

AMENDED IN SENATE MAY 31, 2016
AMENDED IN SENATE MARCH 29, 2016

SENATE BILL

No. 908

Introduced by Senator Hernandez

January 26, 2016

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, 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 to be notified by the health care service plan or health insurer in writing of that determination, and would require the contractholder or policyholder 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.~~ With respect to small group plan contracts or policies offered through the Exchange, the bill would exempt these circumstances from the requirement that a health care service plan or health insurer limit enrollment in a small group health care service plan contract or health insurance policy to specified open, annual, or special enrollment 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, 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 to be notified by the health care service plan or health insurer in writing of 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 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 consistent with Article 6.2 (commencing with Section
28 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
31 coverage, including coverage from another health care service
32 plan. ~~During the 60-day period, the prior rate shall remain in effect~~
33 ~~to allow the purchaser the opportunity to obtain other coverage.~~

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

3
4 “The Department of Managed Health Care has determined that
5 the rate for this product is not reasonable or not justified. All health
6 coverage offered to employers like you is reviewed to determine
7 whether the rates are reasonable and justified. For the next 60 days
8 from the date of this notice you have the option to obtain other
9 coverage from this health plan or another health plan. ~~During this~~
10 ~~60-day period, the prior rate shall remain in effect.~~ For small
11 business purchasers, you may contact Covered California at
12 www.coveredca.com for help in obtaining coverage.”

13
14 (3) *The plan may include in the notification to the contractholder*
15 *the Internet Web site address at which the plan’s final justification*
16 *for implementing an increase that has been determined to be*
17 *unreasonable by the director may be found pursuant to Section*
18 *154.230 of Title 45 of the Code of Federal Regulations.*

19 (3)

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

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

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

37 (2) A local initiative, as defined in subdivision (w) of Section
38 53810 of Title 22 of the California Code of Regulations, that is
39 awarded a contract by the State Department of Health Care Services
40 pursuant to subdivision (b) of Section 53800 of Title 22 of the

1 California Code of Regulations, shall not be subject to this section
2 unless the plan offers coverage in the individual market to persons
3 not covered by Medi-Cal or the Healthy Families Program.

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

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

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

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

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

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

8
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. For the next 60 days
19 from the date of this notice you have the option to obtain other
20 coverage from this health plan or another health plan. During this
21 60-day period, the prior rate shall remain in effect. You may also
22 contact Covered California at www.coveredca.com for help in
23 obtaining coverage. Many Californians are eligible for financial
24 assistance from Covered California to help pay for coverage.”

25
26 (4) *The plan may include in the notification to the contractholder*
27 *the Internet Web site address at which the plan’s final justification*
28 *for implementing an increase that has been determined to be*
29 *unreasonable by the director may be found pursuant to Section*
30 *154.230 of Title 45 of the Code of Federal Regulations.*

31 (4)
32 (5) The notice shall also be provided to the solicitor for the
33 contractholder, if any, so that the solicitor may assist the purchaser
34 in finding other coverage.

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

1 (d) If a plan rejects a dependent of a subscriber applying to be
2 added to the subscriber’s individual grandfathered health plan,
3 rejects an applicant for a Medicare supplement plan contract due
4 to the applicant having end-stage renal disease, or offers an
5 individual grandfathered health plan to an applicant at a rate that
6 is higher than the standard rate, the plan shall inform the applicant
7 about the California Major Risk Medical Insurance Program
8 (MRMIP) (Chapter 4 (commencing with Section 15870) of Part
9 3.3 of Division 9 of the Welfare and Institutions Code) and about
10 the new coverage options and the potential for subsidized coverage
11 through Covered California. The plan shall direct persons seeking
12 more information to MRMIP, Covered California, plan or policy
13 representatives, insurance agents, or an entity paid by Covered
14 California to assist with health coverage enrollment, such as a
15 navigator or an assister.

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

21 (f) For purposes of this section, the following definitions shall
22 apply:

23 (1) “Covered California” means the California Health Benefit
24 Exchange established pursuant to Section 100500 of the
25 Government Code.

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

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

33 SEC. 3. Section 10113.9 of the Insurance Code is amended to
34 read:

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

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

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

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

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

34
35 “The Department of Insurance has determined that the rate for
36 this product is not reasonable and is not justified. All health
37 coverage offered to individuals like you is reviewed to determine
38 whether the rates are reasonable and justified. Open enrollment is
39 from [insert day of month and year] to [insert day of month and
40 year]. During that time, you have the option to obtain other

1 coverage from this health insurer or another health insurer. You
2 may also contact Covered California at www.coveredca.com for
3 help in obtaining coverage. Many Californians are eligible for
4 financial assistance from Covered California to help pay for
5 coverage.”

6

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

12

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

23

24 (4) *The insurer may include in the notification to the*
25 *policyholder the Internet Web site address at which the insurer’s*
26 *final justification for implementing an increase that has been*
27 *determined to be unreasonable by the commissioner may be found*
28 *pursuant to Section 154.230 of Title 45 of the Code of Federal*
29 *Regulations.*

30

~~(4)~~

31 (5) The notice shall also be provided to the agent of record for
32 the policyholder, if any, so that the agent may assist the purchaser
33 in finding other coverage.

34

~~(5)~~

35 (6) The notice shall constitute a triggering event for purposes
36 of special enrollment, as defined in Section 10965.3 if the open
37 enrollment period has closed for the applicable rate year or there
38 are fewer than 60 days remaining in the open enrollment period
39 for the applicable rate year.

1 (d) If an insurer rejects a dependent of a policyholder applying
2 to be added to the policyholder's individual grandfathered health
3 plan, rejects an applicant for a Medicare supplement policy due
4 to the applicant having end-stage renal disease, or offers an
5 individual grandfathered health plan to an applicant at a rate that
6 is higher than the standard rate, the insurer shall inform the
7 applicant about the California Major Risk Medical Insurance
8 Program (MRMIP) (Chapter 4 (commencing with Section 15870)
9 of Part 3.3 of Division 9 of the Welfare and Institutions Code) and
10 about the new coverage options and the potential for subsidized
11 coverage through Covered California. The insurer shall direct
12 persons seeking more information to MRMIP, Covered California,
13 plan or policy representatives, insurance agents, or an entity paid
14 by Covered California to assist with health coverage enrollment,
15 such as a navigator or an assister.

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

21 (f) For purposes of this section, the following definitions shall
22 apply:

23 (1) "Covered California" means the California Health Benefit
24 Exchange established pursuant to Section 100500 of the
25 Government Code.

26 (2) "Grandfathered health plan" has the same meaning as that
27 term is defined in Section 1251 of PPACA.

28 (3) "PPACA" means the federal Patient Protection and
29 Affordable Care Act (Public Law 111-148), as amended by the
30 federal Health Care and Education Reconciliation Act of 2010
31 (Public Law 111-152), and any rules, regulations, or guidance
32 issued pursuant to that law.

33 SEC. 4. Section 10199.1 of the Insurance Code is amended to
34 read:

35 10199.1. (a) (1) An insurer or nonprofit hospital service plan
36 or administrator acting on its behalf shall not terminate a group
37 master policy or contract providing hospital, medical, or surgical
38 benefits, increase premiums or charges therefor, reduce or eliminate
39 benefits thereunder, or restrict eligibility for coverage thereunder
40 without providing prior notice of that action. The action shall not

1 become effective unless written notice of the action was delivered
2 by mail to the last known address of the appropriate insurance
3 producer and the appropriate administrator, if any, at least 45 days
4 prior to the effective date of the action and to the last known
5 address of the group policyholder or group contractholder at least
6 60 days prior to the effective date of the action. If nonemployee
7 certificate holders or employees of more than one employer are
8 covered under the policy or contract, written notice shall also be
9 delivered by mail to the last known address of each nonemployee
10 certificate holder or affected employer or, if the action does not
11 affect all employees and dependents of one or more employers, to
12 the last known address of each affected employee certificate holder,
13 at least 60 days prior to the effective date of the action.

14 (2) The notice delivered pursuant to paragraph (1) for large
15 group health insurance policies shall also include the following
16 information:

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

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

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

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

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

6 (d) (1) Notwithstanding paragraph (3) of subdivision (b) of
7 Section 10753.05, if the department determines that a rate is
8 unreasonable or not justified consistent with Article 4.5
9 (commencing with Section 10181), the insurer shall notify the
10 policyholder of this determination and shall offer the policyholder
11 coverage of no less than 60 days in order for the policyholder to
12 obtain coverage from this health insurer or another health insurer.
13 ~~During the 60-day period, the prior rate shall remain in effect to~~
14 ~~allow the purchaser the opportunity to obtain other coverage,~~
15 ~~including coverage from another health insurer.~~

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

18
19 “The Department of Insurance has determined that the rate for
20 this product is not reasonable or not justified. All health coverage
21 offered to employers like you is reviewed to determine whether
22 the rates are reasonable and justified. For the next 60 days from
23 the date of this notice you have the option to obtain other coverage
24 from this health insurer or another health insurer. ~~During this~~
25 ~~60-day period, the prior rate shall remain in effect.~~ For small
26 business purchasers, you may contact Covered California at
27 www.coveredca.com for help in obtaining coverage.”

28
29 (3) *The insurer may include in the notification to the*
30 *policyholder the Internet Web site address at which the insurer’s*
31 *final justification for implementing an increase that has been*
32 *determined to be unreasonable by the commissioner may be found*
33 *pursuant to Section 154.230 of Title 45 of the Code of Federal*
34 *Regulations.*

35 (3)
36 (4) The notice shall also be provided to the agent of record for
37 the policyholder, if any, so that the agent may assist the purchaser
38 in finding other coverage.

39 SEC. 5. No reimbursement is required by this act pursuant to
40 Section 6 of Article XIII B of the California Constitution because

1 the only costs that may be incurred by a local agency or school
2 district will be incurred because this act creates a new crime or
3 infraction, eliminates a crime or infraction, or changes the penalty
4 for a crime or infraction, within the meaning of Section 17556 of
5 the Government Code, or changes the definition of a crime within
6 the meaning of Section 6 of Article XIII B of the California
7 Constitution.

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