

AMENDED IN SENATE MAY 20, 2010
AMENDED IN SENATE SEPTEMBER 1, 2009
AMENDED IN SENATE JULY 8, 2009
AMENDED IN SENATE JUNE 30, 2009
AMENDED IN SENATE JUNE 16, 2009
AMENDED IN SENATE MAY 27, 2009
AMENDED IN ASSEMBLY APRIL 22, 2009
AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL

No. 718

Introduced by Assembly Member Emmerson
(Coauthor: Senator Negrete McLeod)

February 26, 2009

An act to amend Sections 1399.805, 1399.811, 1399.813, and 1399.815 of the Health and Safety Code, and to amend Sections 10901.3, 10901.9, 10902.1, and 10902.3 of the Insurance Code, relating to health care coverage, *and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 718, as amended, Emmerson. Health care coverage: federally eligible defined individuals: preferred provider products: premium rates. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful

violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual health insurance policies to fairly and affirmatively offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. For those contracts and policies that offer services through a preferred provider arrangement, existing law requires that the premium not exceed the average premium paid by a similar subscriber of the Major Risk Medical Insurance Program (MRMIP), as specified.

This bill would define the “average premium paid” for purposes of this provision as an amount calculated on an annual basis by the Managed Risk Medical Insurance Board using a weighted average based on each plan’s or insurer’s enrollment in MRMIP, as specified. The bill would require plans and insurers to include a statement regarding those maximum premium rates in certain solicitation and sales materials.

Existing law requires plans and insurers to file a specified notice with the Department of Managed Health Care or the Department of Insurance prior to renewing or amending a contract or policy issued to a federally eligible defined individual and prior to changing the premium rates applicable to that contract or policy. Existing law requires the notice or amendment to include a certification of compliance with specified premium requirements.

This bill would specify that this certification binds the plan or insurer to the representation of compliance and subjects the plan or insurer to all remedies available to the Director of the Department of Managed Health Care or the Insurance Commissioner, as specified.

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.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ~~majority~~^{2/3}. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

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

1 SECTION 1. It is the intent of the Legislature, to the extent
2 funding and resources are available, that the Managed Risk Medical
3 Insurance Board shall develop and deliver the average premiums
4 paid to the Department of Managed Health Care and the
5 Department of Insurance for the 2010 calendar year and that the
6 health care service plans and health insurers subject to the
7 provisions of this act shall comply with all of the provisions of
8 this act for all health care service plan contracts and all health
9 insurance policies issued and sold during the 2010 calendar year.

10 SEC. 2. Section 1399.805 of the Health and Safety Code is
11 amended to read:

12 1399.805. (a) (1) After the federally eligible defined
13 individual submits a completed application form for a plan contract,
14 the plan shall, within 30 days, notify the individual of the
15 individual's actual premium charges for that plan contract, unless
16 the plan has provided notice of the premium charge prior to the
17 application being filed. In no case shall the premium charged for
18 any health care service plan contract identified in subdivision (d)
19 of Section 1366.35 exceed the following amounts:

20 (A) For health care service plan contracts that offer services
21 through a preferred provider arrangement, the average premium
22 paid by a subscriber of the Major Risk Medical Insurance Program
23 (MRMIP) who is of the same age and resides in the same
24 geographic area as the federally eligible defined individual.
25 However, for federally qualified individuals who are between the
26 ages of 60 and 64, inclusive, the premium shall not exceed the
27 average premium paid by a subscriber of MRMIP who is 59 years
28 of age and resides in the same geographic area as the federally
29 eligible defined individual.

30 (B) For health care service plan contracts identified in
31 subdivision (d) of Section 1366.35 that do not offer services
32 through a preferred provider arrangement, 170 percent of the
33 standard premium charged to an individual who is of the same age
34 and resides in the same geographic area as the federally eligible
35 defined individual. However, for federally qualified individuals

1 who are between the ages of 60 and 64, inclusive, the premium
2 shall not exceed 170 percent of the standard premium charged to
3 an individual who is 59 years of age and resides in the same
4 geographic area as the federally eligible defined individual. The
5 individual shall have 30 days in which to exercise the right to buy
6 coverage at the quoted premium rates.

7 (2) A plan may adjust the premium based on family size, not
8 to exceed the following amounts:

9 (A) For health care service plans that offer services through a
10 preferred provider arrangement, the average of the MRMIP rate
11 for families of the same size that reside in the same geographic
12 area as the federally eligible defined individual.

13 (B) For health care service plans identified in subdivision (d)
14 of Section 1366.35 that do not offer services through a preferred
15 provider arrangement, 170 percent of the standard premium charged
16 to a family that is of the same size and resides in the same
17 geographic area as the federally eligible defined individual.

18 (b) When a federally eligible defined individual submits a
19 premium payment, based on the quoted premium charges, and that
20 payment is delivered or postmarked, whichever occurs earlier,
21 within the first 15 days of the month, coverage shall begin no later
22 than the first day of the following month. When that payment is
23 neither delivered or postmarked until after the 15th day of a month,
24 coverage shall become effective no later than the first day of the
25 second month following delivery or postmark of the payment.

26 (c) During the first 30 days after the effective date of the plan
27 contract, the individual shall have the option of changing coverage
28 to a different plan contract offered by the same health care service
29 plan. If the individual notified the plan of the change within the
30 first 15 days of a month, coverage under the new plan contract
31 shall become effective no later than the first day of the following
32 month. If an enrolled individual notified the plan of the change
33 after the 15th day of a month, coverage under the new plan contract
34 shall become effective no later than the first day of the second
35 month following notification.

36 (d) (1) For purposes of subparagraph (A) of paragraph (1) of
37 subdivision (a), the “average premium paid” shall be determined
38 by calculating a weighted average that is based upon each health
39 care service plan’s and each health insurer’s aggregate enrollment
40 in MRMIP within each designated geographic region, as follows:

1 (A) Each health care service plan and each health insurer shall
2 have a single weight factor for each geographic region. This weight
3 factor shall be a ratio of each health care service plan's or each
4 health insurer's total MRMIP subscribers in the designated
5 geographic region, divided by the total MRMIP subscribers in that
6 geographic region for all health care service plans and health
7 insurers, for a period of six months.

8 (B) The weight factor for each health care service plan and each
9 health insurer, as calculated under subparagraph (A), shall be
10 multiplied by the premium rate for that health care service plan or
11 health insurer for each age and dependent category. The result of
12 that multiplication shall be added to the corresponding results for
13 all other health care service plans and health insurers. The total
14 sum shall be the average premium paid for the corresponding age
15 and dependent category.

16 (2) The "average premium paid," as defined in paragraph (1),
17 shall be calculated on an annual basis by the Managed Risk
18 Medical Insurance Board, which shall consider six months of
19 enrollment in MRMIP, for the six-month period of January 1 to
20 June 30 immediately preceding the calendar year for which the
21 premiums will be effective. The Managed Risk Medical Insurance
22 Board shall, under its letterhead, provide the average premiums
23 paid to the department and the Department of Insurance no later
24 than October 15 of each year prior to the calendar year for which
25 the premiums will be effective, or 20 working days after the
26 MRMIP premiums are finalized for the upcoming calendar year,
27 whichever is later. At the time it provides the average premiums
28 paid, the Managed Risk Medical Insurance Board shall also provide
29 the department and the Department of Insurance the MRMIP
30 premiums and geographical enrollment data that served as the
31 basis for the calculation of the average premiums paid.

32 SEC. 3. Section 1399.811 of the Health and Safety Code is
33 amended to read:

34 1399.811. Premiums for contracts offered, delivered, amended,
35 or renewed by plans on or after January 1, 2010, shall be subject
36 to the following requirements:

37 (a) The premium for new business for a federally eligible defined
38 individual shall not exceed the following amounts:

39 (1) For health care service plan contracts identified in
40 subdivision (d) of Section 1366.35 that offer services through a

1 preferred provider arrangement, the average premium paid by a
2 subscriber of the Major Risk Medical Insurance Program (MRMIP)
3 who is of the same age and resides in the same geographic area as
4 the federally eligible defined individual. However, for federally
5 qualified individuals who are between the ages of 60 to 64 years,
6 inclusive, the premium shall not exceed the average premium paid
7 by a subscriber of MRMIP who is 59 years of age and resides in
8 the same geographic area as the federally eligible defined
9 individual.

10 (2) For health care service plan contracts identified in
11 subdivision (d) of Section 1366.35 that do not offer services
12 through a preferred provider arrangement, 170 percent of the
13 standard premium charged to an individual who is of the same age
14 and resides in the same geographic area as the federally eligible
15 defined individual. However, for federally qualified individuals
16 who are between the ages of 60 to 64 years, inclusive, the premium
17 shall not exceed 170 percent of the standard premium charged to
18 an individual who is 59 years of age and resides in the same
19 geographic area as the federally eligible defined individual.

20 (b) The premium for in force business for a federally eligible
21 defined individual shall not exceed the following amounts:

22 (1) For health care service plan contracts identified in
23 subdivision (d) of Section 1366.35 that offer services through a
24 preferred provider arrangement, the average premium paid by a
25 subscriber of MRMIP who is of the same age and resides in the
26 same geographic area as the federally eligible defined individual.
27 However, for federally qualified individuals who are between the
28 ages of 60 and 64 years, inclusive, the premium shall not exceed
29 the average premium paid by a subscriber of MRMIP who is 59
30 years of age and resides in the same geographic area as the
31 federally eligible defined individual.

32 (2) For health care service plan contracts identified in
33 subdivision (d) of Section 1366.35 that do not offer services
34 through a preferred provider arrangement, 170 percent of the
35 standard premium charged to an individual who is of the same age
36 and resides in the same geographic area as the federally eligible
37 defined individual. However, for federally qualified individuals
38 who are between the ages of 60 and 64 years, inclusive, the
39 premium shall not exceed 170 percent of the standard premium
40 charged to an individual who is 59 years of age and resides in the

1 same geographic area as the federally eligible defined individual.
2 The premium effective on January 1, 2001, shall apply to in force
3 business at the earlier of either the time of renewal or July 1, 2001.

4 (c) The premium applied to a federally eligible defined
5 individual may not increase by more than the following amounts:

6 (1) For health care service plan contracts identified in
7 subdivision (d) of Section 1366.35 that offer services through a
8 preferred provider arrangement, the average increase in the
9 premiums charged to a subscriber of MRMIP who is of the same
10 age and resides in the same geographic area as the federally eligible
11 defined individual.

12 (2) For health care service plan contracts identified in
13 subdivision (d) of Section 1366.35 that do not offer services
14 through a preferred provider arrangement, the increase in premiums
15 charged to a nonfederally qualified individual who is of the same
16 age and resides in the same geographic area as the federally defined
17 eligible individual. The premium for an eligible individual may
18 not be modified more frequently than every 12 months.

19 (3) For a contract that a plan has discontinued offering, the
20 premium applied to the first rating period of the new contract that
21 the federally eligible defined individual elects to purchase shall
22 be no greater than the premium applied in the prior rating period
23 to the discontinued contract.

24 (d) (1) For purposes of paragraph (1) of subdivision (a) and
25 paragraph (1) of subdivision (b), the “average premium paid” shall
26 be determined by calculating a weighted average that is based upon
27 each health care service plan’s and each health insurer’s aggregate
28 enrollment in MRMIP within each designated geographic region,
29 as follows:

30 (A) Each health care service plan and each health insurer shall
31 have a single weight factor for each geographic region. This weight
32 factor shall be a ratio of each health care service plan’s or each
33 health insurer’s total MRMIP subscribers in the designated
34 geographic region, divided by the total MRMIP subscribers in that
35 geographic region for all health care service plans and health
36 insurers, for a period of six months.

37 (B) The weight factor for each health care service plan and each
38 health insurer, as calculated under subparagraph (A), shall be
39 multiplied by the premium rate for that health care service plan or
40 health insurer for each age and dependent category. The result of

1 that multiplication shall be added to the corresponding results for
2 all other health care service plans and health insurers. The total
3 sum shall be the average premium paid for the corresponding age
4 and dependent category.

5 (2) The “average premium paid,” as defined in paragraph (1),
6 shall be calculated on an annual basis by the Managed Risk
7 Medical Insurance Board, which shall consider six months of
8 enrollment in MRMIP, for the six-month period of January 1 to
9 June 30 immediately preceding the calendar year for which the
10 premiums will be effective. The Managed Risk Medical Insurance
11 Board shall, under its letterhead, provide the average premiums
12 paid to the department and the Department of Insurance no later
13 than October 15 of each year prior to the calendar year for which
14 the premiums will be effective, or 20 working days after the
15 MRMIP premiums are finalized for the upcoming calendar year,
16 whichever is later. At the time it provides the average premiums
17 paid, the Managed Risk Medical Insurance Board shall also provide
18 the department and the Department of Insurance the MRMIP
19 premiums and geographical enrollment data that served as the
20 basis for the calculation of the average premiums paid.

21 SEC. 4. Section 1399.813 of the Health and Safety Code is
22 amended to read:

23 1399.813. (a) In connection with the offering for sale of a plan
24 contract to an individual, each plan shall make a reasonable
25 disclosure, as part of its solicitation and sales materials, of all
26 individual contracts.

27 (b) For plan contracts that offer services through a preferred
28 provider arrangement and that are offered or sold to federally
29 eligible defined individuals, the disclosure described in subdivision
30 (a) shall also include the following statement, which, if the
31 disclosure is made in writing, shall be in at least 12-point boldface
32 type:

33 “The maximum premium rate for this preferred provider product
34 is available on the Internet Web sites of the Department of
35 Managed Health Care, at www.dmhc.ca.gov, and the Department
36 of Insurance, at www.insurance.ca.gov. By visiting either of these
37 Internet Web sites, you can compare the rates that were disclosed
38 to you for this product and ensure that they are less than, or equal
39 to, the maximum rate allowed by law.”

1 SEC. 5. Section 1399.815 of the Health and Safety Code is
2 amended to read:

3 1399.815. (a) At least 20 business days prior to renewing or
4 amending a plan contract subject to this article, or at least 20
5 business days prior to the initial offering of a plan contract subject
6 to this article, a plan shall file a notice of an amendment with the
7 director in accordance with the provisions of Section 1352. The
8 notice of an amendment shall include a statement certifying that
9 the plan is in compliance with subdivision (a) of Section 1399.805
10 and with Section 1399.811. Any action by the director, as permitted
11 under Section 1352, to disapprove, suspend, or postpone the plan's
12 use of a plan contract shall be in writing, specifying the reasons
13 the plan contract does not comply with the requirements of this
14 chapter.

15 (b) Prior to making any changes in the premium, the plan shall
16 file an amendment in accordance with the provisions of Section
17 1352, and shall include a statement certifying the plan is in
18 compliance with subdivision (a) of Section 1399.805 and with
19 Section 1399.811. All other changes to a plan contract previously
20 filed with the director pursuant to subdivision (a) shall be filed as
21 an amendment in accordance with the provisions of Section 1352,
22 unless the change otherwise would require the filing of a material
23 modification.

24 (c) An amendment or notice of an amendment filed pursuant to
25 this section shall not be deemed accepted or approved unless the
26 required statement of certification is concurrently filed with the
27 amendment or notice. The certification required by this section,
28 whether provided by the health care service plan or an independent
29 agent or consultant, binds the plan to the representation of
30 compliance and subjects the plan to all remedies available to the
31 director to the extent the filing or certification is determined to be
32 a misrepresentation, whether or not willful, or a falsification of
33 the information contained therein, or otherwise violates the
34 requirements of this chapter or any of the rules promulgated under
35 this chapter.

36 SEC. 6. Section 10901.3 of the Insurance Code is amended to
37 read:

38 10901.3. (a) (1) After the federally eligible defined individual
39 submits a completed application form for a health benefit plan,
40 the carrier shall, within 30 days, notify the individual of the

1 individual's actual premium charges for that health benefit plan
2 design. In no case shall the premium charged for any health benefit
3 plan identified in subdivision (d) of Section 10785 exceed the
4 following amounts:

5 (A) For health benefit plans that offer services through a
6 preferred provider arrangement, the average premium paid by a
7 subscriber of the Major Risk Medical Insurance Program (MRMIP)
8 who is of the same age and resides in the same geographic area as
9 the federally eligible defined individual. However, for federally
10 qualified individuals who are between the ages of 60 and 64,
11 inclusive, the premium shall not exceed the average premium paid
12 by a subscriber of the MRMIP who is 59 years of age and resides
13 in the same geographic area as the federally eligible defined
14 individual.

15 (B) For health benefit plans identified in subdivision (d) of
16 Section 10785 that do not offer services through a preferred
17 provider arrangement, 170 percent of the standard premium charged
18 to an individual who is of the same age and resides in the same
19 geographic area as the federally eligible defined individual.
20 However, for federally qualified individuals who are between the
21 ages of 60 and 64, inclusive, the premium shall not exceed 170
22 percent of the standard premium charged to an individual who is
23 59 years of age and resides in the same geographic area as the
24 federally eligible defined individual. The individual shall have 30
25 days in which to exercise the right to buy coverage at the quoted
26 premium rates.

27 (2) A carrier may adjust the premium based on family size, not
28 to exceed the following amounts:

29 (A) For health benefit plans that offer services through a
30 preferred provider arrangement, the average of *the* MRMIP rate
31 for families of the same size that reside in the same geographic
32 area as the federally eligible defined individual.

33 (B) For health benefit plans identified in subdivision (d) of
34 Section 10785 that do not offer services through a preferred
35 provider arrangement, 170 percent of the standard premium charged
36 to a family that is of the same size and resides in the same
37 geographic area as the federally eligible defined individual.

38 (b) When a federally eligible defined individual submits a
39 premium payment, based on the quoted premium charges, and that
40 payment is delivered or postmarked, whichever occurs earlier,

1 within the first 15 days of the month, coverage shall begin no later
2 than the first day of the following month. When that payment is
3 neither delivered or postmarked until after the 15th day of a month,
4 coverage shall become effective no later than the first day of the
5 second month following delivery or postmark of the payment.

6 (c) During the first 30 days after the effective date of the health
7 benefit plan, the individual shall have the option of changing
8 coverage to a different health benefit plan design offered by the
9 same carrier. If the individual notified the plan of the change within
10 the first 15 days of a month, coverage under the new health benefit
11 plan shall become effective no later than the first day of the
12 following month. If an enrolled individual notified the carrier of
13 the change after the 15th day of a month, coverage under the health
14 benefit plan shall become effective no later than the first day of
15 the second month following notification.

16 (d) (1) For purposes of subparagraph (A) of paragraph (1) of
17 subdivision (a), the “average premium paid” shall be determined
18 by calculating a weighted average that is based upon each carrier’s
19 and each health care service plan’s aggregate enrollment in MRMIP
20 within each designated geographic region, as follows:

21 (A) Each carrier and each health care service plan shall have a
22 single weight factor for each geographic region. This weight factor
23 shall be a ratio of each carrier’s or each health care service plan’s
24 total MRMIP subscribers in the designated geographic region,
25 divided by the total MRMIP subscribers in that geographic region
26 for all carriers and health care service plans, for a period of six
27 months.

28 (B) The weight factor for each carrier and each health care
29 service plan, as calculated under subparagraph (A), shall be
30 multiplied by the premium rate for that carrier or plan for each age
31 and dependent category. The result of that multiplication shall be
32 added to the corresponding results for all other carriers and health
33 care service plans. The total sum shall be the average premium
34 paid for the corresponding age and dependent category.

35 (2) The “average premium paid,” as defined in paragraph (1),
36 shall be calculated on an annual basis by the Managed Risk
37 Medical Insurance Board, which shall consider six months of
38 enrollment in MRMIP, for the six-month period of January 1 to
39 June 30 immediately preceding the calendar year for which the
40 premiums will be effective. The Managed Risk Medical Insurance

1 Board shall, under its letterhead, provide the average premiums
2 paid to the department and the Department of Managed Health
3 Care no later than October 15 of each year prior to the calendar
4 year for which the premiums will be effective, or 20 working days
5 after the MRMIP premiums are finalized for the upcoming calendar
6 year, whichever is later. At the time it provides the average
7 premiums paid, the Managed Risk Medical Insurance Board shall
8 also provide the department and the Department of Managed Health
9 Care the MRMIP premiums and geographical enrollment data that
10 served as the basis for the calculation of the average premiums
11 paid.

12 SEC. 7. Section 10901.9 of the Insurance Code is amended to
13 read:

14 10901.9. Commencing January 1, 2010, premiums for health
15 benefit plans offered, delivered, amended, or renewed by carriers
16 shall be subject to the following requirements:

17 (a) The premium for new business for a federally eligible defined
18 individual shall not exceed the following amounts:

19 (1) For health benefit plans identified in subdivision (d) of
20 Section 10785 that offer services through a preferred provider
21 arrangement, the average premium paid by a subscriber of the
22 Major Risk Medical Insurance Program (MRMIP) who is of the
23 same age and resides in the same geographic area as the federally
24 eligible defined individual. However, for federally qualified
25 individuals who are between the ages of 60 to 64, inclusive, the
26 premium shall not exceed the average premium paid by a subscriber
27 of MRMIP who is 59 years of age and resides in the same
28 geographic area as the federally eligible defined individual.

29 (2) For health benefit plans identified in subdivision (d) of
30 Section 10785 that do not offer services through a preferred
31 provider arrangement, 170 percent of the standard premium charged
32 to an individual who is of the same age and resides in the same
33 geographic area as the federally eligible defined individual.
34 However, for federally qualified individuals who are between the
35 ages of 60 to 64, inclusive, the premium shall not exceed 170
36 percent of the standard premium charged to an individual who is
37 59 years of age and resides in the same geographic area as the
38 federally eligible defined individual.

39 (b) The premium for in force business for a federally eligible
40 defined individual shall not exceed the following amounts:

1 (1) For health benefit plans identified in subdivision (d) of
2 Section 10785 that offer services through a preferred provider
3 arrangement, the average premium paid by a subscriber of MRMIP
4 who is of the same age and resides in the same geographic area as
5 the federally eligible defined individual. However, for federally
6 qualified individuals who are between the ages of 60 and 64,
7 inclusive, the premium shall not exceed the average premium paid
8 by a subscriber of MRMIP who is 59 years of age and resides in
9 the same geographic area as the federally eligible defined
10 individual.

11 (2) For health benefit plans identified in subdivision (d) of
12 Section 10785 that do not offer services through a preferred
13 provider arrangement, 170 percent of the standard premium charged
14 to an individual who is of the same age and resides in the same
15 geographic area as the federally eligible defined individual.
16 However, for federally qualified individuals who are between the
17 ages of 60 and 64, inclusive, the premium shall not exceed 170
18 percent of the standard premium charged to an individual who is
19 59 years of age and resides in the same geographic area as the
20 federally eligible defined individual. The premium effective on
21 January 1, 2001, shall apply to in force business at the earlier of
22 either the time of renewal or July 1, 2001.

23 (c) The premium applied to a federally eligible defined
24 individual may not increase by more than the following amounts:

25 (1) For health benefit plans identified in subdivision (d) of
26 Section 10785 that offer services through a preferred provider
27 arrangement, the average increase in the premiums charged to a
28 subscriber of MRMIP who is of the same age and resides in the
29 same geographic area as the federally eligible defined individual.

30 (2) For health benefit plans identified in subdivision (d) of
31 Section 10785 that do not offer services through a preferred
32 provider arrangement, the increase in premiums charged to a
33 nonfederally qualified individual who is of the same age and resides
34 in the same geographic area as the federally defined eligible
35 individual. The premium for an eligible individual may not be
36 modified more frequently than every 12 months.

37 (3) For a contract that a carrier has discontinued offering, the
38 premium applied to the first rating period of the new contract that
39 the federally eligible defined individual elects to purchase shall

1 be no greater than the premium applied in the prior rating period
2 to the discontinued contract.

3 (d) (1) For purposes of paragraph (1) of subdivision (a) and
4 paragraph (1) of subdivision (b), the “average premium paid” shall
5 be determined by calculating a weighted average that is based upon
6 each carrier’s and each health care service plan’s aggregate
7 enrollment in MRMIP within each designated geographic region,
8 as follows:

9 (A) Each carrier and each health care service plan shall have a
10 single weight factor for each geographic region. This weight factor
11 shall be a ratio of each carrier’s or each health care service plan’s
12 total MRMIP subscribers in the designated geographic region,
13 divided by the total MRMIP subscribers in that geographic region
14 for all carriers and health care service plans, for a period of six
15 months.

16 (B) The weight factor for each carrier and each health care
17 service plan, as calculated under subparagraph (A), shall be
18 multiplied by the premium rate for that carrier or plan for each age
19 and dependent category. The result of that multiplication shall be
20 added to the corresponding results for all other carriers and health
21 care service plans. The total sum shall be the average premium
22 paid for the corresponding age and dependent category.

23 (2) The “average premium paid,” as defined in paragraph (1),
24 shall be calculated on an annual basis by the Managed Risk
25 Medical Insurance Board, which shall consider six months of
26 enrollment in the MRMIP, for the six-month period of January ~~1st~~
27 ~~1~~ to June ~~30th~~ ~~30~~ immediately preceding the calendar year for
28 which the premiums will be effective. The Managed Risk Medical
29 Insurance Board shall, under its letterhead, provide the average
30 premiums paid to the department and the Department of Managed
31 Health Care no later than October 15 of each year prior to the
32 calendar year for which the premiums will be effective, or 20
33 working days after the MRMIP premiums are finalized for the
34 upcoming calendar year, whichever is later. At the time it provides
35 the average premiums paid, the Managed Risk Medical Insurance
36 Board shall provide the department and the Department of
37 Managed Health Care the MRMIP premiums and geographical
38 enrollment data that served as the basis for the calculation of the
39 average premiums paid.

1 SEC. 8. Section 10902.1 of the Insurance Code is amended to
2 read:

3 10902.1. (a) In connection with the offering for sale of any
4 health benefit plan designed to an individual, each carrier shall
5 make a reasonable disclosure, as part of its solicitation and sales
6 materials, of all individual contracts.

7 (b) For health benefit plans that offer services through a
8 preferred provider arrangement and that are offered or sold to
9 federally eligible defined individuals, the disclosure described in
10 subdivision (a) shall also include the following statement, which,
11 if the disclosure is made in writing, shall be in at least 12-point
12 boldface type:

13 “The maximum premium rate for this preferred provider product
14 is available on the Internet Web sites of the Department of
15 Insurance, at www.dmhca.ca.gov, and the Department of Managed
16 Health Care, at www.mrmib.ca.gov. By visiting either of these
17 Internet Web sites, you can compare the rates that were disclosed
18 to you for this product and ensure that they are less than, or equal
19 to, the maximum rate allowed by law.”

20 SEC. 9. Section 10902.3 of the Insurance Code is amended to
21 read:

22 10902.3. (a) At least 20 business days prior to renewing or
23 amending a health benefit plan contract subject to this chapter, or
24 at least 20 business days prior to the initial offering of a health
25 benefit plan subject to this chapter, a carrier shall file a statement
26 with the commissioner in the same manner as required for small
27 employers as outlined in Section 10717. The statement shall include
28 a statement certifying that the carrier is in compliance with
29 subdivision (a) of Section 10901.3 and with Section 10901.9. Any
30 action by the commissioner, as permitted under Section 10717, to
31 disapprove, suspend, or postpone the plan’s use of a carrier’s health
32 benefit plan design shall be in writing, specifying the reasons the
33 health benefit plan does not comply with the requirements of this
34 chapter.

35 (b) Prior to making any changes in the premium, the carrier
36 shall file an amendment in the same manner as required for small
37 employers as outlined in Section 10717, and shall include a
38 statement certifying the carrier is in compliance with subdivision
39 (a) of Section 10901.3 and with Section 10901.9. All other changes
40 to a health benefit plan previously filed with the commissioner

1 pursuant to subdivision (a) shall be filed as an amendment in the
2 same manner as required for small employers as outlined in Section
3 10717.

4 (c) A statement or amendment filed pursuant to this section
5 shall not be deemed accepted or approved unless the required
6 statement of certification is concurrently filed with the statement
7 or amendment. The certification required by this section, whether
8 provided by the carrier or an independent agent or consultant, binds
9 the carrier to the representation of compliance and subjects the
10 carrier to all remedies available to the commissioner to the extent
11 the filing or certification is determined to be a misrepresentation,
12 whether or not willful, or a falsification of the information
13 contained therein, or otherwise violates the requirements of this
14 code or any of the rules promulgated under this code.

15 SEC. 10. No reimbursement is required by this act pursuant to
16 Section 6 of Article XIII B of the California Constitution because
17 the only costs that may be incurred by a local agency or school
18 district will be incurred because this act creates a new crime or
19 infraction, eliminates a crime or infraction, or changes the penalty
20 for a crime or infraction, within the meaning of Section 17556 of
21 the Government Code, or changes the definition of a crime within
22 the meaning of Section 6 of Article XIII B of the California
23 Constitution.

24 SEC. 11. *This act is an urgency statute necessary for the*
25 *immediate preservation of the public peace, health, or safety within*
26 *the meaning of Article IV of the Constitution and shall go into*
27 *immediate effect. The facts constituting the necessity are:*

28 *In order to ensure that individual health care service plan*
29 *contracts and individual health insurance policies offered to*
30 *federally eligible defined individuals do not charge more for*
31 *premium rates during the 2011 calendar year than is permissible*
32 *due to lack of clarity in existing law, in order to help the Managed*
33 *Risk Medical Insurance Board receive timely information to*
34 *calculate the “average premium paid” in time for this act to apply*
35 *to the 2011 calendar year, and in order to help the Department of*
36 *Insurance and the Department of Managed Health Care to protect*
37 *the interests of the public in carrying out the intent of the*
38 *Legislature to ensure that all Californians are treated equally with*

- 1 *respect to premium rates for these products, it is necessary that*
- 2 *this act take effect immediately.*

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