AMENDED IN ASSEMBLY MARCH 25, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 52

Introduced by Assembly ~~Member Feuer~~ *Members Feuer and Huffman*

December 6, 2010

An act *to amend Section 1386 of, and to add Article 6.1 (commencing with Section 1385.001) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 4.4 (commencing with Section 10180.1) to Chapter 1 of Part 2 of Division 2 of the Insurance Code,* relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 52, as amended, Feuer. 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 *health* 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 *health care service* plan ~~and~~ *or health* insurer during the term of a group plan contract or policy from changing the rate of the

premium, copayment, coinsurance, or deductible during specified time periods. *Existing law requires a health care service plan or health insurer that issues individual or group contracts or policies to file with the Department of Managed Health Care or the Department of Insurance specified rate information at least 60 days prior to the effective date of any rate change.*

This bill would ~~declare the intent of the Legislature to enact legislation to require approval from the Department of Managed Health Care and the Department of Insurance for increases in health care premiums, copayments, or deductibles~~ *further require a health care service plan or health insurer that issues individual or group contracts or policies to file with the Department of Managed Health Care or the Department of Insurance, on and after January 1, 2012, a complete rate application for any proposed rate, as defined, or rate change, and would prohibit the Department of Managed Health Care or the Department of Insurance from approving any rate or rate change that is found to be excessive, inadequate, or unfairly discriminatory. The bill would require the rate application to include certain rate information. The bill would authorize the Department of Managed Health Care or the Department of Insurance to approve, deny, or modify any proposed rate or rate change, and would authorize the Department of Managed Health Care and the Department of Insurance to review any rate or rate change that went into effect between January 1, 2011, and January 1, 2012, and to order refunds, subject to these provisions. The bill would authorize the imposition of fees on health care service plans and health insurers for purposes of implementation, for deposit into newly created funds, subject to appropriation. The bill would impose civil penalties on a health care service plan or health insurer, and subject a health care service plan to discipline, for a violation of these provisions, as specified. The bill would establish proceedings for the review of any action taken under those provisions related to rate applications and would require the Department of Managed Health Care and the Department of Insurance, and plans and insurers, to disclose specified information on the Internet pertaining to rate applications and those proceedings. The bill would require the Department of Managed Health Care or the Department of Insurance, or the court, to award reasonable advocacy fees and costs, including witness fees, in those proceedings under specified circumstances, to be paid by the plan or insurer.*

Because a willful violation of these provisions by a health care service plan 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: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) California consumers *and businesses* are facing excessive health insurance premium increases, placing health insurance out of the reach of millions of families.

(b) Consumers are experiencing significant insurance rate escalations: from 1999 to 2009, health insurance premiums for families rose 131 percent, while the general rate of inflation increased just 28 percent during the same period (according to a report by the Kaiser Family Foundation).

(c) More than 8.2 million Californians are uninsured, or one in four Californians under 65 years of age.

(d) Uninsured individuals delay preventative care, leading to worse health outcomes and costly visits to overcrowded emergency rooms.

(e) The State of California should have the authority to minimize families' loss of health insurance coverage as a result of steeply rising premium costs.

(f) The federal Patient Protection and Affordable Care Act (Public Law 111-148) allows the federal government to work with states to examine "unreasonable increases" in the premiums charged for some individual and small group health plans, and has allotted two hundred fifty million dollars ($250,000,000) for state insurance departments to improve their process for reviewing proposed rate increases.

(g) According to a Kaiser Family Foundation report on state insurance department rate regulation, states with robust and transparent rate review and approval processes have greater power to protect consumers from large rate increases.

~~(h) It is the intent of the Legislature to enact legislation to require approval from the Department of Insurance or the Department of Managed Health Care before health care premiums, copayments, or deductibles may be raised by health insurers or health care service plans.~~

SEC. 2. Article 6.1 (commencing with Section 1385.001) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 6.1. Approval of Rates

1385.001. For purposes of this article, the following definitions shall apply:

(a) "Applicant" means a health care service plan seeking to change the rate it charges its subscribers or to set a rate for a new product.

(b) "Rate" means the charges assessed for a health care service plan contract or anything that affects the charges associated with such a contract, including, but not limited to, premiums, base rates, underwriting relativities, discounts, copayments, coinsurance, deductibles, and any other out-of-pocket costs.

1385.002. (a) No rate shall be approved or remain in effect that is found to be excessive, inadequate, unfairly discriminatory, or otherwise in violation of this article.

(b) No applicant shall implement a rate for a new product or change the rate it charges its subscribers, unless it submits an application to the department and the application is approved by the department.

(c) The director may approve, deny, or modify any proposed rate for a new product or any rate change for an existing product. The presence of competition in the health care service plan market shall not be considered in determining whether a rate change is excessive, inadequate, or unfairly discriminatory. The director shall not approve any rate that does not comply with the requirements of this article.

1385.003. (a) This article shall apply to health care service plan contracts offered in the individual or group market in California. However, this article shall not apply to a specialized health care service plan contract, a Medicare supplement contract subject to Article 3.5 (commencing with Section 1358.1); a health care service plan contract offered 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 contract offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code); a health care service plan conversion contract offered pursuant to Section 1373.6; or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article 10.5 (commencing with Section 1399.801).

(b) The department shall review a rate application pursuant to regulations it promulgates to determine excessive, inadequate, or unfairly discriminatory rates. Such reviews shall consider, but not be limited to, medical expenses and all nonmedical expenses, including, but not limited to, the rate of return, overhead, and administration, and surplus, reserves, investment income, and any information submitted under Section 1385.004 or 1385.005.

(c) In promulgating regulations to determine whether a rate is excessive, inadequate, or unfairly discriminatory, the department shall consider whether the rate is reasonable in comparison to coverage benefits.

1385.004. (a) For individual or small group health care service plan contracts, all health care service plans shall file with the department a complete rate application for any proposed rate change or rate for a new product that would become effective on or after January 1, 2012. The rate application shall be filed at least 60 days prior to the proposed effective date of the proposed rate.

(b) No health care service plan shall submit a rate application within one year of the date of implementation of the most recently approved rate change for each product in the individual or small group market.

(c) A health care service plan shall disclose to the department all of the following for each individual or small group rate application:

(1) All of the information required pursuant to subdivisions (b) and (c) of Section 1385.03, except for the information set forth in paragraph (23) of subdivision (c) of Section 1385.03.

(2) Highest and lowest rate change initially requested for an individual or small group.

(3) Highest and lowest rate of change.

(4) Five-year rate change history for the population affected by the proposed rate change.

(5) The rate of return that would result if the rate application were approved.

(6) The average rate change per affected enrollee or group that would result from approval of the application, as well as the lowest and highest rate increase that would result for any enrollee.

(7) The overhead loss ratio, reserves, excess tangible net equity, surpluses, profitability, reinsurance, dividends, and investment income that exist and would result if the application is approved; the financial condition of the health care service plan for at least the past five years, or total years in existence if less than five years, including, but not limited to, the financial performance for at least the past five years of the plan's statewide individual or small group market business, and the plan's overall statewide business; and the financial performance for at least the past five years of the block of business subject to the proposed rate change, including, but not limited to, past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block. 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 and surgeon, or other provider for the provision of medical care or health care services directly to, or for the benefit of, the enrollee.

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

(9) Dollar amounts of financial or capital disbursements or transfers to affiliates, and dollar amounts of management agreements and service contracts.

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

(11) A line-item report of medical expenses, including aggregate totals paid to hospitals and physicians and surgeons.

(12) The contracted rates between a health care service plan and a provider. Pursuant to Section 1385.008, these rates shall not be disclosed to the public.

(13) Compliance with medical loss ratio standards in effect under federal or state law.

(14) Whether the plan has complied with all federal and state requirements for pooling risk and requirements for participation in risk adjustment programs in effect under federal and state law.

(15) The plan's statement of purpose or mission in its corporate charter or mission statement.

(16) Whether the plan employs provider payment strategies to enhance cost-effective utilization of appropriate services.

(17) Affordability of the health care service plan product or products subject to the proposed rate change.

(18) Public comments received pertaining to the information required in this section.

(19) Any other information deemed necessary by the director.

(d) A plan shall submit any other information required pursuant to any regulation adopted by the department to comply with this article and related regulations.

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

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

1385.005. (a) For large group health care service plan contracts, all large group health care service plans shall file with the department a complete rate application for any proposed rate change or rate for a new product that would become effective on or after January 1, 2012. The rate application shall be filed at least 60 days prior to the proposed effective date of the proposed rate.

(b) No health care service plan shall submit a rate application within one year of the date of implementation of the most recently approved rate change for each product in the large group market.

(c) A health care service plan shall disclose to the department all of the following for each large group rate application:

(1) Company name and contact information.

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

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

(4) Product type, such as a preferred provider organization or health maintenance organization.

(5) Segment type.

(6) Type of plan involved, 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 change initially requested.

(14) Highest and lowest rate change initially requested for a group.

(15) Review category: initial application for a new product, application for an existing product, or resubmission of an application.

(16) Average rate of change.

(17) Highest and lowest rate of change.

(18) Proposed effective date of the proposed rate change.

(19) Five-year rate change history for the population affected by the proposed rate change.

(20) The rate of return that would result if the rate application were approved.

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

(22) The average rate change per affected enrollee or group that would result from approval of the application, as well as the lowest and highest rate increase that would result for any enrollee.

(23) The plan's overall annual medical trend factor assumptions in each rate application for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician and surgeon services, prescription drugs and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in major geographic regions of the state. For purposes of this paragraph, "major geographic region" shall be defined by the department and shall include no more than nine regions. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

(24) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician and surgeon services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.

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

(26) Any changes in enrollee costsharing over the prior year associated with the submitted rate application.

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

(28) Any changes in administrative costs.

(29) The overhead loss ratio, reserves, excess tangible net equity, surpluses, profitability, reinsurance, dividends, and

investment income that exist and will result if the application is approved; the financial condition of the health care service plan for at least the past five years, or total years in existence if less than five years, including, but not limited to, the financial performance for at least the past five years of the plan's statewide large group market business, and the plan's overall statewide business; and the financial performance for at least the past five years of the block of business subject to the proposed rate change, including, but not limited to, past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block. 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 and surgeon, or other provider for the provision of medical care or health care services directly to, or for the benefit of, the enrollee.

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

(31) Dollar amounts of financial or capital disbursements or transfers to affiliates and management agreements and service contracts.

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

(33) A line-item report of medical expenses, including aggregate totals paid to hospitals and physicians and surgeons.

(34) Compliance with medical loss ratio standards in effect under federal or state law.

(35) Whether the plan has complied with all federal and state requirements for pooling risk and requirements for participation in risk adjustment programs in effect under federal and state law.

(36) The plan's statement of purpose or mission in its corporate charter or mission statement.

(37) Whether the plan employs provider payment strategies to enhance cost effective utilization of appropriate services.

(38) Affordability of the health care service plan product or products subject to the proposed rate change.

(39) Public comments received pertaining to the information required in this section.

(40) All of the information required pursuant to subdivision (c) of Section 1385.04.

(41) Any other information required under the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(42) The contracted rates between a health care service plan and a provider. Pursuant to Section 1385.008, these rates shall not be disclosed to the public.

(43) The contracted rates between a health care service plan and a large group subscriber. Pursuant to Section 1385.008, these rates shall not be disclosed to the public.

(44) Any other information deemed necessary by the director.

(d) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article and related regulations.

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

(f) 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 requirements of this article.

1385.006. Notwithstanding any provision in a contract between a health care service plan and a provider, the department may request from a health care service plan, and the health care service plan shall provide, any information required under this article or the federal Patient Protection and Affordable Care Act (Public Law 111-148).

1385.007. A rate by a health care service plan that became effective during the period January 1, 2011, to December 31, 2011, inclusive, shall be subject to review by the department for compliance with this article. The department shall order the refund of payments made pursuant to any such rate, to the extent the department finds the rate to be excessive, inadequate, or unfairly discriminatory.

1385.008. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all

information submitted under this article shall be made publicly available by the department, except as provided in subdivision (b). Subdivision (d) of Section 6254 of the Government Code shall not apply to a public record under this article.

(b) (1) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(2) The contracted rates between a health care service plan and a large group subscriber shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) The information shall be made public and posted to the department's Internet Web site for not less than 60 days after the date of public notice.

(1) The department and the health care service plan shall make the information submitted under this article readily available to the public on their Internet Web sites, in plain language, and in a manner and format specified by the department, except as provided in subdivision (b).

(2) The entirety of the rate application shall be made available upon request to the department, except as provided in subdivision (b).

(e) The department shall accept and post to its Internet Web site any public comment on a proposed rate submitted to the department during the 60-day period described in subdivision (a) of Section 1385.004 or subdivision (a) of Section 1385.005.

1385.009. (a) The department shall notify the public of any rate application by a health care service plan.

(b) If the application process in Section 1385.004 or 1385.005 has been followed, the department shall issue a decision within 60 days after the date of the public notice provided under subdivision (a), unless the department and the applicant agree to

waive the 60-day period or the department notices a public hearing on the application. If the department holds a hearing on the application, the department shall issue a decision and findings within a reasonable time after the hearing. The department shall hold a hearing 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 denies 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 change would exceed 10 percent of the amount of the current rate under the health care service plan contract, or would exceed 15 percent for any individual enrollee subject to the rate increase, in which case the department shall hold a hearing upon a timely request for a hearing.

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

1385.010. 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) For purposes of Sections 11512 and 11517 of the Government Code, the hearing shall be conducted by an administrative law judge 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 conducted in accordance with the requirements, standards, and procedures set forth in 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.

1385.011. (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.

1385.012. (a) A violation of this article is subject to the penalties set forth in Sections 1386 and 1390.

(b) If the director finds that a health care service plan has violated this article, the director may order that plan to pay a civil penalty, in addition to any other penalties that may be prescribed by law, which may be recovered in a civil action, in an amount not exceeding fifty thousand dollars ($50,000), but if the violation is willful, the health care service plan shall be liable for an amount not exceeding one hundred thousand dollars ($100,000). In determining the amount of a civil penalty to be paid under this subdivision, the director shall consider the gravity of the violation, the history of previous violations by the plan, and any other factors the director deems relevant.

(c) Moneys collected under this section shall be deposited in the fund specified in Section 1385.013.

1385.015. (a) The department may charge a health care service plan a fee for the actual and reasonable costs related to filing and reviewing an application 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. Moneys in the fund shall be available to the department, upon appropriation by the Legislature, for the sole purpose of implementing this article.

1385.014. (a) On or before July 1, 2012, the director may issue guidance to health care service plans regarding compliance with this article. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code)

(b) The department shall consult with the Department of Insurance in issuing guidance under subdivision (a), in adopting necessary regulations, in posting information on its Internet Web site under this article, and in taking any other action for the purpose of implementing this article.

(c) 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, 2013.

1395.015. (a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, the department may review any rate to ensure compliance with this article.

(b) The department shall report to the Legislature at least semiannually on all rate applications approved, modified, or denied under this article. The report required pursuant to this subdivision shall be submitted pursuant to the procedures specified under Section 9795 of the Government Code.

(c) The department shall post on its Internet Web site any changes submitted by a plan to a rate application, including any documentation submitted by the plan supporting those changes.

(d) The department shall post on its Internet Web site whether it approved, denied, or modified a proposed rate change pursuant to this article.

(e) If the department finds that a proposed rate is excessive, inadequate, or unfairly discriminatory, or that a rate application contains inaccurate information, the department shall post its finding on its Internet Web site.

(f) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this chapter.

SEC. 3. 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 6.1 (commencing with Section 1385.001).

(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. 4. Article 4.4 (commencing with Section 10180.1) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

Article 4.4. Approval of Rates

10180.1. For purposes of this article, the following definitions shall apply:

(a) "Applicant" means a health insurer seeking to change the rate it charges its policyholders or to set a rate for a new product.

(b) "Rate" means the charges assessed for a health insurance policy or anything that affects the charges associated with such a policy, including, but not limited to, premiums, base rates, underwriting relativities, discounts, copayments, coinsurance, deductibles, and any other out-of-pocket costs.

10180.2. (a) No rate shall be approved or remain in effect that is found to be excessive, inadequate, unfairly discriminatory, or otherwise in violation of this article.

(b) No applicant shall implement a rate for a new product or change the rate it charges its policyholders, unless it submits an application to the department and the application is approved by the department.

(c) The commissioner may approve, deny, or modify any proposed rate for a new product or any rate change for an existing product. The presence of competition in the insurance market shall not be considered in determining whether a rate change is excessive, inadequate, or unfairly discriminatory. The commissioner shall not approve any rate that does not comply with the requirements of this article.

10180.3. (a) This article shall apply to health insurance policies offered in the individual or group market in California. However, this article shall not apply to a specialized health insurance policy; a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05); a health insurance policy offered 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 insurance policy offered in the Healthy Families Program (Part 6.2 (commencing with Section 12693)), the Access for Infants and Mothers Program (Part 6.3 (commencing with Section 12695)), the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), or the Federal Temporary High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a health insurance conversion policy offered pursuant to Section 12682.1; or a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900).

(b) The department shall review a rate application pursuant to regulations it promulgates to determine excessive, inadequate, or unfairly discriminatory rates. Such reviews shall consider, but not be limited to, medical expenses and all nonmedical expenses, including, but not limited to, the rate of return, overhead, and administration, and surplus, reserves, investment income, and any information submitted under Section 10180.4 and 10180.5.

(c) In promulgating regulations to determine whether a rate is excessive, inadequate, or unfairly discriminatory, the department shall consider whether the rate is reasonable in comparison to coverage benefits.

10180.4. (a) For individual or small group health insurance policies, all health insurers shall file with the department a complete rate application for any proposed rate change or rate for a new product that would become effective on or after January 1, 2012. The rate application shall be filed at least 60 days prior to the proposed effective date of the proposed rate.

(b) No health insurer shall submit a rate application within one year of the date of implementation of the most recently approved rate change for each product in the individual or small group market.

(c) An insurer shall disclose to the department all of the following for each individual or small group rate application:

(1) All of the information required pursuant to subdivisions (b) and (c) of Section 10181.3, except for the information set forth in paragraph (23) of subdivision (b) of Section 10181.3.

(2) Highest and lowest rate change initially requested for an individual or small group.

(3) Highest and lowest rate of change.

(4) Five-year rate change history for the population affected by the proposed rate change.

(5) The rate of return that would result if the rate application were approved.

(6) The average rate change per affected insured or group that would result from approval of the application, as well as the lowest and highest rate increase that would result for any insured.

(7) The overhead loss ratio, reserves, excess tangible net equity, surpluses, profitability, reinsurance, dividends, and investment income that exist and would result if the application is approved; the financial condition of the health insurer for at least the past five years, or total years in existence if less than five years, including, but not limited to, the financial performance for at least the past five years of the insurer's statewide individual or small group market business, and the insurer's overall statewide business; and the financial performance for at least the past five years of the block of business subject to the proposed rate change, including, but not limited to, past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block. 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 and surgeon, or other provider for the provision of medical care or health care services directly to, or for the benefit of, the insured.

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

(9) Dollar amounts of financial or capital disbursements or transfers to affiliates, and dollar amounts of management agreements and service contracts.

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

(11) A line-item report of medical expenses, including aggregate totals paid to hospitals and physicians and surgeons.

(12) The contracted rates between a health insurer and a provider. Pursuant to Section 10181.8, these rates shall not be disclosed to the public.

(13) Compliance with medical loss ratio standards in effect under federal or state law.

(14) Whether the insurer has complied with all federal and state requirements for pooling risk and requirements for participation in risk adjustment programs in effect under federal and state law.

(15) The insurer's statement of purpose or mission in its corporate charter or mission statement.

(16) Whether the insurer employs provider payment strategies to enhance cost-effective utilization of appropriate services.

(17) Affordability of the insurance product or products subject to the proposed rate change.

(18) Public comments received pertaining to the information required in this section.

(19) Any other information deemed necessary by the commissioner.

(d) An insurer shall submit any other information required pursuant to any regulation adopted by the department to comply with this article and related regulations.

(e) The rate application shall be signed by the officers of the health insurer who exercise the functions of a chief executive officer and chief financial officer. Each officer shall certify that the

representations, data, and information provided to the department to support the application are true.

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

10180.5. (a) For large group health insurance policies, all large group health insurers shall file with the department a complete rate application for any proposed rate change or rate for a new product that would become effective on or after January 1, 2012. The rate application shall be filed at least 60 days prior to the proposed effective date of the proposed rate.

(b) No health insurer shall submit a rate application within one year of the date of implementation of the most recently approved rate change for each product in the large group market.

(c) An insurer shall disclose to the department all of the following for each large group rate application:

(1) Company name and contact information.

(2) Number of policy forms covered by the application.

(3) Policy form numbers covered by the application.

(4) Product type, such as indemnity or preferred provider organization.

(5) Segment type.

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

(7) Whether the products are opened or closed.

(8) Enrollment in each policy and rating form.

(9) Insured 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 change initially requested.

(14) Highest and lowest rate change initially requested for a group.

(15) Review category: initial application for a new product, application for an existing product, or resubmission of an application.

(16) Average rate of change.

(17) Highest and lowest rate of change.

(18) Proposed effective date of the proposed rate change.

(19) Five-year rate change history for the population affected by the proposed rate change.

(20) The rate of return that would result if the rate application were approved.

(21) Number of policyholders or insureds affected by each policy form.

(22) The average rate change per affected insured or group that would result from approval of the application, as well as the lowest and highest rate increase that would result for any insured.

(23) The insurer's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician and surgeon services, prescription drugs and other ancillary services, laboratory, and radiology. An insurer may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in major geographic regions of the state. For purposes of this paragraph, "major geographic region" shall be defined by the department and shall include no more than nine regions.

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

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

(26) Any changes in insured costsharing over the prior year associated with the submitted rate application.

(27) Any changes in insured benefits over the prior year associated with the submitted rate application.

(28) Any changes in administrative costs.

(29) The overhead loss ratio, reserves, excess tangible net equity, surpluses, profitability, reinsurance, dividends, and investment income that exist and will result if the application is approved; the financial condition of the insurer for at least the past five years, or total years in existence if less than five years, including, but not limited to, the financial performance for at least the past five years of the insurer's statewide large group market business, and the insurer's overall statewide business; and the financial performance for at least the past five years of the block of business subject to the proposed rate change, including, but not

limited to, past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block. 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 and surgeon, or other provider for the provision of medical care or health care services directly to, or for the benefit of, the insured.

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

(31) Dollar amounts of financial or capital disbursements or transfers to affiliates and management agreements and service contracts.

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

(33) A line-item report of medical expenses, including aggregate totals paid to hospitals and physicians and surgeons.

(34) Compliance with medical loss ratio standards in effect under federal or state law.

(35) Whether the insurer has complied with all federal and state requirements for pooling risk and requirements for participation in risk adjustment programs in effect under federal and state law.

(36) The insurer's statement of purpose or mission in its corporate charter or mission statement.

(37) Whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services.

(38) Affordability of the insurance product or products subject to the proposed rate change.

(39) Public comments received pertaining to the information required in this section.

(40) All of the information required pursuant to subdivision (c) of Section 10181.4.

(41) Any other information required under the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(42) The contracted rates between a health insurer and a provider. Pursuant to Section 10180.8, these rates shall not be disclosed to the public.

(43) The contracted rates between a health insurer and a large group policyholder. Pursuant to Section 10180.8, these rates shall not be disclosed to the public.

(44) Any other information deemed necessary by the commissioner.

(d) An insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article and related regulations.

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

(f) 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 requirements of this article.

10180.6. Notwithstanding any provision in a contract between a health insurer and a provider, the department may request from a health insurer, and the health insurer shall provide, any information required under this article or the federal Patient Protection and Affordable Care Act (Public Law 111-148).

10180.7. A rate change by a health insurer that became effective during the period January 1, 2011, to December 31, 2011, inclusive, shall be subject to review by the department for compliance with this article. The department shall order the refund of payments made pursuant to any such rate, to the extent the department finds the rate to be excessive, inadequate, or unfairly discriminatory.

10180.8. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department, except as provided in subdivision (b). Subdivision (d) of Section 6254 of the Government Code shall not apply to a public record under this article.

(b) (1) The contracted rates between a health insurer and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing

with Section 6250) of Division 7 of Title 1 of the Government Code).

(2) The contracted rates between a health insurer and a large group subscriber shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) The information shall be made public and posted to the department's Internet Web site for not less than 60 days after the date of public notice.

(1) The department and the health insurer shall make the information submitted under this article readily available to the public on their Internet Web sites, in plain language, and in a manner and format specified by the department, except as provided in subdivision (b).

(2) The entirety of the rate application shall be made available upon request to the department, except as provided in subdivision (b).

(e) The department shall accept and post to its Internet Web site any public comment on a proposed rate submitted to the department during the 60-day period described in subdivision (a) of Section 10180.4 or subdivision (a) of Section 10180.5.

10180.9. (a) The department shall notify the public of any rate application by a health insurer.

(b) If the application process in Section 10180.4 or 10180.5 has been followed, the department shall issue a decision within 60 days after the date of the public notice provided under subdivision (a), unless the department and the applicant agree to waive the 60-day period or the department notices a public hearing on the application. If the department holds a hearing on the application, the department shall issue a decision and findings within a reasonable time after the hearing. The department shall hold a hearing 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 denies 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 change would exceed 10 percent of the amount of the current rate under the plan contract, or would exceed 15 percent for any individual insured subject to the rate increase, in which case the department shall hold a hearing upon a timely request for a hearing.

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

10180.10. 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) For purposes of Sections 11512 and 11517 of the Government Code, the hearing shall be conducted by an administrative law judge 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 conducted 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 an 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.

10180.11. (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.

10180.12. (a) 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.

(b) If the commissioner finds that a health insurer has violated this article, the commissioner may order that insurer to pay a civil penalty, in addition to any other penalties that may be prescribed by law, which may be recovered in a civil action, in an amount not exceeding fifty thousand dollars ($50,000), but if the violation is willful, the insurer shall be liable for an amount not exceeding one hundred thousand dollars ($100,000). In determining the amount of a civil penalty to be paid under this subdivision, the commissioner shall consider the gravity of the violation, the history of previous violations by the insurer, and any other factors the commissioner deems relevant.

(c) Moneys collected under this section shall be deposited in the fund specified in Section 10180.13.

10180.13. (a) The department may charge a health insurer a fee for the actual and reasonable costs related to filing and reviewing an application 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. Moneys in the fund shall be available to the department, upon appropriation by the Legislature, for the sole purpose of implementing this article.

10180.14. (a) On or before July 1, 2012, the commissioner may issue guidance to health insurers regarding compliance with

this article. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) The department shall consult with the Department of Managed Health Care in issuing guidance under subdivision (a), in adopting necessary regulations, in posting information on its Internet Web site under this article, and in taking any other action for the purpose of implementing this article.

(c) 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, 2013.

10180.15. (a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, the department may review any rate to ensure compliance with this article.

(b) The department shall report to the Legislature at least semiannually on all rate applications approved, modified, or denied under this article. The report required pursuant to this subdivision shall be submitted pursuant to the procedures specified under Section 9795 of the Government Code.

(c) The department shall post on its Internet Web site any changes submitted by an insurer to a rate application, including any documentation submitted by the insurer supporting those changes.

(d) The department shall post on its Internet Web site whether it approved, denied, or modified a proposed rate change pursuant to this article.

(e) If the department finds that a rate change is excessive, inadequate, or unfairly discriminatory, or that a rate application contains inaccurate information, the department shall post its finding on its Internet Web site.

(f) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this chapter.

SEC. 5. 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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