicitor~~ agent may*  
26 *assist the purchaser in finding other coverage.*

27 ~~(4)~~

28 *(5) The notice shall constitute a ~~trigger~~ triggering event for*  
29 *purposes of special enrollment, as defined in Section ~~10965.3-~~*  
30 *10965.3 if the open enrollment period has closed for the applicable*  
31 *rate year or there are fewer than 60 days remaining in the open*  
32 *enrollment period for the applicable rate year.*

33 *(d) If an insurer rejects a dependent of a policyholder applying*  
34 *to be added to the policyholder’s individual grandfathered health*  
35 *plan, rejects an applicant for a Medicare supplement policy due*  
36 *to the applicant having end-stage renal disease, or offers an*  
37 *individual grandfathered health plan to an applicant at a rate that*  
38 *is higher than the standard rate, the insurer shall inform the*  
39 *applicant about the California Major Risk Medical Insurance*  
40 *Program (MRMIP) (Chapter 4 (commencing with Section 15870))*

1 of Part 3.3 of Division 9 of the Welfare and Institutions Code) and  
2 about the new coverage options and the potential for subsidized  
3 coverage through Covered California. The insurer shall direct  
4 persons seeking more information to MRMIP, Covered California,  
5 plan or policy representatives, insurance agents, or an entity paid  
6 by Covered California to assist with health coverage enrollment,  
7 such as a navigator or an assister.

8 (e) A notice provided pursuant to this section is a private and  
9 confidential communication and, at the time of application, the  
10 insurer shall give the applicant the opportunity to designate the  
11 address for receipt of the written notice in order to protect the  
12 confidentiality of any personal or privileged information.

13 (f) For purposes of this section, the following definitions shall  
14 apply:

15 (1) “Covered California” means the California Health Benefit  
16 Exchange established pursuant to Section 100500 of the  
17 Government Code.

18 (2) “Grandfathered health plan” has the same meaning as that  
19 term is defined in Section 1251 of PPACA.

20 (3) “PPACA” means the federal Patient Protection and  
21 Affordable Care Act (Public Law 111-148), as amended by the  
22 federal Health Care and Education Reconciliation Act of 2010  
23 (Public Law 111-152), and any rules, regulations, or guidance  
24 issued pursuant to that law.

25 SEC. 4. Section 10199.1 of the Insurance Code is amended to  
26 read:

27 10199.1. (a) (1) An insurer or nonprofit hospital service plan  
28 or administrator acting on its behalf shall not terminate a group  
29 master policy or contract providing hospital, medical, or surgical  
30 benefits, increase premiums or charges therefor, reduce or eliminate  
31 benefits thereunder, or restrict eligibility for coverage thereunder  
32 without providing prior notice of that action. The action shall not  
33 become effective unless written notice of the action was delivered  
34 by mail to the last known address of the appropriate insurance  
35 producer and the appropriate administrator, if any, at least 45 days  
36 prior to the effective date of the action and to the last known  
37 address of the group policyholder or group contractholder at least  
38 60 days prior to the effective date of the action. If nonemployee  
39 certificate holders or employees of more than one employer are  
40 covered under the policy or contract, written notice shall also be

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

6 (2) The notice delivered pursuant to paragraph (1) for large  
7 group health insurance policies shall also include the following  
8 information:

9 (A) Whether the rate proposed to be in effect is greater than the  
10 average rate increase for individual market products negotiated by  
11 the California Health Benefit Exchange for the most recent calendar  
12 year for which the rates are final.

13 (B) Whether the rate proposed to be in effect is greater than the  
14 average rate increase negotiated by the Board of Administration  
15 of the Public Employees' Retirement System for the most recent  
16 calendar year for which the rates are final.

17 (C) Whether the rate change includes any portion of the excise  
18 tax paid by the health insurer.

19 (b) A holder of a master group policy or a master group  
20 nonprofit hospital service plan contract or administrator acting on  
21 its behalf shall not terminate the coverage of, increase premiums  
22 or charges for, or reduce or eliminate benefits available to, or  
23 restrict eligibility for coverage of a covered person, employer unit,  
24 or class of certificate holders covered under the policy or contract  
25 for hospital, medical, or surgical benefits without first providing  
26 prior notice of the action. The action shall not become effective  
27 unless written notice was delivered by mail to the last known  
28 address of each affected nonemployee certificate holder or  
29 employer, or if the action does not affect all employees and  
30 dependents of one or more employers, to the last known address  
31 of each affected employee certificate holder, at least 60 days prior  
32 to the effective date of the action.

33 (c) A health insurer that declines to offer coverage to or denies  
34 enrollment for a large group applying for coverage shall, at the  
35 time of the denial of coverage, provide the applicant with the  
36 specific reason or reasons for the decision in writing, in clear,  
37 easily understandable language.

38 (d) (1) Notwithstanding paragraph (3) of subdivision (b) of  
39 Section 10753.05, if the department determines that a rate is  
40 unreasonable or not ~~justified~~, *justified consistent with Article 4.5*

1 (*commencing with Section 10181*), the insurer shall notify the  
 2 policyholder of this determination and shall offer the policyholder  
 3 coverage of no less than 60 days in order for the policyholder to  
 4 obtain coverage from this health insurer or another health insurer.  
 5 During the 60-day period, the prior rate shall remain in effect to  
 6 allow the purchaser the opportunity to obtain other coverage,  
 7 including coverage from another health insurer.

8 (2) The notification to the policyholder shall state the following  
 9 in 14-point type:

10  
 11 “The Department of Insurance has determined that the rate for  
 12 this product is not reasonable or not justified. All health coverage  
 13 offered to employers like you is reviewed to determine whether  
 14 the rates are reasonable and justified. ~~You have~~ *For the next 60*  
 15 *days from the date of this notice you have the option* to obtain  
 16 *other* coverage from this health insurer or another health insurer.  
 17 ~~During that time, this 60-day period,~~ the prior rate shall remain in  
 18 effect. For small-~~group~~ *business* purchasers, *you may* contact  
 19 Covered California at [www.coveredca.com](http://www.coveredca.com) for help in obtaining  
 20 coverage.”

21  
 22 (3) The notice shall also be provided to the ~~solicitor agent of~~  
 23 *record* for the policyholder, if any, so that the ~~solicitor agent~~  
 24 assist the purchaser in finding other coverage.

25 SEC. 5. No reimbursement is required by this act pursuant to  
 26 Section 6 of Article XIII B of the California Constitution because  
 27 the only costs that may be incurred by a local agency or school  
 28 district will be incurred because this act creates a new crime or  
 29 infraction, eliminates a crime or infraction, or changes the penalty  
 30 for a crime or infraction, within the meaning of Section 17556 of  
 31 the Government Code, or changes the definition of a crime within  
 32 the meaning of Section 6 of Article XIII B of the California  
 33 Constitution.