AMENDED IN SENATE AUGUST 18, 2010

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CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1759

Introduced by Assembly Member Blumenfield
(Coauthors: Assembly Members Huffman and Yamada)
(Coauthor: Senator Pavley)

February 8, 2010

An act to amend Section 1374.20 of the Health and Safety Code, and to amend Section 10199.48 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1759, as amended, Blumenfield. Health care coverage: premium rates.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), 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 regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan or a health insurer from changing its premium rates or applicable copayments or coinsurances or deductibles for group health care service plan contracts or group

health insurance policies during specified time periods; however, changes to the premium rates or applicable copayments or coinsurances or deductibles are allowed when, among other things, the change is authorized or required in the group contract.

This bill would require a health care service plan or health insurer that includes a provision in a group contract or policy that authorizes or requires a change in premium rates, copayments, coinsurances, or deductibles, to provide an additional disclosure that describes the circumstances under which a change may occur and that provides defined terms and examples of those circumstances, to be signed by the group contractholder or group policyholder and provided to the subscribers or insureds, as specified. Because a willful violation of those provisions would be a crime under the Knox-Keene Act, 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:

SECTION 1. Section 1374.20 of the Health and Safety Code is amended to read:

1374.20. (a) No group health care service plan shall change the premium rates or applicable copayments or coinsurances or deductibles for the length of the contract, except as specified in subdivision (b), during any of the following time periods:

(1) After the group contractholder has delivered written notice of acceptance of the contract.

(2) After the start of the employer's annual open enrollment period.

(3) After the receipt of payment of the premium for the first month of coverage in accordance with the contract effective date.

(b) Changes to the premium rates or applicable copayments or coinsurances or deductibles of a contract shall, subject to the plan meeting the requirements of this article, be allowed in any of the following circumstances:

(1) When authorized or required in the group contract. If a provision authorizing or requiring that change is to be included in a group contract, other than for contracts issued to a small employer and subject to the disclosure requirements of Section 1357.14, the health care service plan shall provide, at the point of sale, a separate~~, enhanced~~ disclosure to the subscribers, which the group contractholder shall sign before that provision can be entered into as part of the contract. The health care service plan may make the contract contingent upon the group contractholder's signature of the separate~~, enhanced~~ disclosure. The separate~~, enhanced~~ disclosure shall explain the circumstances under which a change in premium rates or applicable copayments, coinsurances, or deductibles in a contract may occur, and shall include defined terms and specific examples of those circumstances.

(2) When the contract was agreed to under a preliminary agreement that states that it is subject to execution of a definitive agreement.

(3) When the plan and contractholder mutually agree in writing.

SEC. 2. Section 10199.48 of the Insurance Code is amended to read:

10199.48. (a) No health insurer shall, with regard to a group contract, change the premium rates or applicable copayments or coinsurances or deductibles for the length of the contract, except as specified in subdivision (b), during any of the following time periods:

(1) After the group policyholder or group contractholder has delivered written notice of acceptance of the contract or policy.

(2) After the start of the employer's annual open enrollment period.

(3) After the receipt of payment of the premium for the first month of coverage in accordance with the contract or policy effective date.

(b) Changes to the premium rates or applicable copayments or coinsurances or deductibles of a contract or policy shall, subject to the insurer meeting the requirements of this chapter, be allowed in any of the following circumstances:

(1) When authorized or required in the group contract or policy. If a provision authorizing or requiring that change is to be included in a group contract or policy, other than for contracts or policies issued to a small employer and subject to the disclosure

requirements of Article 2 (commencing with Section 10702) of Chapter 8, the health insurer shall provide, at the point of sale, a separate~~, enhanced~~ disclosure to the insureds, which the group contractholder or group policyholder shall sign before that provision can be entered into as part of the contract or policy. The health insurer may make the contract or policy contingent upon the group contractholder's or group policyholder's signature of the separate~~, enhanced~~ disclosure. The separate~~, enhanced~~ disclosure shall explain the circumstances under which a change in premium rates or applicable copayments, coinsurances, or deductibles in a contract or policy may occur, and shall include defined terms and specific examples of those circumstances.

(2) When the contract or policy was agreed to under a preliminary agreement that states that it is subject to execution of a definitive agreement.

(3) When the insurer and the policyholder or contractholder mutually agree in writing.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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