

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:

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) California consumers *and businesses* are facing excessive
- 4 health insurance premium increases, placing health insurance out
- 5 of the reach of millions of families.
- 6 (b) Consumers are experiencing significant insurance rate
- 7 escalations: from 1999 to 2009, health insurance premiums for
- 8 families rose 131 percent, while the general rate of inflation
- 9 increased just 28 percent during the same period (according to a
- 10 report by the Kaiser Family Foundation).
- 11 (c) More than 8.2 million Californians are uninsured, or one in
- 12 four Californians under 65 years of age.
- 13 (d) Uninsured individuals delay preventative care, leading to
- 14 worse health outcomes and costly visits to overcrowded emergency
- 15 rooms.
- 16 (e) The State of California should have the authority to minimize
- 17 families' loss of health insurance coverage as a result of steeply
- 18 rising premium costs.
- 19 (f) The federal Patient Protection and Affordable Care Act
- 20 (Public Law 111-148) allows the federal government to work with
- 21 states to examine "unreasonable increases" in the premiums
- 22 charged for some individual and small group health plans, and has
- 23 allotted two hundred fifty million dollars (\$250,000,000) for state
- 24 insurance departments to improve their process for reviewing
- 25 proposed rate increases.

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

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

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

13
 14 *Article 6.1. Approval of Rates*

15
 16 1385.001. For purposes of this article, the following definitions
 17 shall apply:

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

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

26 1385.002. (a) No rate shall be approved or remain in effect
 27 that is found to be excessive, inadequate, unfairly discriminatory,
 28 or otherwise in violation of this article.

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

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

1 1385.003. (a) *This article shall apply to health care service*
2 *plan contracts offered in the individual or group market in*
3 *California. However, this article shall not apply to a specialized*
4 *health care service plan contract, a Medicare supplement contract*
5 *subject to Article 3.5 (commencing with Section 1358.1); a health*
6 *care service plan contract offered in the Medi-Cal program*
7 *(Chapter 7 (commencing with Section 14000) of Part 3 of Division*
8 *9 of the Welfare and Institutions Code); a health care service plan*
9 *contract offered in the Healthy Families Program (Part 6.2*
10 *(commencing with Section 12693) of Division 2 of the Insurance*
11 *Code), the Access for Infants and Mothers Program (Part 6.3*
12 *(commencing with Section 12695) of Division 2 of the Insurance*
13 *Code), the California Major Risk Medical Insurance Program*
14 *(Part 6.5 (commencing with Section 12700) of Division 2 of the*
15 *Insurance Code), or the Federal Temporary High Risk Pool (Part*
16 *6.6 (commencing with Section 12739.5) of Division 2 of the*
17 *Insurance Code); a health care service plan conversion contract*
18 *offered pursuant to Section 1373.6; or a health care service plan*
19 *contract offered to a federally eligible defined individual under*
20 *Article 4.6 (commencing with Section 1366.35) or Article 10.5*
21 *(commencing with Section 1399.801).*

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

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

33 1385.004. (a) *For individual or small group health care service*
34 *plan contracts, all health care service plans shall file with the*
35 *department a complete rate application for any proposed rate*
36 *change or rate for a new product that would become effective on*
37 *or after January 1, 2012. The rate application shall be filed at*
38 *least 60 days prior to the proposed effective date of the proposed*
39 *rate.*

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

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

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

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

13 (3) Highest and lowest rate of change.

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

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

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

21 (7) The overhead loss ratio, reserves, excess tangible net equity,
22 surpluses, profitability, reinsurance, dividends, and investment
23 income that exist and would result if the application is approved;
24 the financial condition of the health care service plan for at least
25 the past five years, or total years in existence if less than five years,
26 including, but not limited to, the financial performance for at least
27 the past five years of the plan's statewide individual or small group
28 market business, and the plan's overall statewide business; and
29 the financial performance for at least the past five years of the
30 block of business subject to the proposed rate change, including,
31 but not limited to, past and projected profits, surplus, reserves,
32 investment income, and reinsurance applicable to the block. For
33 the purposes of this section, "overhead loss ratio" means the ratio
34 of revenue dedicated to all nonmedical expenses and expenditures,
35 including profit, to revenue dedicated to medical expenses. A
36 medical expense is any payment to a hospital, physician and
37 surgeon, or other provider for the provision of medical care or
38 health care services directly to, or for the benefit of, the enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 1385.005. (a) For large group health care service plan
2 contracts, all large group health care service plans shall file with
3 the department a complete rate application for any proposed rate
4 change or rate for a new product that would become effective on
5 or after January 1, 2012. The rate application shall be filed at
6 least 60 days prior to the proposed effective date of the proposed
7 rate.
- 8 (b) No health care service plan shall submit a rate application
9 within one year of the date of implementation of the most recently
10 approved rate change for each product in the large group market.
- 11 (c) A health care service plan shall disclose to the department
12 all of the following for each large group rate application:
- 13 (1) Company name and contact information.
 - 14 (2) Number of plan contract forms covered by the application.
 - 15 (3) Plan contract form numbers covered by the application.
 - 16 (4) Product type, such as a preferred provider organization or
17 health maintenance organization.
 - 18 (5) Segment type.
 - 19 (6) Type of plan involved, such as for profit or not for profit.
 - 20 (7) Whether the products are opened or closed.
 - 21 (8) Enrollment in each plan contract and rating form.
 - 22 (9) Enrollee months in each plan contract form.
 - 23 (10) Annual rate.
 - 24 (11) Total earned premiums in each plan contract form.
 - 25 (12) Total incurred claims in each plan contract form.
 - 26 (13) Average rate change initially requested.
 - 27 (14) Highest and lowest rate change initially requested for a
28 group.
 - 29 (15) Review category: initial application for a new product,
30 application for an existing product, or resubmission of an
31 application.
 - 32 (16) Average rate of change.
 - 33 (17) Highest and lowest rate of change.
 - 34 (18) Proposed effective date of the proposed rate change.
 - 35 (19) Five-year rate change history for the population affected
36 by the proposed rate change.
 - 37 (20) The rate of return that would result if the rate application
38 were approved.
 - 39 (21) Number of subscribers or enrollees affected by each plan
40 contract form.

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

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

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

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

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

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

38 (28) *Any changes in administrative costs.*

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

1 investment income that exist and will result if the application is
2 approved; the financial condition of the health care service plan
3 for at least the past five years, or total years in existence if less
4 than five years, including, but not limited to, the financial
5 performance for at least the past five years of the plan's statewide
6 large group market business, and the plan's overall statewide
7 business; and the financial performance for at least the past five
8 years of the block of business subject to the proposed rate change,
9 including, but not limited to, past and projected profits, surplus,
10 reserves, investment income, and reinsurance applicable to the
11 block. For the purposes of this section, "overhead loss ratio"
12 means the ratio of revenue dedicated to all nonmedical expenses
13 and expenditures, including profit, to revenue dedicated to medical
14 expenses. A medical expense is any payment to a hospital,
15 physician and surgeon, or other provider for the provision of
16 medical care or health care services directly to, or for the benefit
17 of, the enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 1385.006. *Notwithstanding any provision in a contract between*
27 *a health care service plan and a provider, the department may*
28 *request from a health care service plan, and the health care service*
29 *plan shall provide, any information required under this article or*
30 *the federal Patient Protection and Affordable Care Act (Public*
31 *Law 111-148).*

32 1385.007. *A rate by a health care service plan that became*
33 *effective during the period January 1, 2011, to December 31, 2011,*
34 *inclusive, shall be subject to review by the department for*
35 *compliance with this article. The department shall order the refund*
36 *of payments made pursuant to any such rate, to the extent the*
37 *department finds the rate to be excessive, inadequate, or unfairly*
38 *discriminatory.*

39 1385.008. (a) *Notwithstanding Chapter 3.5 (commencing with*
40 *Section 6250) of Division 7 of Title 1 of the Government Code, all*

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

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

11 (2) The contracted rates between a health care service plan and
12 a large group subscriber shall be deemed confidential information
13 that shall not be made public by the department and are exempt
14 from disclosure under the California Public Records Act (Chapter
15 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the
16 Government Code).

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

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

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

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

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

35 1385.009. (a) The department shall notify the public of any
36 rate application by a health care service plan.

37 (b) If the application process in Section 1385.004 or 1385.005
38 has been followed, the department shall issue a decision within
39 60 days after the date of the public notice provided under
40 subdivision (a), unless the department and the applicant agree to

1 waive the 60-day period or the department notices a public hearing
2 on the application. If the department holds a hearing on the
3 application, the department shall issue a decision and findings
4 within a reasonable time after the hearing. The department shall
5 hold a hearing on any of the following grounds:

6 (1) A consumer, or his or her representative, requests a hearing
7 within 45 days of the date of the public notice, and the department
8 grants the request for a hearing. If the department denies the
9 request for a hearing, it shall issue written findings in support of
10 that decision.

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

13 (3) The proposed change would exceed 10 percent of the amount
14 of the current rate under the health care service plan contract, or
15 would exceed 15 percent for any individual enrollee subject to the
16 rate increase, in which case the department shall hold a hearing
17 upon a timely request for a hearing.

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

23 1385.010. All hearings under this article shall be conducted
24 pursuant to the provisions of Chapter 5 (commencing with Section
25 11500) of Part 1 of Division 3 of Title 2 of the Government Code,
26 with the following exceptions:

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

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

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

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

1 (e) *Judicial review shall be conducted in accordance with the*
2 *requirements, standards, and procedures set forth in Section 1858.6*
3 *of the Insurance Code. For purposes of judicial review, a decision*
4 *by the department to hold a hearing on the application is not a*
5 *final order or decision; however, a decision not to hold a hearing*
6 *on an application is a final order or decision for purposes of*
7 *judicial review.*

8 1385.011. (a) *A person may initiate or intervene in any*
9 *proceeding permitted or established pursuant to this article,*
10 *challenge any action of the department under this article, and*
11 *enforce any provision of this article on behalf of himself or herself*
12 *or members of the public.*

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

17 (A) *The person represents the interests of consumers.*

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

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

23 1385.012. (a) *A violation of this article is subject to the*
24 *penalties set forth in Sections 1386 and 1390.*

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

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

38 1385.015. (a) *The department may charge a health care service*
39 *plan a fee for the actual and reasonable costs related to filing and*
40 *reviewing an application under this article.*

1 (b) *The fees shall be deposited into the Department of Managed*
2 *Health Care Health Rate Approval Fund, which is hereby created*
3 *in the State Treasury. Moneys in the fund shall be available to the*
4 *department, upon appropriation by the Legislature, for the sole*
5 *purpose of implementing this article.*

6 1385.014. (a) *On or before July 1, 2012, the director may*
7 *issue guidance to health care service plans regarding compliance*
8 *with this article. This guidance shall not be subject to the*
9 *Administrative Procedure Act (Chapter 3.5 (commencing with*
10 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
11 *Code)*

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

17 (c) *The department, working in coordination with the*
18 *Department of Insurance, shall have all necessary and proper*
19 *powers to implement this article and shall adopt regulations to*
20 *implement this article no later than January 1, 2013.*

21 1395.015. (a) *Whenever it appears to the department that any*
22 *person has engaged, or is about to engage, in any act or practice*
23 *constituting a violation of this article, the department may review*
24 *any rate to ensure compliance with this article.*

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

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

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

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

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

4 SEC. 3. *Section 1386 of the Health and Safety Code is amended*
5 *to read:*

6 1386. (a) The director may, after appropriate notice and
7 opportunity for a hearing, by order suspend or revoke any license
8 issued under this chapter to a health care service plan or assess
9 administrative penalties if the director determines that the licensee
10 has committed any of the acts or omissions constituting grounds
11 for disciplinary action.

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

14 (1) The plan is operating at variance with the basic
15 organizational documents as filed pursuant to Section 1351 or
16 1352, or with its published plan, or in any manner contrary to that
17 described in, and reasonably inferred from, the plan as contained
18 in its application for licensure and annual report, or any
19 modification thereof, unless amendments allowing the variation
20 have been submitted to, and approved by, the director.

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

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

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

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

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

38 (7) The plan has engaged in any conduct that constitutes fraud
39 or dishonest dealing or unfair competition, as defined by Section
40 17200 of the Business and Professions Code.

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

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

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

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

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

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

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

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

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

38 (17) The plan violates Section 1262.8.

39 (18) *The plan has failed to comply with the requirements of*
40 *Article 6.1 (commencing with Section 1385.001).*

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

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

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

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

18 (d) A proceeding under this section shall be subject to
 19 appropriate notice to, and the opportunity for a hearing with regard
 20 to, the person affected in accordance with subdivision (a) of Section
 21 1397.

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

25
 26 *Article 4.4. Approval of Rates*
 27

28 *10180.1. For purposes of this article, the following definitions*
 29 *shall apply:*

30 (a) *“Applicant” means a health insurer seeking to change the*
 31 *rate it charges its policyholders or to set a rate for a new product.*

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

37 *10180.2. (a) No rate shall be approved or remain in effect*
 38 *that is found to be excessive, inadequate, unfairly discriminatory,*
 39 *or otherwise in violation of this article.*

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

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

12 10180.3. (a) This article shall apply to health insurance
13 policies offered in the individual or group market in California.
14 However, this article shall not apply to a specialized health
15 insurance policy; a Medicare supplement policy subject to Article
16 6 (commencing with Section 10192.05); a health insurance policy
17 offered in the Medi-Cal program (Chapter 7 (commencing with
18 Section 14000) of Part 3 of Division 9 of the Welfare and
19 Institutions Code); a health insurance policy offered in the Healthy
20 Families Program (Part 6.2 (commencing with Section 12693)),
21 the Access for Infants and Mothers Program (Part 6.3
22 (commencing with Section 12695)), the California Major Risk
23 Medical Insurance Program (Part 6.5 (commencing with Section
24 12700)), or the Federal Temporary High Risk Pool (Part 6.6
25 (commencing with Section 12739.5)); a health insurance
26 conversion policy offered pursuant to Section 12682.1; or a health
27 insurance policy offered to a federally eligible defined individual
28 under Chapter 9.5 (commencing with Section 10900).

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

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

1 10180.4. (a) For individual or small group health insurance
2 policies, all health insurers shall file with the department a
3 complete rate application for any proposed rate change or rate
4 for a new product that would become effective on or after January
5 1, 2012. The rate application shall be filed at least 60 days prior
6 to the proposed effective date of the proposed rate.

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

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

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

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

18 (3) Highest and lowest rate of change.

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

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

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

26 (7) The overhead loss ratio, reserves, excess tangible net equity,
27 surpluses, profitability, reinsurance, dividends, and investment
28 income that exist and would result if the application is approved;
29 the financial condition of the health insurer for at least the past
30 five years, or total years in existence if less than five years,
31 including, but not limited to, the financial performance for at least
32 the past five years of the insurer's statewide individual or small
33 group market business, and the insurer's overall statewide
34 business; and the financial performance for at least the past five
35 years of the block of business subject to the proposed rate change,
36 including, but not limited to, past and projected profits, surplus,
37 reserves, investment income, and reinsurance applicable to the
38 block. For the purposes of this section, "overhead loss ratio"
39 means the ratio of revenue dedicated to all nonmedical expenses
40 and expenditures, including profit, to revenue dedicated to medical

1 *expenses. A medical expense is any payment to a hospital,*
2 *physician and surgeon, or other provider for the provision of*
3 *medical care or health care services directly to, or for the benefit*
4 *of, the insured.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 *10180.5. (a) For large group health insurance policies, all*
8 *large group health insurers shall file with the department a*
9 *complete rate application for any proposed rate change or rate*
10 *for a new product that would become effective on or after January*
11 *1, 2012. The rate application shall be filed at least 60 days prior*
12 *to the proposed effective date of the proposed rate.*

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

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

18 *(1) Company name and contact information.*

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

20 *(3) Policy form numbers covered by the application.*

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

23 *(5) Segment type.*

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

25 *(7) Whether the products are opened or closed.*

26 *(8) Enrollment in each policy and rating form.*

27 *(9) Insured months in each policy form.*

28 *(10) Annual rate.*

29 *(11) Total earned premiums in each policy form.*

30 *(12) Total incurred claims in each policy form.*

31 *(13) Average rate change initially requested.*

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

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

37 *(16) Average rate of change.*

38 *(17) Highest and lowest rate of change.*

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

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

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

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

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

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

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

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

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

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

30 (28) *Any changes in administrative costs.*

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

1 limited to, past and projected profits, surplus, reserves, investment
2 income, and reinsurance applicable to the block. For the purposes
3 of this section, “overhead loss ratio” means the ratio of revenue
4 dedicated to all nonmedical expenses and expenditures, including
5 profit, to revenue dedicated to medical expenses. A medical expense
6 is any payment to a hospital, physician and surgeon, or other
7 provider for the provision of medical care or health care services
8 directly to, or for the benefit of, the insured.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 10180.6. *Notwithstanding any provision in a contract between*
19 *a health insurer and a provider, the department may request from*
20 *a health insurer, and the health insurer shall provide, any*
21 *information required under this article or the federal Patient*
22 *Protection and Affordable Care Act (Public Law 111-148).*

23 10180.7. *A rate change by a health insurer that became*
24 *effective during the period January 1, 2011, to December 31, 2011,*
25 *inclusive, shall be subject to review by the department for*
26 *compliance with this article. The department shall order the refund*
27 *of payments made pursuant to any such rate, to the extent the*
28 *department finds the rate to be excessive, inadequate, or unfairly*
29 *discriminatory.*

30 10180.8. (a) *Notwithstanding Chapter 3.5 (commencing with*
31 *Section 6250) of Division 7 of Title 1 of the Government Code, all*
32 *information submitted under this article shall be made publicly*
33 *available by the department, except as provided in subdivision (b).*
34 *Subdivision (d) of Section 6254 of the Government Code shall not*
35 *apply to a public record under this article.*

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

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

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

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

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

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

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

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

27 10180.9. (a) The department shall notify the public of any rate
28 application by a health insurer.

29 (b) If the application process in Section 10180.4 or 10180.5 has
30 been followed, the department shall issue a decision within 60
31 days after the date of the public notice provided under subdivision
32 (a), unless the department and the applicant agree to waive the
33 60-day period or the department notices a public hearing on the
34 application. If the department holds a hearing on the application,
35 the department shall issue a decision and findings within a
36 reasonable time after the hearing. The department shall hold a
37 hearing on any of the following grounds:

38 (1) A consumer, or his or her representative, requests a hearing
39 within 45 days of the date of the public notice, and the department
40 grants the request for a hearing. If the department denies the

1 *request for a hearing, it shall issue written findings in support of*
2 *that decision.*

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

5 *(3) The proposed change would exceed 10 percent of the amount*
6 *of the current rate under the plan contract, or would exceed 15*
7 *percent for any individual insured subject to the rate increase, in*
8 *which case the department shall hold a hearing upon a timely*
9 *request for a hearing.*

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

15 *10180.10. All hearings under this article shall be conducted*
16 *pursuant to the provisions of Chapter 5 (commencing with Section*
17 *11500) of Part 1 of Division 3 of Title 2 of the Government Code,*
18 *with the following exceptions:*

19 *(a) For purposes of Sections 11512 and 11517 of the*
20 *Government Code, the hearing shall be conducted by an*
21 *administrative law judge appointed pursuant to Section 11502 of*
22 *the Government Code or by the commissioner.*

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

25 *(c) The commissioner shall adopt, amend, or reject a decision*
26 *only under Section 11518.5 of the Government Code and*
27 *subdivisions (b) and (c) of Section 11517 of the Government Code*
28 *and solely on the basis of the record as provided in Section*
29 *11425.50 of the Government Code.*

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

33 *(e) Judicial review shall be conducted in accordance with*
34 *Section 1858.6 of the Insurance Code. For purposes of judicial*
35 *review, a decision by the department to hold a hearing on an*
36 *application is not a final order or decision; however, a decision*
37 *not to hold a hearing on an application is a final order or decision*
38 *for purposes of judicial review.*

39 *10180.11. (a) A person may initiate or intervene in any*
40 *proceeding permitted or established pursuant to this article,*

1 challenge any action of the department under this article, and
2 enforce any provision of this article on behalf of himself or herself
3 or members of the public.

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

8 (A) The person represents the interests of consumers.

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

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

14 10180.12. (a) A violation of this article is subject to the
15 penalties set forth in Section 1859.1. The commissioner may also
16 suspend or revoke in whole or in part the certificate of authority
17 of a health insurer for a violation of this article.

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

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

31 10180.13. (a) The department may charge a health insurer a
32 fee for the actual and reasonable costs related to filing and
33 reviewing an application under this article.

34 (b) The fees shall be deposited into the Department of Insurance
35 Health Rate Approval Fund, which is hereby created in the State
36 Treasury. Moneys in the fund shall be available to the department,
37 upon appropriation by the Legislature, for the sole purpose of
38 implementing this article.

39 10180.14. (a) On or before July 1, 2012, the commissioner
40 may issue guidance to health insurers regarding compliance with

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

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

9 *(c) The department, working in coordination with the*
10 *Department of Managed Health Care, shall have all necessary*
11 *and proper powers to implement this article and shall adopt*
12 *regulations to implement this article no later than January 1, 2013.*

13 *10180.15. (a) Whenever it appears to the department that any*
14 *person has engaged, or is about to engage, in any act or practice*
15 *constituting a violation of this article, the department may review*
16 *any rate to ensure compliance with this article.*

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

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

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

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

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

36 *SEC. 5. No reimbursement is required by this act pursuant to*
37 *Section 6 of Article XIII B of the California Constitution because*
38 *the only costs that may be incurred by a local agency or school*
39 *district will be incurred because this act creates a new crime or*
40 *infraction, eliminates a crime or infraction, or changes the penalty*

1 *for a crime or infraction, within the meaning of Section 17556 of*
2 *the Government Code, or changes the definition of a crime within*
3 *the meaning of Section 6 of Article XIII B of the California*
4 *Constitution.*

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