AMENDED IN ASSEMBLY MARCH 18, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2578

Introduced by Assembly Members Jones and Feuer
(Principal coauthor: Senator Leno)
(~~Coauthor~~ *Coauthors*: Assembly ~~Member Brownley~~ *Members Brownley and Salas*)

February 19, 2010

~~An act to add Section 1385.1 to the Health and Safety Code, and to add Section 10181 to the Insurance Code, relating to health care coverage.~~ *An act to amend Section 1386 of, and to add Article 6.2 (commencing with Section 1385.01) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 4.5 (commencing with Section 10181) to Chapter 1 of Part 2 of Division 2 of the Insurance Code, relating to health care coverage, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2578, as amended, Jones. Health care coverage: rate approval.

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 the act a crime. Existing law also provides for the regulation of insurers by the Department of Insurance, including health insurers. Existing law makes the violation of a final order by the Insurance Commissioner relating to rates imposed by certain insurers, other than health insurers, subject to assessment of a civil penalty and makes the willful violation by those insurers of specified rate provisions a misdemeanor. Under existing law, no change in premium rates or

coverage in a health care service plan or a health insurance policy may become effective without prior written notification of the change to the contractholder or policyholder. Existing law prohibits a plan and insurer during the term of a plan contract or policy from changing the rate of the premium, copayment, coinsurance, or deductible during specified time periods.

This bill would require approval by the Department of Managed Health Care or the Department of Insurance of an increase in the amount of the premium, copayment, coinsurance obligation, deductible, and other charges under health care service plan contracts or health insurance policies, other than Medicare supplement contracts or policies. The bill would require a plan or insurer to submit to the Department of Managed Health Care or the Department of Insurance, respectively, an application for a rate increase that would be effective on or after January 1, 2012, and would require review of the application in accordance with regulations that each department would be required to adopt no later than January 1, 2012. The bill would subject a rate increase that became effective January 1, 2010, to December 31, 2011, inclusive, to review by the appropriate department.

The bill would require each department to notify the public of a rate application and would deem the application approved within 60 days of the date of that notice unless the department holds a hearing on the application, as specified. The bill would authorize the initiation of, and intervention in, proceedings relating to rate approvals and the award of advocacy fees and costs in those proceedings in specified circumstances. The bill would require the departments to work together in implementation of these provisions, and to take specified actions in order to ensure coordination and consistency in implementation.

The bill would authorize each department to assess a charge in connection with its costs associated with a rate application. The bill would direct the deposit of these fees into the respective department's Health Rate Approval Fund, which would be created by the bill, and would continuously appropriate the revenue to each department, thereby making an appropriation. The bill would specify that a violation of its provisions is punishable by criminal sanctions under the Knox-Keene Act and under provisions applicable to insurers and, therefore, 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.

~~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 the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, no change in premium rates or coverage in a health care service plan or a health insurance policy may become effective without prior written notification of the change to the contract holder or policyholder. Existing law prohibits a plan and an insurer during the term of a plan contract or policy from changing the rate of the premium, copayment, coinsurance, or deductible during specified time periods.~~

~~This bill would require approval by the Department of Managed Health Care or the Department of Insurance of an increase in the amount of the premium, copayment, coinsurance obligation, deductible, and other charges under a health care service plan or health insurance policy.~~

~~Because the bill would specify an additional requirement under the Knox-Keene Act, the willful violation of which 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~~ *yes*. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Article 6.2 (commencing with Section 1385.01) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 6.2. Approval of Rates

1385.01. (a) The following definitions apply for the purposes of this article:

(1) "Applicant" means a health care service plan seeking to increase the rate it charges its subscribers.

(2) "Rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, and other charges.

(b) No applicant shall increase the rate it charges its subscribers unless it submits an application to the department, and the application is approved by the department.

(c) This article shall not apply to Medicare supplement contracts.

1385.02. (a) No rate shall be approved or remain in effect that is excessive, inadequate, unfairly discriminatory, or otherwise in violation of this article. In considering whether a rate is excessive, inadequate, or unfairly discriminatory, the department shall consider whether the rate mathematically reflects the health care service plan's investment income and is reasonable in comparison to coverage benefits. The department shall not consider the degree of competition in determining whether a rate is excessive, inadequate, or unfairly discriminatory.

(b) The department shall review a rate application pursuant to regulations it promulgates to determine reasonable rates for medical expenses and all nonmedical expenses, including the rate of return, surplus, overhead, and administration.

1385.03. (a) A health care service plan shall file a complete rate application with the department for a rate increase that will become effective on or after January 1, 2012.

(b) The rate application shall be signed by the officers of the health care service plan who exercise the functions of a chief executive and chief financial officer. Each officer shall certify that the representations, data, and information provided to the department to support the application are true.

(c) No health care service plan shall submit more than one rate application each calendar year.

(d) A rate application submitted to the department pursuant to this section shall include the following information:

(1) The rate of return that will result if the rate application is approved.

(2) The average rate change per affected enrollee or group that will result from approval of the application.

(3) The overhead loss ratio, reserves, excess tangible net equity, and surpluses that will result if the application is approved. For

the purposes of this section, "overhead loss ratio" means the ratio of revenue dedicated to all nonmedical expenses and expenditures, including profit, to revenue dedicated to medical expenses. A medical expense is any payment to a hospital, physician, or other provider for the provision of medical care or health care services directly to, or for the benefit of, the enrollee.

(4) Salary and bonus compensation paid to the 10 highest paid officers and employees of the applicant for the most recent fiscal year.

(5) Dollar amounts of shareholder dividends paid, financial or capital disbursements to affiliates, and management agreements and service contracts.

(6) A statement setting forth all of the applicant's nonmedical expenses for the most recent fiscal year including administration, dividends, rate of return, advertising, and salaries.

(7) A line-item report of medical expenses, including aggregate totals paid to hospitals and physicians, and the amount paid by the applicant for the 100 most common medical expenses incurred by enrollees during the previous calendar year.

(e) The health care service plan has the burden to provide the department with evidence and documents establishing, by a preponderance of the evidence, the application's compliance with the requirement of this article.

(f) Rate applications shall be submitted by the health care service plan electronically, and the department shall post the applications on its Internet Web site within 10 days of the date of their receipt by the department.

(g) All information in a rate application and all materials submitted in its support by the applicant shall constitute a public record for purposes of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) except for financial data the disclosure of which would be competitively injurious to the applicant, as determined by the director.

1385.04. A rate increase by a health care service plan that became effective during the period January 1, 2010, to December 31, 2011, inclusive, shall be subject to review by the department for compliance with this article.

1385.05. (a) The department shall notify the public of any rate application by a health care service plan.

(b) The application shall be deemed approved by the department 60 days after the date of the public notice provided under subdivision (a) unless the department conducts a hearing on the application on any of the following grounds:

(1) A consumer, or his or her representative, requests a hearing within 45 days of the date of the public notice, and the department grants the request for a hearing. If the department determines not to grant the request for a hearing, it shall issue written findings in support of that decision.

(2) The department determines for any reason to hold a hearing on the application.

(3) The proposed increase would exceed 7 percent of the amount of the current rate under the plan contract.

(c) The public notice required by this section shall be posted on the department's Internet Web site and distributed to major statewide media and to any member of the public who requests placement on a mailing list or electronic mail list to receive the notice.

1385.06. All hearings under this article shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, with the following exceptions:

(a) The hearing shall be conducted by an administrative law judge for purposes of Sections 11512 and 11517 of the Government Code, appointed pursuant to Section 11502 of the Government Code or by the director.

(b) The hearing shall be commenced by filing a notice, in lieu of Sections 11503 and 11504 of the Government Code.

(c) The director shall adopt, amend, or reject a decision only under Section 11518.5 of the Government Code and subdivisions (b) and (c) of Section 11517 of the Government Code and solely on the basis of the record as provided in Section 11425.50 of the Government Code.

(d) The right to discovery shall be liberally construed, and discovery disputes shall be determined by the administrative law judge as provided in Section 11507.7 of the Government Code.

(e) Judicial review shall be in accordance with Section 1858.6 of the Insurance Code. For purposes of judicial review, a decision by the department to hold a hearing on the application is not a final order or decision; however a decision not to hold a hearing

on an application is a final order or decision for purposes of judicial review.

1385.07. (a) A person may initiate or intervene in any proceeding permitted or established pursuant to this article, challenge any action of the department under this article, and enforce any provision of this article on behalf of himself or herself or members of the public.

(b) (1) The department or a court shall award reasonable advocacy fees and costs, including witness fees, in a proceeding described in subdivision (a) to a person who demonstrates both of the following:

(A) The person represents the interests of consumers.

(B) The person has made a substantial contribution to the adoption of any order, regulation, or decision by the department or a court.

(2) The award made under this section shall be paid by the rate applicant.

1385.08. A violation of this article is subject to the penalties set forth in Sections 1386 and 1390.

1385.09. (a) The department may charge a health care service plan a fee for the actual, reasonable costs associated with an application filed by the plan under this article.

(b) The fees shall be deposited into the Department of Managed Health Care Health Rate Approval Fund, which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in this fund are continuously appropriated to the department for the sole purpose of implementing this article.

1385.10. The department, working in coordination with the Department of Insurance, shall have all necessary and proper powers to implement this article and shall adopt regulations to implement this article no later than January 1, 2012. In implementing this article, the department and the Department of Insurance shall jointly develop any regulations, rate review standards, staff training, policies, and procedures in order to ensure maximum coordination and consistency of implementation.

SEC. 2. Section 1386 of the Health and Safety Code is amended to read:

1386. (a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license

issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

(2) The plan has issued, or permits others to use, evidence of coverage or uses a schedule of charges for health care services that do not comply with those published in the latest evidence of coverage found unobjectionable by the director.

(3) The plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage. This subdivision shall not apply to specialized health care service plan contracts.

(4) The plan is no longer able to meet the standards set forth in Article 5 (commencing with Section 1367).

(5) The continued operation of the plan will constitute a substantial risk to its subscribers and enrollees.

(6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.

(7) The plan has engaged in any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.

(8) The plan has permitted, or aided or abetted any violation by an employee or contractor who is a holder of any certificate, license, permit, registration, or exemption issued pursuant to the Business and Professions Code or this code that would constitute grounds for discipline against the certificate, license, permit, registration, or exemption.

(9) The plan has aided or abetted or permitted the commission of any illegal act.

(10) The engagement of a person as an officer, director, employee, associate, or provider of the plan contrary to the provisions of an order issued by the director pursuant to subdivision (c) of this section or subdivision (d) of Section 1388.

(11) The engagement of a person as a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the director pursuant to Section 1388.

(12) The plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position in the plan, management company, or affiliate, has been convicted of or pleaded nolo contendere to a crime, or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with this chapter. The director may revoke or deny a license hereunder irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code.

(13) The plan violates Section 510, 2056, or 2056.1 of the Business and Professions Code or Section 1375.7.

(14) The plan has been subject to a final disciplinary action taken by this state, another state, an agency of the federal government, or another country for any act or omission that would constitute a violation of this chapter.

(15) The plan violates the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(16) The plan violates Section 806 of the Military and Veterans Code.

(17) The plan violates Section 1262.8.

(18) The plan has failed to comply with the requirements of Article 6.2 (commencing with Section 1385.01).

(c) (1) The director may prohibit any person from serving as an officer, director, employee, associate, or provider of any plan or solicitor firm, or of any management company of any plan, or as a solicitor, if either of the following applies:

(A) The prohibition is in the public interest and the person has committed, caused, participated in, or had knowledge of a violation of this chapter by a plan, management company, or solicitor firm.

(B) The person was an officer, director, employee, associate, or provider of a plan or of a management company or solicitor firm of any plan whose license has been suspended or revoked pursuant to this section and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked.

(2) A proceeding for the issuance of an order under this subdivision may be included with a proceeding against a plan under this section or may constitute a separate proceeding, subject in either case to subdivision (d).

(d) A proceeding under this section shall be subject to appropriate notice to, and the opportunity for a hearing with regard to, the person affected in accordance with subdivision (a) of Section 1397.

SEC. 3. Article 4.5 (commencing with Section 10181) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 4.5. Approval of Rates

10181. (a) The following definitions apply for the purposes of this article:

(1) "Applicant" means a health insurer seeking to increase the rate it charges its policyholders for health insurance, as defined in Section 106.

(2) "Rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, and other charges.

(b) No applicant shall increase the rate it charges its policyholders unless it submits an application to the department, and the application is approved by the department.

(c) This article shall not apply to Medicare supplement policies.

10181.01. (a) No rate shall be approved or remain in effect that is excessive, inadequate, unfairly discriminatory, or otherwise in violation of this article. In considering whether a rate is excessive, inadequate, or unfairly discriminatory, the department shall consider whether the rate mathematically reflects the health insurer's investment income and is reasonable in comparison to

coverage benefits. The department shall not consider the degree of competition in determining whether a rate is excessive, inadequate, or unfairly discriminatory.

(b) The department shall review a rate application pursuant to regulations it promulgates to determine reasonable rates for medical expenses and all nonmedical expenses, including the rate of return, surplus, overhead, and administration.

10181.02. (a) A health insurer shall file a complete rate application with the department for a rate increase that will become effective on or after January 1, 2012.

(b) The rate application shall be signed by the officers of the health insurer who exercise the functions of a chief executive and chief financial officer. Each officer shall certify that the representations, data, and information provided to the department to support the application are true.

(c) No health insurer shall submit more than one rate application each calendar year.

(d) A rate application submitted to the department pursuant to this section shall include the following information:

(1) The rate of return that will result if the rate application is approved.

(2) The average rate change per affected insured or group that will result from approval of the application.

(3) The overhead loss ratio, reserves, excess tangible net equity, and surpluses that will result if the application is approved. For the purposes of this section, "overhead loss ratio" means the ratio of revenue dedicated to all nonmedical expenses and expenditures, including profit, to revenue dedicated to medical expenses. A medical expense is any payment to a hospital, physician, or other provider for the provision of medical care or health care services directly to, or for the benefit of, the insured.

(4) Salary and bonus compensation paid to the 10 highest paid officers and employees of the applicant for the most recent fiscal year.

(5) Dollar amounts of shareholder dividends paid, financial or capital disbursements to affiliates, and management agreements and service contracts.

(6) A statement setting forth all of the applicant's nonmedical expenses for the most recent fiscal year including administration, dividends, rate of return, advertising, and salaries.

(7) A line-item report of medical expenses, including aggregate totals paid to hospitals and physicians, and the amount paid by the applicant for the 100 most common medical expenses incurred by insureds during the previous calendar year.

(e) The health insurer has the burden to provide the department with evidence and documents establishing, by a preponderance of the evidence, the application's compliance with the requirement of this article.

(f) Rate applications shall be submitted by the health insurer electronically, and the department shall post the applications on its Internet Web site within 10 days of the date of their receipt by the department.

(g) All information in a rate application and all materials submitted in its support by the applicant shall constitute a public record for purposes of the California Public Records Act (Chapter 3.5(commencing with Section 6250) of Division 7 of Title 1 of the Government Code) except for financial data the disclosure of which would be competitively injurious to the applicant, as determined by the commissioner.

10181.03. A rate increase by a health insurer that became effective during the period January 1, 2010, to December 31, 2011, inclusive, shall be subject to review by the department for compliance with this article.

10181.04. (a) The department shall notify the public of any rate application by a health insurer.

(b) The application shall be deemed approved by the department 60 days after the date of the public notice provided under subdivision (a) unless the department conducts a hearing on the application on any of the following grounds:

(1) A consumer, or his or her representative, requests a hearing within 45 days of the date of the public notice, and the department grants the request for a hearing. If the department determines not to grant the request for a hearing, it shall issue written findings in support of that decision.

(2) The department determines for any reason to hold a hearing on the application.

(3) The proposed increase would exceed 7 percent of the amount of the current rate under the policy.

(c) The public notice required by this section shall be posted on the department's Internet Web site and distributed to major

statewide media and to any member of the public who requests placement on a mailing list or electronic mail list to receive the notice.

10181.05. All hearings under this article shall be conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, with the following exceptions:

(a) The hearing shall be conducted by an administrative law judge for purposes of Sections 11512 and 11517 of the Government Code, appointed pursuant to Section 11502 of the Government Code or by the commissioner.

(b) The hearing shall be commenced by filing a notice, in lieu of Sections 11503 and 11504 of the Government Code.

(c) The commissioner shall adopt, amend, or reject a decision only under Section 11518.5 of the Government Code and subdivisions (b) and (c) of Section 11517 of the Government Code and solely on the basis of the record as provided in Section 11425.50 of the Government Code.

(d) The right to discovery shall be liberally construed, and discovery disputes shall be determined by the administrative law judge as provided in Section 11507.7 of the Government Code.

(e) Judicial review shall be in accordance with Section 1858.6. For purposes of judicial review, a decision by the department to hold a hearing on the application is not a final order or decision; however a decision not to hold a hearing on an application is a final order or decision for purposes of judicial review.

10181.06. (a) A person may initiate or intervene in any proceeding permitted or established pursuant to this article, challenge any action of the department under this article, and enforce any provision of this article on behalf of himself or herself or members of the public.

(b) (1) The department or a court shall award reasonable advocacy fees and costs, including witness fees, in a proceeding described in subdivision (a) to a person who demonstrates both of the following:

(A) The person represents the interests of consumers.

(B) The person has made a substantial contribution to the adoption of any order, regulation, or decision by the department or a court.

(2) The award made under this section shall be paid by the rate applicant.

10181.07. A violation of this article is subject to the penalties set forth in Section 1859.1. The commissioner may also suspend or revoke in whole or in part the certificate of authority of a health insurer for a violation of this article.

10181.08. (a) The department may charge a health insurer a fee for the actual, reasonable costs associated with an application filed by the insurer under this article.

(b) The fees shall be deposited into the Department of Insurance Health Rate Approval Fund, which is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, all moneys in this fund are continuously appropriated to the department for the sole purpose of implementing this article.

10181.09. The department, working in coordination with the Department of Managed Health Care, shall have all necessary and proper powers to implement this article and shall adopt regulations to implement this article no later than January 1, 2012. In implementing this article, the department and the Department of Managed Health Care shall jointly develop any regulations, rate review standards, staff training, policies, and procedures in order to ensure maximum coordination and consistency of implementation.

SEC. 4. 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.

~~SECTION 1. Section 1385.1 is added to the Health and Safety Code, to read:~~

~~1385.1. (a) The following definitions apply for the purposes of this section:~~

~~(1) "Applicant" means a health care service plan seeking to increase the rate it charges its subscribers.~~

~~(2) "Rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, charges, and the cost of coverage per exposure base unit.~~

~~(b) No applicant shall increase the rate it charges a subscriber unless it submits an application to the department, and the application is approved by the department.~~

~~SEC. 2. Section 10181 is added to the Insurance Code, to read:~~

~~10181. (a) The following definitions apply for the purposes of this section:~~

~~(1) "Applicant" means a health insurer seeking to increase the rate it charges its policyholders.~~

~~(2) "Rate" includes, but is not limited to, premiums, copayments, coinsurance obligations, deductibles, charges, and the cost of insurance per exposure base unit.~~

~~(b) No applicant shall increase the rate it charges a policyholder unless it submits an application to the department, and the application is approved by the department.~~

~~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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