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 1389.25 of, to add Sections 1389.45 and 1389.46 to, and to add and repeal Section 1389.26 of, the Health and Safety Code, and to amend Section 10113.9 of, to add Sections 10113.96 and 10113.97 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 the individual, small group, and large group markets. The bill would require the departments to post summary information in that regard on the Internet and to provide access to the full information on request. The bill would also require plans and

insurers to annually disclose certain information relating to rate increases for each product.

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 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. 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 of the following:

~~(1)~~

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

~~(2)~~

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

~~(3)~~

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

~~(4)~~

(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:

~~(1)~~

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

~~(2)~~

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

~~(3)~~

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

~~(4)~~

(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) 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) 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) 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. 5. 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. 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 of the following:

~~(1)~~

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

~~(2)~~

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

~~(3)~~

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

~~(4)~~

(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:

~~(1)~~

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

~~(2)~~

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

~~(3)~~

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

~~(4)~~

(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) 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) 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) 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. 9. 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.

CORRECTIONS:

Text—Page 5.

O