AMENDED IN ASSEMBLY JUNE 23, 2010

AMENDED IN SENATE APRIL 28, 2010

AMENDED IN SENATE APRIL 19, 2010

AMENDED IN SENATE APRIL 5, 2010

SENATE BILL No. 1163

Introduced by Senator Leno
(Coauthor: Senator Pavley)

February 18, 2010

An act to amend ~~Section~~ *Sections 1342, 1342.4, 1367, and* 1389.25 of, to add Sections ~~1389.45 and 1389.46~~ *1389.90, 1389.91, 1389.92, 1389.93, and 1389.94* to, and to add and repeal Section 1389.26 of, the Health and Safety Code, and to amend ~~Section 10113.9~~ *Sections 10113.9 and 12923.5* of, to add Sections ~~10113.96 and 10113.97~~ *12969.1, 12969.2, 12969.3, 12969.4, and 12969.5* to, and to add and repeal Section 10113.91 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1163, as amended, Leno. Health care coverage: denials: 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 that offers health care coverage in the individual market to provide an individual to whom it denies coverage or enrollment or offers coverage at a rate higher than

the standard rate with the specific reason or reasons for that decision in writing. Existing law also prohibits a health care service plan or a health insurer offering coverage in the individual market from changing the premium rate or coverage without providing specified notice at least 30 days prior to the effective date of the change.

This bill would require a health care service plan and a health insurer that offers health care coverage in the individual or group market to provide an individual or group to whom it denies coverage or enrollment or offers coverage at a rate higher than the standard rate with the specific reason or reasons for that decision in writing. With respect to both health insurers and health care service plans issuing individual or group policies or contracts, the bill would require that the reasons for a denial or a higher than standard rate be stated in clear, easily understandable language. The bill would require notice of a change to the premium rate of coverage to be provided at least 180 days prior to the effective date of the change.

The bill would also require a health care service plan or health insurer that declines to offer coverage to, or denies enrollment of, any individual ~~or large group~~ to report quarterly, until January 1, 2014, to the Department of Managed Health Care or the Department of Insurance, the Managed Risk Medical Insurance Board, and the public, on the number of applicants that are denied coverage and various related matters. The bill would require the departments to post certain information in that regard on the Internet. The bill would require that reports to the public maintain patient privacy.

Existing law requires a health care service plan and a health insurer to ~~annually~~ file with the Department of Managed Health Care or the Department of Insurance a general description of the criteria, policies, procedures, or guidelines the plan or insurer uses for rating and underwriting decisions related to individual contracts and policies.

This bill would require a plan or health insurer to annually disclose to the Department of Managed Health Care or the Department of Insurance ~~written policies, procedures, or underwriting guidelines under which the plan or insurer makes its decision to determine the standard rate and to issue a contract or policy at a rate higher or lower than the standard rate. The bill would also require, among other things, disclosure of the various rates for each product in the individual and small group markets, and the number and proportion of contract holders and policyholders in each rate category for~~ *specified information for rate filings in* the individual, small group, and large group markets*, including*

information on product types, rate increases, and changes in benefits. The bill would require the departments to *review each rate filing and* post summary information in that regard on the Internet ~~and to provide access to the full information on request~~, *including accompanying documentation regarding rate changes*. The bill would ~~also require plans and insurers to annually disclose certain information relating to rate increases for each product.~~ *require the departments to provide data to the United States Secretary of Health and Human Services on health insurance rate trends in premium ratings and information summarizing the nature of consumer inquiries and complaints relating to health care coverage rates, as specified. The bill would also require the departments to apply for grant funding from the federal government for the purposes of rate review and would authorize the departments to impose fees on health care service plans and health insurers for rate review.*

Because a willful violation of the bill's requirements relative 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:

SECTION 1. Section 1342 of the Health and Safety Code is amended to read:

1342. It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:

(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

(b) Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace.

(c) Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public.

(d) Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Ensuring the financial stability thereof by means of proper regulatory procedures.

(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

(h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department.

(i) Ensuring that the rates charged to subscribers and enrollees are consistent with state and federal law.

SEC. 2. Section 1342.4 of the Health and Safety Code is amended to read:

1342.4. (a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments.

(b) The joint working group shall undertake a review and examination of the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code as they apply to the Department of Managed Health Care and the Department of Insurance to ensure consistency in consumer protection.

(c) The joint working group shall review and examine all of the following ~~processes~~ in each department:

(1) Grievance and consumer complaint processes, including, but not limited to, outreach, standard complaints, including coverage and medical necessity complaints, independent medical review, and information developed for consumer use.

(2) The processes used to ensure enforcement of the law, including, but not limited to, the medical survey and audit process in the Health and Safety Code and market conduct exams in the Insurance Code.

(3) The processes for regulating the timely payment of claims.

(4) Rates in the individual and group markets consistent with federal law.

(d) The joint working group shall report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care for review and approval. The commissioner and the director shall submit the approved final report under signature to the Legislature by January 1 of every year for five years.

SEC. 3. Section 1367 of the Health and Safety Code is amended to read:

1367. A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these

services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) (1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for

licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) A health care service plan shall not require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

~~Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.~~

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

~~SECTION 1.~~

SEC. 4. Section 1389.25 of the Health and Safety Code is amended to read:

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

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is

awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section unless the plan offers coverage to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) A health care service plan that declines to offer coverage or denies enrollment for an individual or his or her dependents or a group applying for coverage or that offers coverage at a rate that is higher than the standard rate, shall, at the time of the denial or offer of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(2) No change in the premium rate or coverage for a plan contract shall become effective unless the plan has delivered a written notice of the change at least 180 days prior to the effective date of the contract renewal or the date on which the rate or coverage changes. A notice of an increase in the premium rate shall include the reasons for the rate increase.

(3) The written notice required pursuant to paragraph (2) shall be delivered to the contractholder at his or her last address known to the plan, at least 180 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium rate increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change to the plan design or benefits.

(4) If a plan rejects an individual applicant or the dependents of an individual applicant for individual coverage or offers individual coverage at a rate that is higher than the standard rate, the plan shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code). The information provided to the applicant by the plan shall specifically include the program's toll-free telephone number and its Internet Web site address. The requirement to notify applicants of the availability of the California

Major Risk Medical Insurance Program shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

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

~~SEC. 2.~~

SEC. 5. Section 1389.26 is added to the Health and Safety Code, to read:

1389.26. (a) (1) A health care service plan subject to Section 1389.25 that declines to offer coverage to or denies enrollment of any individual shall quarterly provide to the department, the Managed Risk Medical Insurance Board, and the public ~~all~~ *both* of the following:

(A) The number and proportion of applicants for individual coverage that were denied coverage for each product offered by the plan.

(B) The health status and risk factors for each applicant denied coverage, by product.

~~(C) Demographic information about applicants denied coverage, including age, gender, language spoken, occupation, and geographic region of the applicant, by product.~~

~~(D) The written policies, procedures, or underwriting guidelines whereby the plan makes its decision to provide or to deny coverage to applicants.~~

(2) Public reporting shall be done in a manner consistent with maintaining patient privacy. Academic institutions and other entities, including those eligible for the Consumer Participation Program, as defined in Section 1348.9, and that have the capacity to maintain patient privacy, shall be able to obtain patient-specific data without patient name or identifier.

~~(b) (1) A health care service plan subject to Section 1389.25 that declines to offer coverage to or denies enrollment of any large group shall quarterly provide to the department, the Managed Risk Medical Insurance Board, and the public all of the following:~~

~~(A) The number and proportion of applicants for large group coverage that were denied coverage for each product offered by the plan.~~

~~(B) The health status and risk factors for each applicant denied coverage, by product.~~

~~(C) Demographic information about applicants denied coverage, including age, gender, language spoken, occupation, and geographic region of the applicant, by product.~~

~~(D) The written policies, procedures, or underwriting guidelines whereby the plan makes its decision to provide or to deny coverage to applicants.~~

~~(2) Public reporting shall be done in a manner consistent with maintaining patient privacy. Academic institutions and other entities, including those eligible for the Consumer Participation Program, as defined in Section 1348.9, and that have the capacity to maintain patient privacy, shall be able to obtain patient-specific data without patient name or identifier.~~

~~(c)~~

(b) The department shall post on its Internet Web site the following information for each product offered by a health care service plan and for all products offered by the plan:

(1) The number and proportion of applicants for individual coverage denied coverage as well as aggregate information about health status and demographics of those denied coverage.

~~(2) The number and proportion of applicants for large group coverage denied coverage as well as aggregate information about health status and demographics of the employees of those large groups denied coverage.~~

~~(3)~~

(2) The written policies, procedures, or underwriting guidelines whereby the plan makes its decision to provide or to deny coverage to applicants.

~~(d) For purposes of this section, "large group health plan contract" or "large group coverage" means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357.~~

~~(e)~~

(c) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

~~SEC. 3. Section 1389.45 is added to the Health and Safety Code, to read:~~

~~1389.45. (a) A full service health care service plan that issues, renews, or amends health plan contracts shall be subject to this section.~~

~~(b) On or before June 1, 2011, and annually thereafter, a plan shall disclose to the department all of the following:~~

~~(1) The written policies, procedures, or underwriting guidelines whereby the plan makes its decision to determine the standard rate and to issue a plan contract at a rate higher or lower than the standard rate.~~

~~(2) For each product in the individual or small group market, the rates charged, including the standard rate, rates that are higher than the standard rate, and rates that are lower than the standard rate.~~

~~(3) For the individual, small group, and large group markets, the number and proportion of subscribers in each category charged a standard rate, a rate that is higher than the standard rate, or a rate that is lower than the standard rate. For each of these categories, demographic information shall be provided, including age, gender, language spoken, and geographic region.~~

~~(c) The department shall disclose the information provided pursuant to this section to the public, both in summary fashion on the department's Internet Web site and in full, on request.~~

~~(d) This section shall not apply to a closed block of business, as defined in Section 1367.15.~~

~~SEC. 4. Section 1389.46 is added to the Health and Safety Code, to read:~~

~~1389.46. (a) A full service health care service plan that issues, renews, or amends health plan contracts shall be subject to this section.~~

~~(b) On or before June 1, 2011, and no less than annually thereafter, a plan shall disclose to the department all of the following with respect to rate increases for each product:~~

~~(1) Any change in rate.~~

~~(2) Any change in cost sharing.~~

~~(3) Any change in covered benefits.~~

~~(c) On or before June 1, 2011, and no less than annually thereafter, a plan shall also disclose to the department all of the following with respect to rate increases for each product:~~

~~(1) Actuarial memorandum.~~

~~(2) Assumptions on trends in medical inflation, including justification.~~

~~(3) Specific worksheets or exhibits documenting increases in costs.~~

~~(4) Enrollee population characteristics that increase or decrease costs.~~

~~(5) Utilization increases.~~

~~(6) Provider prices.~~

~~(7) Administrative costs.~~

~~(8) Medical loss ratios.~~

~~(9) Reserves and surplus levels, including tangible net equity and reserves in excess of tangible net equity.~~

~~(10) Changes in cost sharing.~~

SEC. 6. Section 1389.90 is added to the Health and Safety Code, to read:

1389.90. (a) A full service health care service plan that issues, renews, or amends health care service plan contracts shall be subject to this section. On or before June 1, 2011, and for each rate filing thereafter, a plan shall disclose to the department all of the following for each rate filing in the individual, small employer, and large group health plan markets:

(1) Company name and contact information.

(2) Number of plan contract forms covered by the filing.

(3) Plan contract form numbers covered by the filing.

(4) Product type.

(5) Market segment.

(6) Type of plan, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each plan contract and rating form.

(9) Enrollee months in each plan contract form.

(10) Annual rate.

(11) Total earned premiums in each plan contract form.

(12) Total incurred claims in each plan contract form.

(13) Average rate increase initially requested.

(14) Rate of review category, including approved as originally submitted, initially rejected, or resubmitted with modifications, and initially rejected and not resubmitted or initially rejected and challenged.

(15) Average rate of increase approved.

(16) Effective date of rate increase.

(17) Number of subscribers or enrollees affected by each plan contract form.

(18) Overall annual medical trend factor assumptions in each rate filing for all benefits and disaggregated by benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs, and other ancillary services, laboratory, and radiology.

(19) The amount of the projected trend attributable to the use, price inflation, or fees and risk for annual plan contract trends by benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The number and a summary of the nature of consumer inquiries and complaints related to health plan rates that have been received for the past two plan years.

(b) A health care service plan subject to subdivision (a) shall also disclose the following required aggregate data for rate filings in the individual, small employer, and large group health plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The average rate increase by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(c) For purposes of this section, "large group health plan contract" means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357.

SEC. 7. Section 1389.91 is added to the Health and Safety Code, to read:

1389.91. (a) Each rate filing described in Section 1389.90, including all supporting material, shall be publicly available on the department's Internet Web site. All submissions to the department shall be made electronically in order to facilitate review by the department and the public. Each rate filing shall include a summary of rate changes offered in plain language for consumers.

(b) The department shall post to its public Internet Web site information about the rate filing and justification in an easy to understand language for the public.

(c) A plan shall post all proposed rate increases, including all accompanying documentation, on its Internet Web site.

SEC. 8. Section 1389.92 is added to the Health and Safety Code, to read:

1389.92. (a) The department shall review each rate filing described in Section 1389.90 for consistency with applicable state law and regulations as well as federal law, regulations, rules, or other guidance.

(b) The department shall also review each rate filing to determine that it is actuarially sound.

(c) The department shall consider public comment on the rate filing for no less than 60 days and respond pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) The department shall conduct a public hearing on the rate filing on any of the following grounds:

(1) A consumer or consumer advocacy organization requests a hearing within 45 days of the rate filing. If the department grants a hearing, it shall issue written findings in support of that decision.

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

(3) The department finds that the rate filing does not comply with the provisions of this section.

(e) After completing a review pursuant to this section, the department shall post to its Internet Web site any changes to the rates and the reason for those changes, including any documentation to support those changes.

SEC. 9. Section 1389.93 is added to the Health and Safety Code, to read:

1389.93. (a) Consistent with federal law, rules, and guidance, the department shall do all of the following:

(1) Provide data to the United States Secretary of Health and Human Services on health plan rate trends in premium rating areas.

(2) Provide to the United States Secretary of Health and Human Services the number and summarize the nature of consumer inquiries and complaints related to health plan rates that have been received for the past two plan years.

(b) Commencing with the creation of the Exchange, provide to the Exchange such information as may be necessary to allow compliance with federal law, rules, and guidance. The department shall develop an interagency agreement with the Exchange to facilitate the reporting of information regarding rate filings that is consistent with the responsibilities of the Exchange. As used in this subdivision, the "Exchange" means the American Health Benefit Exchange established in California pursuant to Section 1311 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 10. Section 1389.94 is added to the Health and Safety Code, to read:

1389.94. (a) The department shall apply for grant funding from the federal government for the purposes of rate review consistent with the requirements of federal law, rules, and guidance.

(b) Additional costs and expenses associated with rate reviews shall be supported by fees consistent with the provisions of Section 1356.

~~SEC. 5.~~

SEC. 11. Section 10113.9 of the Insurance Code is amended to read:

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

(b) (1) A health insurer that declines to offer coverage or denies enrollment for an individual or his or her dependents or a group applying for coverage or that offers coverage at a rate that is higher than the standard rate shall, at the time of the denial or offer of

coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(2) No change in the premium rate or coverage for a health insurance policy shall become effective unless the insurer has delivered a written notice of the change at least 180 days prior to the effective date of the policy renewal or the date on which the rate or coverage changes. A notice of an increase in the premium rate shall include the reasons for the rate increase.

(3) The written notice required pursuant to paragraph (2) shall be delivered to the policyholder at his or her last address known to the insurer, at least 180 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(4) If an insurer rejects an individual applicant or the dependents of an individual applicant for individual coverage or offers individual coverage at a rate that is higher than the standard rate, the insurer shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)). The information provided to the applicant by the insurer shall specifically include the program's toll-free telephone number and its Internet Web site address. The requirement to notify applicants of the availability of the California Major Risk Medical Insurance Program shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

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

~~SEC. 6.~~

SEC. 12. Section 10113.91 is added to the Insurance Code, to read:

10113.91. (a) (1) A health insurer subject to Section 10113.9 that declines to offer coverage to or denies enrollment of any individual shall quarterly provide to the commissioner, the Managed Risk Medical Insurance Board, and the public ~~all~~ *both* of the following:

(A) The number and proportion of applicants for individual coverage that were denied coverage for each product offered by the insurer.

(B) The health status and risk factors for each applicant denied coverage, by product.

~~(C) Demographic information about applicants denied coverage, including age, gender, language spoken, occupation, and geographic region of the applicant, by product.~~

~~(D) The written policies, procedures, or underwriting guidelines whereby the insurer makes its decision to provide or to deny coverage to applicants.~~

(2) Public reporting shall be done in a manner consistent with maintaining patient privacy. Academic institutions and other entities, including those eligible for the Consumer Participation Program, as defined in Section 1348.9 of the Health and Safety Code, and that have the capacity to maintain patient privacy, shall be able to obtain patient-specific data without patient name or identifier.

~~(b) (1) A health insurer subject to Section 10113.9 that declines to offer coverage to or denies enrollment of any large group shall quarterly provide to the commissioner, the Managed Risk Medical Insurance Board, and the public all of the following:~~

~~(A) The number and proportion of applicants for large group coverage that were denied coverage for each product offered by the insurer.~~

~~(B) The health status and risk factors for each applicant denied coverage, by product.~~

~~(C) Demographic information about applicants denied coverage, including age, gender, language spoken, occupation, and geographic region of the applicant, by product.~~

~~(D) The written policies, procedures, or underwriting guidelines whereby the insurer makes its decision to provide or to deny coverage to applicants.~~

~~(2) Public reporting shall be done in a manner consistent with maintaining patient privacy. Academic institutions and other~~

~~entities, including those eligible for the Consumer Participation Program, as defined in Section 1348.9 of the Health and Safety Code, and that have the capacity to maintain patient privacy, shall be able to obtain patient-specific data without patient name or identifier.~~

~~(c)~~

(b) The commissioner shall post on the department's Internet Web site the following information for each product offered by a health insurer and for all products offered by the insurer:

(1) The number and proportion of applicants for individual coverage denied coverage as well as aggregate information about health status and demographics of those denied coverage.

~~(2) The number and proportion of applicants for large group coverage denied coverage as well as aggregate information about health status and demographics of the employees of those denied coverage.~~

~~(3)~~

(2) The written policies, procedures, or underwriting guidelines whereby the insurer makes its decision to provide or to deny coverage to applicants.

~~(d) For purposes of this section, "large group policy" or "large group coverage" means a group health insurance policy other than a policy issued to a small employer, as defined in Section 10700.~~

~~(e)~~

(c) This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.

~~SEC. 7. Section 10113.96 is added to the Insurance Code, to read:~~

~~10113.96. (a) A health insurer that issues, renews, or amends health insurance policies shall be subject to this section.~~

~~(b) On or before June 1, 2011, and annually thereafter, an insurer shall disclose to the commissioner all of the following:~~

~~(1) The written policies, procedures, or underwriting guidelines whereby the insurer makes its decision to determine the standard rate and to issue a policy at a rate higher or lower than the standard rate.~~

~~(2) For each product in the individual or small group market, the rates charged, including the standard rate, rates that are higher~~

~~than the standard rate, and rates that are lower than the standard rate.~~

~~(3) For the individual, small group, and large group markets, the number and proportion of policyholders in each category charged a standard rate, a rate that is higher than the standard rate, or a rate that is lower than the standard rate. For each of these categories, demographic information shall be provided, including age, gender, language spoken, and geographic region.~~

~~(c) The commissioner shall disclose the information provided pursuant to this section to the public, both in summary fashion on the department's Internet Web site and in full, on request.~~

~~(d) This section shall not apply to a closed block of business, as defined in Section 10176.10.~~

~~SEC. 8. Section 10113.97 is added to the Insurance Code, to read:~~

~~10113.97. (a) A health insurer that issues, renews, or amends health insurance policies shall be subject to this section.~~

~~(b) On or before June 1, 2011, and no less than annually thereafter, an insurer shall disclose to the commissioner all of the following with respect to rate increases for each product:~~

~~(1) Any change in rate.~~

~~(2) Any change in cost sharing.~~

~~(3) Any change in covered benefits.~~

~~(c) On or before June 1, 2011, and no less than annually thereafter, an insurer shall also disclose to the commissioner all of the following with respect to rate increases for each product:~~

~~(1) Actuarial memorandum.~~

~~(2) Assumptions on trends in medical inflation, including justification.~~

~~(3) Specific worksheets or exhibits documenting increases in costs.~~

~~(4) Insured population characteristics that increase or decrease costs.~~

~~(5) Utilization increases.~~

~~(6) Provider prices.~~

~~(7) Administrative costs.~~

~~(8) Medical loss ratios.~~

~~(9) Reserves and surplus levels, including tangible net equity and reserves in excess of tangible net equity.~~

~~(10) Changes in cost sharing.~~

SEC. 13. Section 12923.5 of the Insurance Code is amended to read:

12923.5. (a) The Department of Managed Health Care and the Department of Insurance shall maintain a joint senior level working group to ensure clarity for health care consumers about who enforces their patient rights and consistency in the regulations of these departments.

(b) The joint working group shall undertake a review and examination of the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code as they apply to the Department of Managed Health Care and the Department of Insurance to ensure consistency in consumer protection.

(c) The joint working group shall review and examine all of the following processes in each department:

(1) Grievance and consumer complaint processes, including, but not limited to, outreach, standard complaints, including coverage and medical necessity complaints, independent medical review, and information developed for consumer use.

(2) The processes used to ensure enforcement of the law, including, but not limited to, the medical survey and audit process in the Health and Safety Code and market conduct exams in the Insurance Code.

(3) The processes for regulating the timely payment of claims.

(4) Review of rates in the individual and group markets consistent with federal law.

(d) The joint working group shall report its findings to the Insurance Commissioner and the Director of the Department of Managed Health Care for review and approval. The commissioner and the director shall submit the approved final report under signature to the Legislature by January 1 of every year for five years.

SEC. 14. Section 12969.1 is added to the Insurance Code, to read:

12969.1. (a) A health insurer that issues, renews, or amends health insurance policies shall be subject to this section. On or before June 1, 2011, and for each rate filing thereafter, an insurer shall disclose to the commissioner all of the following for each rate filing in the individual, small employer, and large group policy markets:

(1) Company name and contact information.

(2) Number of policy forms covered by the filing.
(3) Policy form numbers covered by the filing.
(4) Product type.
(5) Market segment.
(6) Type of insurer.
(7) Whether the products are opened or closed.
(8) Enrollment in each policy and rating form.
(9) Member months in each policy form.
(10) Annual rate.
(11) Total earned premiums in each policy form.
(12) Total incurred claims in each policy form.
(13) Average rate increase initially requested.
(14) Rate of review category, including approved as originally submitted, initially rejected, or resubmitted with modifications, and initially rejected and not resubmitted or initially rejected and challenged.
(15) Average rate of increase approved.
(16) Effective date of rate increase.
(17) Number of policyholders or insureds affected by each policy form.
(18) Overall annual medical trend factor assumptions in each rate filing for all benefits and disaggregated by benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs, and other ancillary services, laboratory, and radiology.
(19) The amount of the projected trend attributable to the use, price inflation, or fees and risk for annual insurance trends by benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.
(20) A comparison of claims cost and rate of changes over time.
(21) Any changes in the cost sharing of insureds over the prior year associated with the submitted rate filing.
(22) Any changes in insured benefits over the prior year associated with the submitted rate filing.
(23) The number and a summary the nature of consumer inquiries and complaints related to health insurance rates that have been received for the past two policy years.

(b) A health insurer subject to subdivision (a) shall also disclose the following required aggregate data for rate filings in the individual, small employer, and large group policy markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Policy year.

(B) Segment type.

(C) Product type.

(D) Number of policyholders.

(E) Number of covered lives affected.

(2) The average rate increase by the following:

(A) Policy year.

(B) Segment type.

(C) Product type.

(c) For purposes of this section, "large group policy" means a group health insurance policy other than a policy issued to a small employer, as defined in Section 10700.

(d) This section shall not apply to specialized health insurance.

SEC. 15. Section 12969.2 is added to the Insurance Code, to read:

12969.2. (a) Each rate filing described in Section 12969.1, including all supporting material, shall be publicly available on the department's Internet Web site. All submissions to the commissioner shall be made electronically in order to facilitate review by the commissioner and the public. Each rate filing shall include a summary of rate changes offered in plain language for consumers.

(b) The commissioner shall post to its public Internet Web site information about the rate filing and justification in an easy to understand language for the public.

(c) Health insurers shall post all proposed rate increases, including all accompanying documentation on their Internet Web site.

SEC. 16. Section 12969.3 is added to the Insurance Code, to read:

12969.3. (a) The commissioner shall review each rate filing described in Section 12969.1 for consistency with applicable state law and regulations as well as federal law, regulations, rules, or other guidance.

(b) The commissioner shall also review each rate filing to determine that it is actuarially sound.

(c) The commissioner shall consider public comment on the rate filing for no less than 60 days and respond pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) The commissioner shall conduct a public hearing on the rate filing on any of the following grounds:

(1) A consumer or consumer advocacy organization requests a hearing within 45 days of the rate filing. If the commissioner grants a hearing, it shall issue written findings in support of that decision.

(2) The commissioner determines for any reason to hold a hearing.

(3) The commissioner finds that the rate filing does not comply with the provisions of this section.

(e) After completing a review pursuant to this section, the commissioner shall post to its Internet Web site any changes to the rates and the reason for those changes, including any documentation to support those changes.

SEC. 17. Section 12969.4 is added to the Insurance Code, to read:

12969.4. (a) Consistent with federal law, rules, and guidance, the commissioner shall do all of the following:

(1) Provide data to the United States Secretary of Health and Human Services on health insurance rate trends in premium rating areas.

(2) Provide to the United States Secretary of Health and Human Services the number and summarize the nature of consumer inquiries and complaints related to health insurance rates that have been received for the past two plan years.

(b) Commencing with the creation of the Exchange, provide to the Exchange such information as may be necessary to allow compliance with federal law, rules, and guidance. The commissioner shall develop an interagency agreement with the Exchange to facilitate the reporting of information regarding rate filings that is consistent with the responsibilities of the Exchange. As used in this subdivision, the "Exchange" means the American Health Benefit Exchange established in California pursuant to Section 1311 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

SEC. 18. Section 12969.5 is added to the Insurance Code, to read:

12969.5. (a) The commissioner shall apply for grant funding from the federal government for the purposes of rate review consistent with the requirements of federal law, rules, and guidance.

(b) Additional costs and expenses associated with rate reviews shall be supported by fees established by the commissioner.

~~SEC. 9.~~

SEC. 19. 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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