

AMENDED IN ASSEMBLY JUNE 30, 2016

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~~ 1374.21, 1385.03, 1385.07, 1385.11, and 1389.25 of the Health and Safety Code, and to amend Sections ~~10113.9~~ 10113.9, 10181.3, 10181.7, 10181.11, 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

(1) *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~~ *delivered*, as specified.

This bill would require, if the Department of Managed Health Care or the Department of Insurance determines that a *small* group rate is unreasonable or not justified, the contractholder or policyholder *of a*

small group health care service plan contract or health insurance policy 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. 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. determination. The bill would require the notification to be developed by the Department of Managed Health Care and the Department of Insurance, as specified.

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 *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 require the notification to be developed by the Department of Managed Health Care and the Department of Insurance, as specified.* 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.

(2) *Existing law requires a health care service plan or health insurer in the individual or small group market to file rate information with the Department of Managed Health Care or the Department of Insurance, as applicable, at least 60 days prior to implementing any rate change and requires that the information include a certification by an independent actuary that the rate increase is reasonable or unreasonable. Existing law authorizes the Department of Managed Health Care and the Department of Insurance to review these filings to, among other things, make a determination that an unreasonable rate increase is not justified.*

This bill would instead require a health care service plan or health insurer in the individual or small group market to file rate information at least 120 days prior to implementing any rate change. The bill would require a health care service plan or health insurer to respond to any request for additional rate information necessary for the Department of Managed Health Care or the Department of Insurance to complete its review of the rate filing for products in the individual or small group market within 3 business days of the request and would require the Department of Managed Health Care and the Department of Insurance to review these filings and make its determination no later than 60 days following receipt of the rate information.

This

(3) *This bill would also revise obsolete references and would make other conforming and technical, nonsubstantive changes.*

Because

(4) *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 For small group health care service plan contracts, if the~~
27 ~~department determines that a rate is unreasonable or not justified~~
28 ~~consistent with Article 6.2 (commencing with Section 1385.01),~~
29 ~~the plan shall notify the contractholder of this determination and~~
30 ~~shall offer the contractholder coverage of no less than 60 days in~~
31 ~~order for the contractholder to obtain other coverage, including~~
32 ~~coverage from another health care service plan: determination.~~

33 ~~(2) 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 health~~
38 ~~coverage offered to employers like you is reviewed to determine~~

1 ~~whether the rates are reasonable and justified. For the next 60 days~~
 2 ~~from the date of this notice you have the option to obtain other~~
 3 ~~coverage from this health plan or another health plan. For small~~
 4 ~~business purchasers, you may contact Covered California at~~
 5 ~~www.coveredca.com for help in obtaining coverage.”~~

6
 7 *(2) The notification to the contractholder shall be developed by*
 8 *the department and shall include the following statements in*
 9 *14-point type:*

10 *(A) The Department of Managed Health Care has determined*
 11 *that the rate for this product is unreasonable or not justified after*
 12 *reviewing information submitted to it by the plan.*

13 *(B) The contractholder has the option to obtain other coverage*
 14 *from this plan or another plan, or to keep this coverage.*

15 *(C) Small business purchasers may want to contact Covered*
 16 *California at www.coveredca.com for help in understanding*
 17 *available options.*

18 *(3) The development of the notification required under this*
 19 *subdivision shall not be subject to the Administrative Procedure*
 20 *Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of*
 21 *Division 3 of Title 2 of the Government Code).*

22 ~~(3)~~

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

28 ~~(4)~~

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

32 *SEC. 2. Section 1385.03 of the Health and Safety Code is*
 33 *amended to read:*

34 1385.03. (a) All health care service plans shall file with the
 35 department all required rate information for individual and small
 36 group health care service plan contracts at least ~~60~~ 120 days prior
 37 to implementing any rate change.

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

40 (1) Company name and contact information.

- 1 (2) Number of plan contract forms covered by the filing.
- 2 (3) Plan contract form numbers covered by the filing.
- 3 (4) Product type, such as a preferred provider organization or
- 4 health maintenance organization.
- 5 (5) Segment type.
- 6 (6) Type of plan involved, such as for profit or not for profit.
- 7 (7) Whether the products are opened or closed.
- 8 (8) Enrollment in each plan contract and rating form.
- 9 (9) Enrollee months in each plan contract form.
- 10 (10) Annual rate.
- 11 (11) Total earned premiums in each plan contract form.
- 12 (12) Total incurred claims in each plan contract form.
- 13 (13) Average rate increase initially requested.
- 14 (14) Review category: initial filing for new product, filing for
- 15 existing product, or resubmission.
- 16 (15) Average rate of increase.
- 17 (16) Effective date of rate increase.
- 18 (17) Number of subscribers or enrollees affected by each plan
- 19 contract form.
- 20 (18) The plan's overall annual medical trend factor assumptions
- 21 in each rate filing for all benefits and by aggregate benefit category,
- 22 including hospital inpatient, hospital outpatient, physician services,
- 23 prescription drugs and other ancillary services, laboratory, and
- 24 radiology. A plan may provide aggregated additional data that
- 25 demonstrates or reasonably estimates year-to-year cost increases
- 26 in specific benefit categories in the geographic regions listed in
- 27 Sections 1357.512 and 1399.855. A health plan that exclusively
- 28 contracts with no more than two medical groups in the state to
- 29 provide or arrange for professional medical services for the
- 30 enrollees of the plan shall instead disclose the amount of its actual
- 31 trend experience for the prior contract year by aggregate benefit
- 32 category, using benefit categories that are, to the maximum extent
- 33 possible, the same or similar to those used by other plans.
- 34 (19) The amount of the projected trend attributable to the use
- 35 of services, price inflation, or fees and risk for annual plan contract
- 36 trends by aggregate benefit category, such as hospital inpatient,
- 37 hospital outpatient, physician services, prescription drugs and other
- 38 ancillary services, laboratory, and radiology. A health plan that
- 39 exclusively contracts with no more than two medical groups in the
- 40 state to provide or arrange for professional medical services for

1 the enrollees of the plan shall instead disclose the amount of its
2 actual trend experience for the prior contract year by aggregate
3 benefit category, using benefit categories that are, to the maximum
4 extent possible, the same or similar to those used by other plans.
5 (20) A comparison of claims cost and rate of changes over time.
6 (21) Any changes in enrollee cost sharing over the prior year
7 associated with the submitted rate filing.
8 (22) Any changes in enrollee benefits over the prior year
9 associated with the submitted rate filing.
10 (23) The certification described in subdivision (b) of Section
11 1385.06.
12 (24) Any changes in administrative costs.
13 (25) Any other information required for rate review under
14 PPACA.
15 (c) A health care service plan subject to subdivision (a) shall
16 also disclose the following aggregate data for all rate filings
17 submitted under this section in the individual and small group
18 health plan markets:
19 (1) Number and percentage of rate filings reviewed by the
20 following:
21 (A) Plan year.
22 (B) Segment type.
23 (C) Product type.
24 (D) Number of subscribers.
25 (E) Number of covered lives affected.
26 (2) The plan's average rate increase by the following categories:
27 (A) Plan year.
28 (B) Segment type.
29 (C) Product type.
30 (3) Any cost containment and quality improvement efforts since
31 the plan's last rate filing for the same category of health benefit
32 plan. To the extent possible, the plan shall describe any significant
33 new health care cost containment and quality improvement efforts
34 and provide an estimate of potential savings together with an
35 estimated cost or savings for the projection period.
36 (d) The department may require all health care service plans to
37 submit all rate filings to the National Association of Insurance
38 Commissioners' System for Electronic Rate and Form Filing
39 (SERFF). Submission of the required rate filings to SERFF shall

1 be deemed to be filing with the department for purposes of
2 compliance with this section.

3 (e) A plan shall submit any other information required under
4 PPACA. A plan shall also submit any other information required
5 pursuant to any regulation adopted by the department to comply
6 with this article.

7 (f) (1) *A plan shall respond to the department's request for any*
8 *additional information necessary for the department to complete*
9 *its review of the plan's rate filing for individual and small group*
10 *health care service plan contracts under this article within three*
11 *business days of the department's request or as otherwise required*
12 *by the department.*

13 (2) *The department shall determine whether a plan's rate*
14 *increase for individual and small group health care service plan*
15 *contracts is unreasonable or not justified no later than 60 days*
16 *following receipt of all the information the department requires*
17 *to makes its determination.*

18 SEC. 3. *Section 1385.07 of the Health and Safety Code is*
19 *amended to read:*

20 1385.07. (a) Notwithstanding Chapter 3.5 (commencing with
21 Section 6250) of Division 7 of Title 1 of the Government Code,
22 all information submitted under this article shall be made publicly
23 available by the department except as provided in subdivision (b).

24 (b) (1) The contracted rates between a health care service plan
25 and a provider shall be deemed confidential information that shall
26 not be made public by the department and are exempt from
27 disclosure under the California Public Records Act (Chapter 3.5
28 (commencing with Section 6250) of Division 7 of Title 1 of the
29 Government Code). The contracted rates between a health care
30 service plan and a provider shall not be disclosed by a health care
31 service plan to a large group purchaser that receives information
32 pursuant to Section 1385.10.

33 (2) The contracted rates between a health care service plan and
34 a large group shall be deemed confidential information that shall
35 not be made public by the department and are exempt from
36 disclosure under the California Public Records Act (Chapter 3.5
37 (commencing with Section 6250) of Division 7 of Title 1 of the
38 Government Code). Information provided to a large group
39 purchaser pursuant to Section 1385.10 shall be deemed confidential
40 information that shall not be made public by the department and

1 shall be exempt from disclosure under the California Public
2 Records Act (Chapter 3.5 (commencing with Section 6250) of
3 Division 7 of Title 1 of the Government Code).

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

7 (d) In addition, the department and the health care service plan
8 shall, at a minimum, make the following information readily
9 available to the public on their Internet Web sites, in plain language
10 and in a manner and format specified by the department, except
11 as provided in subdivision (b). ~~The~~ *For individual and small group*
12 *health care service plan contracts, the information shall be made*
13 *public for 120 days prior to the implementation of the rate increase.*
14 *For large group health care service plan contracts, the* information
15 shall be made public for 60 days prior to the implementation of
16 the rate increase. The information shall include:

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

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

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

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

37 *SEC. 4. Section 1385.11 of the Health and Safety Code is*
38 *amended to read:*

39 1385.11. (a) Whenever it appears to the department that any
40 person has engaged, or is about to engage, in any act or practice

1 constituting a violation of this article, including the filing of
 2 inaccurate or unjustified rates or inaccurate or unjustified rate
 3 information, the department may review the rate filing to ensure
 4 compliance with the law.

5 (b) The department may review other filings.

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

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

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

16 (f) If the director makes a decision that an unreasonable rate
 17 increase is not justified or that a rate filing contains inaccurate
 18 information, the department shall post that decision on its Internet
 19 Web site.

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

23 ~~SEC. 2.~~

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

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

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

1 pursuant to subdivision (b) of Section 53800 of Title 22 of the
2 California Code of Regulations, shall not be subject to this section
3 unless the plan offers coverage in the individual market to persons
4 not covered by Medi-Cal or the Healthy Families Program.

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

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

23 (c) (1) Notwithstanding subdivision (c) of Section 1399.849,
24 if the department determines that a rate is unreasonable or not
25 justified consistent with Article 6.2 (commencing with Section
26 1385.01), the plan shall notify the contractholder of this
27 determination and, if the open enrollment period has closed for
28 the applicable rate year or there are fewer than 60 days remaining
29 in the open enrollment period for the applicable rate year, shall
30 offer the contractholder coverage of no less than 60 days to obtain
31 other 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.~~
34 *The notification to the contractholder shall be developed by the*
35 *department. The development of the notification required under*
36 *this subdivision shall not be subject to the Administrative*
37 *Procedure Act (Chapter 3.5 (commencing with Section 11340) of*
38 *Part 1 of Division 3 of Title 2 of the Government Code).*

1 (2) If it is prior to the open enrollment period for the applicable
 2 rate year, the notification to the contractholder shall ~~state the~~
 3 ~~following~~ *include the following statements* in 14-point type:

4
 5 ~~“The Department of Managed Health Care has determined that~~
 6 ~~the rate for this product is not reasonable or not justified. All health~~
 7 ~~coverage offered to individuals like you is reviewed to determine~~
 8 ~~whether the rates are reasonable and justified. Open enrollment is~~
 9 ~~from [insert day of month and year] to [insert day of month and~~
 10 ~~year]. During that time, you have the option to obtain other~~
 11 ~~coverage from this health plan or another health plan. You may~~
 12 ~~also contact Covered California at www.coveredca.com for help~~
 13 ~~in obtaining coverage. Many Californians are eligible for financial~~
 14 ~~assistance from Covered California to help pay for coverage.”~~

15
 16 (A) *The Department of Managed Health Care has determined*
 17 *that the rate for this product is unreasonable or not justified after*
 18 *reviewing information submitted to it by the plan.*

19 (B) *During the upcoming open enrollment period, the*
 20 *contractholder has the option to obtain other coverage from this*
 21 *plan or another plan, or to keep this coverage.*

22 (C) *The contractholder may want to contact Covered California*
 23 *at www.coveredca.com for help in understanding available options.*

24 (D) *Many Californians are eligible for financial assistance from*
 25 *Covered California to help pay for coverage.*

26 (3) If there are less than 60 days remaining in the open
 27 enrollment period for the applicable rate year or after the open
 28 enrollment period has closed for the applicable rate year, the
 29 notification to the contractholder shall ~~state the following~~ *include*
 30 *the following statements* in 14-point type:

31
 32 ~~“The Department of Managed Health Care has determined that~~
 33 ~~the rate for this product is not reasonable or not justified. All health~~
 34 ~~coverage offered to individuals like you is reviewed to determine~~
 35 ~~whether the rates are reasonable and justified. For the next 60 days~~
 36 ~~from the date of this notice you have the option to obtain other~~
 37 ~~coverage from this health plan or another health plan. During this~~
 38 ~~60-day period, the prior rate shall remain in effect. You may also~~
 39 ~~contact Covered California at www.coveredca.com for help in~~

1 ~~obtaining coverage. Many Californians are eligible for financial~~
2 ~~assistance from Covered California to help pay for coverage.”~~

3
4 *(A) The Department of Managed Health Care has determined*
5 *that the rate for this product is unreasonable or not justified after*
6 *reviewing information submitted to it by the plan.*

7 *(B) The contractholder has the option to obtain other coverage*
8 *from this plan or another plan, or to keep this coverage.*

9 *(C) The contractholder may want to contact Covered California*
10 *at www.coveredca.com for help in understanding available options.*

11 *(D) Many Californians are eligible for financial assistance from*
12 *Covered California to help pay for coverage.*

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

18 (5) 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 (6) The notice shall constitute a triggering event for purposes
22 of special enrollment, as defined in Section 1399.849 if the open
23 enrollment period has closed for the applicable rate year or there
24 are fewer than 60 days remaining in the open enrollment period
25 for the applicable rate year.

26 (d) If a plan rejects a dependent of a subscriber applying to be
27 added to the subscriber’s individual grandfathered health plan,
28 rejects an applicant for a Medicare supplement plan contract due
29 to the applicant having end-stage renal disease, or offers an
30 individual grandfathered health plan to an applicant at a rate that
31 is higher than the standard rate, the plan shall inform the applicant
32 about the California Major Risk Medical Insurance Program
33 (MRMIP) (Chapter 4 (commencing with Section 15870) of Part
34 3.3 of Division 9 of the Welfare and Institutions Code) and about
35 the new coverage options and the potential for subsidized coverage
36 through Covered California. The plan shall direct persons seeking
37 more information to MRMIP, Covered California, plan or policy
38 representatives, insurance agents, or an entity paid by Covered
39 California to assist with health coverage enrollment, such as a
40 navigator or an assister.

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

6 (f) For purposes of this section, the following definitions shall
7 apply:

8 (1) “Covered California” means the California Health Benefit
9 Exchange established pursuant to Section 100500 of the
10 Government Code.

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

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

18 ~~SEC. 3.~~

19 *SEC. 6.* Section 10113.9 of the Insurance Code is amended to
20 read:

21 10113.9. (a) This section shall not apply to short-term limited
22 duration health insurance, vision-only, dental-only, or
23 CHAMPUS-supplement insurance, or to hospital indemnity,
24 hospital-only, accident-only, or specified disease insurance that
25 does not pay benefits on a fixed benefit, cash payment only basis.

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

32 (2) The written notice required pursuant to paragraph (1) shall
33 be delivered to the individual policyholder at his or her last address
34 known to the insurer. The notice shall state in italics and in 12-point
35 type the actual dollar amount of the premium increase and the
36 specific percentage by which the current premium will be
37 increased. The notice shall describe in plain, understandable
38 English any changes in the policy or any changes in benefits,
39 including a reduction in benefits or changes to waivers, exclusions,
40 or conditions, and highlight this information by printing it in italics.

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

4 (c) (1) Notwithstanding subdivision (c) of Section 10965.3, if
5 the department determines that a rate is unreasonable or not
6 justified consistent with Article 4.5 (commencing with Section
7 10181), the insurer shall notify the policyholder of this
8 determination and, if the open enrollment period has closed for
9 the applicable rate year or there are fewer than 60 days remaining
10 in the open enrollment period for the applicable rate year, shall
11 offer the policyholder coverage of no less than 60 days in order to
12 obtain other coverage, including coverage from another health
13 insurer. ~~During the 60-day period, the prior rate shall remain in~~
14 ~~effect to allow the purchaser the opportunity to obtain other~~
15 ~~coverage. The notification to the policyholder shall be developed~~
16 ~~by the department. The development of the notification required~~
17 ~~under this subdivision shall not be subject to the Administrative~~
18 ~~Procedure Act (Chapter 3.5 (commencing with Section 11340) of~~
19 ~~Part 1 of Division 3 of Title 2 of the Government Code).~~

20 (2) If it is prior to the open enrollment period for the applicable
21 rate year, the notification to the policyholder shall ~~state the~~
22 ~~following~~ include the following statements in 14-point type:

23
24 ~~“The Department of Insurance has determined that the rate for~~
25 ~~this product is not reasonable and is not justified. All health~~
26 ~~coverage offered to individuals like you is reviewed to determine~~
27 ~~whether the rates are reasonable and justified. Open enrollment is~~
28 ~~from [insert day of month and year] to [insert day of month and~~
29 ~~year]. During that time, you have the option to obtain other~~
30 ~~coverage from this health insurer or another health insurer. You~~
31 ~~may also contact Covered California at www.coveredca.com for~~
32 ~~help in obtaining coverage. Many Californians are eligible for~~
33 ~~financial assistance from Covered California to help pay for~~
34 ~~coverage.”~~

35
36 (A) *The Department of Insurance has determined that the rate*
37 *for this product is unreasonable or not justified after reviewing*
38 *information submitted to it by the insurer.*

1 (B) During the upcoming open enrollment period, the
2 policyholder has the option to obtain other coverage from this
3 insurer or another insurer, or to keep this coverage.

4 (C) The policyholder may want to contact Covered California
5 at www.coveredca.com for help in understanding available options.

6 (D) Many Californians are eligible for financial assistance from
7 Covered California to help pay for coverage.

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

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

24
25 (A) ~~The Department of Insurance has determined that the rate
26 for this product is unreasonable or not justified after reviewing
27 information submitted to it by the insurer.~~

28 (B) ~~The policyholder has the option to obtain other coverage
29 from this insurer or another insurer, or to keep this coverage.~~

30 (C) ~~The policyholder may want to contact Covered California
31 at www.coveredca.com for help in understanding available options.~~

32 (D) ~~Many Californians are eligible for financial assistance from
33 Covered California to help pay for coverage.~~

34 (4) The insurer may include in the notification to the
35 policyholder the Internet Web site address at which the insurer’s
36 final justification for implementing an increase that has been
37 determined to be unreasonable by the commissioner may be found
38 pursuant to Section 154.230 of Title 45 of the Code of Federal
39 Regulations.

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

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

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

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

29 (f) For purposes of this section, the following definitions shall
30 apply:

31 (1) “Covered California” means the California Health Benefit
32 Exchange established pursuant to Section 100500 of the
33 Government Code.

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

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

1 SEC. 7. Section 10181.3 of the Insurance Code is amended to
2 read:

3 10181.3. (a) All health insurers shall file with the department
4 all required rate information for individual and small group health
5 insurance policies at least ~~60~~ 120 days prior to implementing any
6 rate change.

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

- 9 (1) Company name and contact information.
- 10 (2) Number of policy forms covered by the filing.
- 11 (3) Policy form numbers covered by the filing.
- 12 (4) Product type, such as indemnity or preferred provider
13 organization.
- 14 (5) Segment type.
- 15 (6) Type of insurer involved, such as for profit or not for profit.
- 16 (7) Whether the products are opened or closed.
- 17 (8) Enrollment in each policy and rating form.
- 18 (9) Insured months in each policy form.
- 19 (10) Annual rate.
- 20 (11) Total earned premiums in each policy form.
- 21 (12) Total incurred claims in each policy form.
- 22 (13) Average rate increase initially requested.
- 23 (14) Review category: initial filing for new product, filing for
24 existing product, or resubmission.
- 25 (15) Average rate of increase.
- 26 (16) Effective date of rate increase.
- 27 (17) Number of policyholders or insureds affected by each
28 policy form.
- 29 (18) The insurer’s overall annual medical trend factor
30 assumptions in each rate filing for all benefits and by aggregate
31 benefit category, including hospital inpatient, hospital outpatient,
32 physician services, prescription drugs and other ancillary services,
33 laboratory, and radiology. An insurer may provide aggregated
34 additional data that demonstrates or reasonably estimates
35 year-to-year cost increases in specific benefit categories in the
36 geographic regions listed in Sections 10753.14 and 10965.9. For
37 purposes of this paragraph, “major geographic region” shall be
38 defined by the department and shall include no more than nine
39 regions.

- 1 (19) The amount of the projected trend attributable to the use
2 of services, price inflation, or fees and risk for annual policy trends
3 by aggregate benefit category, such as hospital inpatient, hospital
4 outpatient, physician services, prescription drugs and other
5 ancillary services, laboratory, and radiology.
- 6 (20) A comparison of claims cost and rate of changes over time.
- 7 (21) Any changes in insured cost sharing over the prior year
8 associated with the submitted rate filing.
- 9 (22) Any changes in insured benefits over the prior year
10 associated with the submitted rate filing.
- 11 (23) The certification described in subdivision (b) of Section
12 10181.6.
- 13 (24) Any changes in administrative costs.
- 14 (25) Any other information required for rate review under
15 PPACA.
- 16 (c) An insurer subject to subdivision (a) shall also disclose the
17 following aggregate data for all rate filings submitted under this
18 section in the individual and small group health insurance markets:
- 19 (1) Number and percentage of rate filings reviewed by the
20 following:
- 21 (A) Plan year.
22 (B) Segment type.
23 (C) Product type.
24 (D) Number of policyholders.
25 (E) Number of covered lives affected.
- 26 (2) The insurer's average rate increase by the following
27 categories:
- 28 (A) Plan year.
29 (B) Segment type.
30 (C) Product type.
- 31 (3) Any cost containment and quality improvement efforts since
32 the insurer's last rate filing for the same category of health benefit
33 plan. To the extent possible, the insurer shall describe any
34 significant new health care cost containment and quality
35 improvement efforts and provide an estimate of potential savings
36 together with an estimated cost or savings for the projection period.
- 37 (d) The department may require all health insurers to submit all
38 rate filings to the National Association of Insurance
39 Commissioners' System for Electronic Rate and Form Filing
40 (SERFF). Submission of the required rate filings to SERFF shall

1 be deemed to be filing with the department for purposes of
 2 compliance with this section.

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

7 (f) (1) *A health insurer shall respond to the department's*
 8 *request for any additional information necessary for the department*
 9 *to complete its review of the health insurer's rate filing for*
 10 *individual and small group health insurance policies under this*
 11 *article within three business days of the department's request or*
 12 *as otherwise required by the department.*

13 (2) *The department shall determine whether a health insurer's*
 14 *rate increase for individual and small group insurance policies is*
 15 *unreasonable or not justified no later than 60 days following*
 16 *receipt of all the information the department requires to make its*
 17 *determination.*

18 SEC. 8. *Section 10181.7 of the Insurance Code is amended to*
 19 *read:*

20 10181.7. (a) Notwithstanding Chapter 3.5 (commencing with
 21 Section 6250) of Division 7 of Title 1 of the Government Code,
 22 all information submitted under this article shall be made publicly
 23 available by the department except as provided in subdivision (b).

24 (b) (1) Any contracted rates between a health insurer and a
 25 provider shall be deemed confidential information that shall not
 26 be made public by the department and are exempt from disclosure
 27 under the California Public Records Act (Chapter 3.5 (commencing
 28 with Section 6250) of Division 7 of Title 1 of the Government
 29 Code). The contracted rates between a health insurer and a provider
 30 shall not be disclosed by a health insurer to a large group purchaser
 31 that receives information pursuant to Section 10181.10.

32 (2) The contracted rates between a health insurer and a large
 33 group shall be deemed confidential information that shall not be
 34 made public by the department and are exempt from disclosure
 35 under the California Public Records Act (Chapter 3.5 (commencing
 36 with Section 6250) of Division 7 of Title 1 of the Government
 37 Code). Information provided to a large group purchaser pursuant
 38 to Section 10181.10 shall be deemed confidential information that
 39 shall not be made public by the department and shall be exempt
 40 from disclosure under the California Public Records Act (Chapter

1 3.5 (commencing with Section 6250) of Division 7 of Title 1 of
2 the Government Code).

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

6 (d) In addition, the department and the health insurer shall, at
7 a minimum, make the following information readily available to
8 the public on their Internet Web sites, in plain language and in a
9 manner and format specified by the department, except as provided
10 in subdivision (b). ~~The~~ *For individual and small group health*
11 *insurance policies, the information shall be made public for 120*
12 *days prior to the implementation of the rate increase. For large*
13 *group health care insurance policies, the information shall be*
14 *made public for 60 days prior to the implementation of the rate*
15 *increase. The information shall include:*

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

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

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

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

30 *SEC. 9. Section 10181.11 of the Insurance Code is amended*
31 *to read:*

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

38 (b) The department may review other filings.

39 (c) The department shall accept and post to its Internet Web site
40 any public comment on a rate increase submitted to the department

1 during the ~~60-day~~ *applicable* period described in subdivision (d)
2 of Section 10181.7.

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

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

9 (f) If the commissioner makes a decision that an unreasonable
10 rate increase is not justified or that a rate filing contains inaccurate
11 information, the department shall post that decision on its Internet
12 Web site.

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

16 ~~SEC. 4.~~

17 *SEC. 10.* Section 10199.1 of the Insurance Code is amended
18 to read:

19 10199.1. (a) (1) An insurer or nonprofit hospital service plan
20 or administrator acting on its behalf shall not terminate a group
21 master policy or contract providing hospital, medical, or surgical
22 benefits, increase premiums or charges therefor, reduce or eliminate
23 benefits thereunder, or restrict eligibility for coverage thereunder
24 without providing prior notice of that action. The action shall not
25 become effective unless written notice of the action was delivered
26 by mail to the last known address of the appropriate insurance
27 producer and the appropriate administrator, if any, at least 45 days
28 prior to the effective date of the action and to the last known
29 address of the group policyholder or group contractholder at least
30 60 days prior to the effective date of the action. If nonemployee
31 certificate holders or employees of more than one employer are
32 covered under the policy or contract, written notice shall also be
33 delivered by mail to the last known address of each nonemployee
34 certificate holder or affected employer or, if the action does not
35 affect all employees and dependents of one or more employers, to
36 the last known address of each affected employee certificate holder,
37 at least 60 days prior to the effective date of the action.

38 (2) The notice delivered pursuant to paragraph (1) for large
39 group health insurance policies shall also include the following
40 information:

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

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

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

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

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

30 (d) (1) ~~Notwithstanding paragraph (3) of subdivision (b) of~~
31 ~~Section 10753.05, if~~ *For small group health insurance policies,*
32 *if* the department determines that a rate is unreasonable or not
33 justified consistent with Article 4.5 (commencing with Section
34 10181), the insurer shall notify the policyholder of this
35 determination and shall offer the policyholder coverage of no less
36 than 60 days in order for the policyholder to obtain coverage from
37 this health insurer or another health insurer. *determination.*

38 (2) ~~The notification to the policyholder shall state the following~~
39 ~~in 14-point type:~~

40

1 ~~“The Department of Insurance has determined that the rate for~~
 2 ~~this product is not reasonable or not justified. All health coverage~~
 3 ~~offered to employers like you is reviewed to determine whether~~
 4 ~~the rates are reasonable and justified. For the next 60 days from~~
 5 ~~the date of this notice you have the option to obtain other coverage~~
 6 ~~from this health insurer or another health insurer. For small~~
 7 ~~business purchasers, you may contact Covered California at~~
 8 ~~www.coveredca.com for help in obtaining coverage.”~~

9
 10 *(2) The notification to the policyholder shall be developed by*
 11 *the department and shall include the following statements in*
 12 *14-point type:*

13 *(A) The Department of Insurance has determined that the rate*
 14 *for this product is unreasonable or not justified after reviewing*
 15 *information submitted to it by the insurer.*

16 *(B) The policyholder has the option to obtain other coverage*
 17 *from this insurer or another insurer, or to keep this coverage.*

18 *(C) Small business purchasers may want to contact Covered*
 19 *California at www.coveredca.com for help in understanding*
 20 *available options.*

21 *(3) The development of the notification required under this*
 22 *subdivision shall not be subject to the Administrative Procedure*
 23 *Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of*
 24 *Division 3 of Title 2 of the Government Code).*

25 ~~(3)~~

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

32 ~~(4)~~

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

36 ~~SEC. 5.~~

37 *SEC. 11. No reimbursement is required by this act pursuant to*
 38 *Section 6 of Article XIII B of the California Constitution because*
 39 *the only costs that may be incurred by a local agency or school*
 40 *district will be incurred because this act creates a new crime or*

1 infraction, eliminates a crime or infraction, or changes the penalty
2 for a crime or infraction, within the meaning of Section 17556 of
3 the Government Code, or changes the definition of a crime within
4 the meaning of Section 6 of Article XIII B of the California
5 Constitution.

O