

AMENDED IN ASSEMBLY MAY 3, 2011

AMENDED IN ASSEMBLY MARCH 25, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 52

Introduced by Assembly Members Feuer and Huffman

(Principal coauthor: Senator Leno)

(Coauthor: Senator DeSaulnier)

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, 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 provides for the regulation of health insurers by the Department of Insurance. Under existing law, no change in premium rates or coverage in a health care service plan or a health insurance policy may become effective without prior written notification of the change to the contractholder or policyholder. Existing law prohibits a health care service plan 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 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: yes.
State-mandated local program: 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.

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

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

Article 6.1. Approval of Rates

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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~~, *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

1 Insurance Code), or the Federal Temporary High Risk Pool (Part
2 6.6 (commencing with Section 12739.5) of Division 2 of the
3 Insurance Code); a health care service plan conversion contract
4 offered pursuant to Section 1373.6; or a health care service plan
5 contract offered to a federally eligible defined individual under
6 Article 4.6 (commencing with Section 1366.35) or Article 10.5
7 (commencing with Section 1399.801).

8 (b) The department shall review a rate application pursuant to
9 regulations it promulgates to determine excessive, inadequate, or
10 unfairly discriminatory rates. ~~Such reviews~~ *The review* shall
11 consider, but not be limited to, medical expenses and all
12 nonmedical expenses, including, but not limited to, the rate of
13 return, overhead, and administration, and surplus, reserves,
14 investment income, and any information submitted under Section
15 1385.004 or 1385.005.

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

20 1385.004. (a) For individual or small group health care service
21 plan contracts, all health care service plans shall file with the
22 department a complete rate application for any proposed rate
23 change or rate for a new product that would become effective on
24 or after January 1, 2012. The rate application shall be filed at least
25 60 days prior to the proposed effective date of the proposed rate.

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

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

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

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

38 (3) Highest and lowest rate of change.

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

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

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

6 (7) The overhead loss ratio, reserves, excess tangible net equity,
7 surpluses, profitability, reinsurance, dividends, and investment
8 income that exist and would result if the application is approved;
9 the financial condition of the health care service plan for at least
10 the past five years, or total years in existence if less than five years,
11 including, but not limited to, the financial performance for at least
12 the past five years of the plan's statewide individual or small group
13 market business, and the plan's overall statewide business; and
14 the financial performance for at least the past five years of the
15 block of business subject to the proposed rate change, including,
16 but not limited to, past and projected profits, surplus, reserves,
17 investment income, and reinsurance applicable to the block. For
18 the purposes of this section, "overhead loss ratio" means the ratio
19 of revenue dedicated to all nonmedical expenses and expenditures,
20 including profit, to revenue dedicated to medical expenses. A
21 medical expense is any payment to a hospital, physician and
22 surgeon, or other provider for the provision of medical care or
23 health care services directly to, or for the benefit of, the enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 1385.005. (a) For large group health care service plan
26 contracts, all large group health care service plans shall file with
27 the department a complete rate application for any proposed rate
28 change or rate for a new product that would become effective on
29 or after January 1, 2012. The rate application shall be filed at least
30 60 days prior to the proposed effective date of the proposed rate.

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

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

- 37 (1) Company name and contact information.
38 (2) Number of plan contract forms covered by the application.
39 (3) Plan contract form numbers covered by the application.

- 1 (4) Product type, such as a preferred provider organization or
- 2 health maintenance organization.
- 3 (5) Segment type.
- 4 (6) Type of plan involved, such as for profit or not for profit.
- 5 (7) Whether the products are opened or closed.
- 6 ~~(8) Enrollment~~
- 7 (8) *Enrollment* in each plan contract and rating form.
- 8 (9) Enrollee months in each plan contract form.
- 9 (10) Annual rate.
- 10 (11) Total earned premiums in each plan contract form.
- 11 (12) Total incurred claims in each plan contract form.
- 12 (13) Average rate change initially requested.
- 13 (14) Highest and lowest rate change initially requested for a
- 14 group.
- 15 (15) Review category: initial application for a new product,
- 16 application for an existing product, or resubmission of an
- 17 application.
- 18 (16) Average rate of change.
- 19 (17) Highest and lowest rate of change.
- 20 (18) Proposed effective date of the proposed rate change.
- 21 (19) Five-year rate change history for the population affected
- 22 by the proposed rate change.
- 23 (20) The rate of return that would result if the rate application
- 24 were approved.
- 25 (21) Number of subscribers or enrollees affected by each plan
- 26 contract form.
- 27 (22) The average rate change per affected enrollee or group that
- 28 would result from approval of the application, as well as the lowest
- 29 and highest rate increase that would result for any enrollee.
- 30 (23) The plan's overall annual medical trend factor assumptions
- 31 in each rate application for all benefits and by aggregate benefit
- 32 category, including hospital inpatient, hospital outpatient, physician
- 33 and surgeon services, prescription drugs and other ancillary
- 34 services, laboratory, and radiology. A plan may provide aggregated
- 35 additional data that demonstrates or reasonably estimates
- 36 year-to-year cost increases in specific benefit categories in major
- 37 geographic regions of the state. For purposes of this paragraph,
- 38 "major geographic region" shall be defined by the department and
- 39 shall include no more than nine regions. A health plan that
- 40 exclusively contracts with no more than two medical groups in the

1 state to provide or arrange for professional medical services for
2 the enrollees of the plan shall instead disclose the amount of its
3 actual trend experience for the prior contract year by aggregate
4 benefit category, using benefit categories that are, to the maximum
5 extent possible, the same or similar to those used by other plans.

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

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

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

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

23 (28) Any changes in administrative costs.

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

1 other provider for the provision of medical care or health care
2 services directly to, or for the benefit of, the enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (d) A *health care service* plan shall also submit any other
39 information required pursuant to any regulation adopted by the
40 department to comply with this article and related regulations.

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

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

10 1385.006. Notwithstanding any provision in a contract between
11 a health care service plan and a provider, the department may
12 request from a health care service plan, and the health care service
13 plan shall provide, any information required under this article or
14 the federal Patient Protection and Affordable Care Act (Public
15 Law 111-148).

16 1385.007. A rate by a health care service plan that became
17 effective during the period January 1, 2011, to December 31, 2011,
18 inclusive, shall be subject to review by the department for
19 compliance with this article. The department shall order the refund
20 of payments made pursuant to any such rate, to the extent the
21 department finds the rate to be excessive, inadequate, or unfairly
22 discriminatory.

23 1385.008. (a) Notwithstanding Chapter 3.5 (commencing with
24 Section 6250) of Division 7 of Title 1 of the Government Code,
25 all information submitted under this article shall be made publicly
26 available by the department, except as provided in subdivision (b).
27 Subdivision (d) of Section 6254 of the Government Code shall not
28 apply to a public record under this article.

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

35 (2) The contracted rates between a health care service plan and
36 a large group subscriber shall be deemed confidential information
37 that shall not be made public by the department and are exempt
38 from disclosure under the California Public Records Act (Chapter
39 3.5 (commencing with Section 6250) of Division 7 of Title 1 of
40 the Government Code).

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

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

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

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

15 (e) The department shall accept and post to its Internet Web site
16 any public comment on a proposed rate submitted to the department
17 during the 60-day period described in subdivision (a) of Section
18 1385.004 or subdivision (a) of Section 1385.005.

19 1385.009. (a) The department shall notify the public of any
20 rate application by a health care service plan.

21 (b) If the application process in Section 1385.004 or 1385.005
22 has been followed, the department shall issue a decision within 60
23 days after the date of the public notice provided under subdivision
24 (a), unless the department and the applicant agree to waive the
25 60-day period or the department notices a public hearing on the
26 application. If the department holds a hearing on the application,
27 the department shall issue a decision and findings within—
28 ~~reasonable time~~ *100 days* after the hearing. The department shall
29 hold a hearing on any of the following grounds:

30 (1) A consumer, or his or her representative, requests a hearing
31 within 45 days of the date of the public notice, and the department
32 grants the request for a hearing. If the department denies the request
33 for a hearing, it shall issue written findings in support of that
34 decision.

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

37 (3) The proposed change would exceed 10 percent of the amount
38 of the current rate under the health care service plan contract, or
39 would exceed 15 percent for any individual enrollee subject to the

1 rate increase, in which case the department shall hold a hearing
2 upon a timely request for a hearing.

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

8 1385.010. All hearings under this article shall be conducted
9 pursuant to the provisions of Chapter 5 (commencing with Section
10 11500) of Part 1 of Division 3 of Title 2 of the Government Code,
11 with the following exceptions:

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

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

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

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

26 (e) Judicial review shall be conducted in accordance with the
27 requirements, standards, and procedures set forth in Section 1858.6
28 of the Insurance Code. For purposes of judicial review, a decision
29 by the department to hold a hearing on the application is not a final
30 order or decision; however, a decision not to hold a hearing on an
31 application is a final order or decision for purposes of judicial
32 review.

33 1385.011. (a) A person may initiate or intervene in any
34 proceeding permitted or established pursuant to this article,
35 challenge any action of the department under this article, and
36 enforce any provision of this article on behalf of himself or herself
37 or members of the public.

38 (b) (1) The department or a court shall award reasonable
39 advocacy fees and costs, including witness fees, in a proceeding

1 described in subdivision (a) to a person who demonstrates both of
2 the following:

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

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

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

9 1385.012. (a) A violation of this article is subject to the
10 penalties set forth in Sections 1386 and 1390.

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

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

24 ~~1385.015.~~

25 *1385.013.* (a) The department may charge a health care service
26 plan a fee for the actual and reasonable costs related to filing and
27 reviewing an application under this article.

28 (b) The fees shall be deposited into the Department of Managed
29 Health Care Health Rate Approval Fund, which is hereby created
30 in the State Treasury. Moneys in the fund shall be available to the
31 department, upon appropriation by the Legislature, for the sole
32 purpose of implementing this article.

33 1385.014. (a) On or before July 1, 2012, the director may issue
34 guidance to health care service plans regarding compliance with
35 this article. This guidance shall not be subject to the Administrative
36 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
37 Part 1 of Division 3 of Title 2 of the Government Code).

38 (b) The department shall consult with the Department of
39 Insurance in issuing guidance under subdivision (a), in adopting
40 necessary regulations, in posting information on its Internet Web

1 site under this article, and in taking any other action for the purpose
2 of implementing this article.

3 (c) The department, working in coordination with the
4 Department of Insurance, shall have all necessary and proper
5 powers to implement this article and shall adopt regulations to
6 implement this article no later than January 1, 2013.

7 ~~1395.015.~~

8 *1385.015.* (a) Whenever it appears to the department that any
9 person has engaged, or is about to engage, in any act or practice
10 constituting a violation of this article, the department may review
11 any rate to ensure compliance with this article.

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

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

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

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

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

30 SEC. 3. Section 1386 of the Health and Safety Code is amended
31 to read:

32 1386. (a) The director may, after appropriate notice and
33 opportunity for a hearing, by order suspend or revoke any license
34 issued under this chapter to a health care service plan or assess
35 administrative penalties if the director determines that the licensee
36 has committed any of the acts or omissions constituting grounds
37 for disciplinary action.

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

- 1 (1) The plan is operating at variance with the basic
2 organizational documents as filed pursuant to Section 1351 or
3 1352, or with its published plan, or in any manner contrary to that
4 described in, and reasonably inferred from, the plan as contained
5 in its application for licensure and annual report, or any
6 modification thereof, unless amendments allowing the variation
7 have been submitted to, and approved by, the director.
- 8 (2) The plan has issued, or permits others to use, evidence of
9 coverage or uses a schedule of charges for health care services that
10 do not comply with those published in the latest evidence of
11 coverage found unobjectionable by the director.
- 12 (3) The plan does not provide basic health care services to its
13 enrollees and subscribers as set forth in the evidence of coverage.
14 This subdivision shall not apply to specialized health care service
15 plan contracts.
- 16 (4) The plan is no longer able to meet the standards set forth in
17 Article 5 (commencing with Section 1367).
- 18 (5) The continued operation of the plan will constitute a
19 substantial risk to its subscribers and enrollees.
- 20 (6) The plan has violated or attempted to violate, or conspired
21 to violate, directly or indirectly, or assisted in or abetted a violation
22 or conspiracy to violate any provision of this chapter, any rule or
23 regulation adopted by the director pursuant to this chapter, or any
24 order issued by the director pursuant to this chapter.
- 25 (7) The plan has engaged in any conduct that constitutes fraud
26 or dishonest dealing or unfair competition, as defined by Section
27 17200 of the Business and Professions Code.
- 28 (8) The plan has permitted, or aided or abetted any violation by
29 an employee or contractor who is a holder of any certificate,
30 license, permit, registration, or exemption issued pursuant to the
31 Business and Professions Code or this code that would constitute
32 grounds for discipline against the certificate, license, permit,
33 registration, or exemption.
- 34 (9) The plan has aided or abetted or permitted the commission
35 of any illegal act.
- 36 (10) The engagement of a person as an officer, director,
37 employee, associate, or provider of the plan contrary to the
38 provisions of an order issued by the director pursuant to subdivision
39 (c) of this section or subdivision (d) of Section 1388.

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

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

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

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

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

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

26 (17) The plan violates Section 1262.8.

27 (18) The plan has failed to comply with the requirements of
28 Article 6.1 (commencing with Section 1385.001).

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

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

36 (B) The person was an officer, director, employee, associate,
37 or provider of a plan or of a management company or solicitor
38 firm of any plan whose license has been suspended or revoked
39 pursuant to this section and the person had knowledge of, or

1 participated in, any of the prohibited acts for which the license
2 was suspended or revoked.

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

7 (d) A proceeding under this section shall be subject to
8 appropriate notice to, and the opportunity for a hearing with regard
9 to, the person affected in accordance with subdivision (a) of Section
10 1397.

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

14
15 Article 4.4. Approval of Rates

16
17 10180.1. For purposes of this article, the following definitions
18 shall apply:

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

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

26 10180.2. (a) No rate shall be approved or remain in effect that
27 is found to be excessive, inadequate, unfairly discriminatory, or
28 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 policyholders, unless it submits an
31 application to the department and the application is approved by
32 the department.

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

1 10180.3. (a) This article shall apply to health insurance policies
2 offered in the individual or group market in California. However,
3 this article shall not apply to a specialized health insurance policy;
4 a Medicare supplement policy subject to Article 6 (commencing
5 with Section 10192.05); a health insurance policy offered in the
6 Medi-Cal program (Chapter 7 (commencing with Section 14000)
7 of Part 3 of Division 9 of the Welfare and Institutions Code); a
8 health insurance policy offered in the Healthy Families Program
9 (Part 6.2 (commencing with Section 12693)), the Access for Infants
10 and Mothers Program (Part 6.3 (commencing with Section 12695)),
11 the California Major Risk Medical Insurance Program (Part 6.5
12 (commencing with Section 12700)), or the Federal Temporary
13 High Risk Pool (Part 6.6 (commencing with Section 12739.5)); a
14 health insurance conversion policy offered pursuant to Section
15 12682.1; or a health insurance policy offered to a federally eligible
16 defined individual under Chapter 9.5 (commencing with Section
17 10900).

18 (b) The department shall review a rate application pursuant to
19 regulations it promulgates to determine excessive, inadequate, or
20 unfairly discriminatory rates. ~~Such reviews~~ *The review* shall
21 consider, but not be limited to, medical expenses and all
22 nonmedical expenses, including, but not limited to, the rate of
23 return, overhead, and administration, and surplus, reserves,
24 investment income, and any information submitted under Section
25 10180.4 ~~and~~ *or* 10180.5.

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

30 10180.4. (a) For individual or small group health insurance
31 policies, all health insurers shall file with the department a
32 complete rate application for any proposed rate change or rate for
33 a new product that would become effective on or after January 1,
34 2012. The rate application shall be filed at least 60 days prior to
35 the proposed effective date of the proposed rate.

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

- 1 (c) An insurer shall disclose to the department all of the
2 following for each individual or small group rate application:
- 3 (1) All of the information required pursuant to subdivisions (b)
4 and (c) of Section 10181.3, except for the information set forth in
5 paragraph (23) of subdivision (b) of Section 10181.3.
- 6 (2) Highest and lowest rate change initially requested for an
7 individual or small group.
- 8 (3) Highest and lowest rate of change.
- 9 (4) Five-year rate change history for the population affected by
10 the proposed rate change.
- 11 (5) The rate of return that would result if the rate application
12 were approved.
- 13 (6) The average rate change per affected insured or group that
14 would result from approval of the application, as well as the lowest
15 and highest rate increase that would result for any insured.
- 16 (7) The overhead loss ratio, reserves, excess tangible net equity,
17 surpluses, profitability, reinsurance, dividends, and investment
18 income that exist and would result if the application is approved;
19 the financial condition of the health insurer for at least the past
20 five years, or total years in existence if less than five years,
21 including, but not limited to, the financial performance for at least
22 the past five years of the insurer's statewide individual or small
23 group market business, and the insurer's overall statewide business;
24 and the financial performance for at least the past five years of the
25 block of business subject to the proposed rate change, including,
26 but not limited to, past and projected profits, surplus, reserves,
27 investment income, and reinsurance applicable to the block. For
28 the purposes of this section, "overhead loss ratio" means the ratio
29 of revenue dedicated to all nonmedical expenses and expenditures,
30 including profit, to revenue dedicated to medical expenses. A
31 medical expense is any payment to a hospital, physician and
32 surgeon, or other provider for the provision of medical care or
33 health care services directly to, or for the benefit of, the insured.
- 34 (8) Salary and bonus compensation paid to the 10 highest paid
35 officers and employees of the applicant for the most recent fiscal
36 year.
- 37 (9) Dollar amounts of financial or capital disbursements or
38 transfers to affiliates, and dollar amounts of management
39 agreements and service contracts.

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

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

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

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

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

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

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

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

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

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

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

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

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

36 10180.5. (a) For large group health insurance policies, all large
37 group health insurers shall file with the department a complete
38 rate application for any proposed rate change or rate for a new
39 product that would become effective on or after January 1, 2012.

1 The rate application shall be filed at least 60 days prior to the
2 proposed effective date of the proposed rate.

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

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

9 (1) Company name and contact information.

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

11 (3) Policy form numbers covered by the application.

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

14 (5) Segment type.

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

16 (7) Whether the products are opened or closed.

17 (8) Enrollment in each policy and rating form.

18 (9) Insured months in each policy form.

19 (10) Annual rate.

20 (11) Total earned premiums in each policy form.

21 (12) Total incurred claims in each policy form.

22 (13) Average rate change initially requested.

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

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

28 (16) Average rate of change.

29 (17) Highest and lowest rate of change.

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

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

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

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

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

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

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

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

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

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

21 (28) Any changes in administrative costs.

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

- 1 (30) 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 (31) Dollar amounts of financial or capital disbursements or
5 transfers to affiliates and management agreements and service
6 contracts.
- 7 (32) 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 (33) A line-item report of medical expenses, including aggregate
11 totals paid to hospitals and physicians and surgeons.
- 12 (34) Compliance with medical loss ratio standards in effect
13 under federal or state law.
- 14 (35) Whether the insurer has complied with all federal and state
15 requirements for pooling risk and requirements for participation
16 in risk adjustment programs in effect under federal and state law.
- 17 (36) The insurer’s statement of purpose or mission in its
18 corporate charter or mission statement.
- 19 (37) Whether the insurer employs provider payment strategies
20 to enhance cost-effective utilization of appropriate services.
- 21 (38) Affordability of the insurance product or products subject
22 to the proposed rate change.
- 23 (39) Public comments received pertaining to the information
24 required in this section.
- 25 (40) All of the information required pursuant to subdivision (c)
26 of Section 10181.4.
- 27 (41) Any other information required under the federal Patient
28 Protection and Affordable Care Act (Public Law 111-148).
- 29 (42) The contracted rates between a health insurer and a
30 provider. Pursuant to Section 10180.8, these rates shall not be
31 disclosed to the public.
- 32 (43) The contracted rates between a health insurer and a large
33 group policyholder. Pursuant to Section 10180.8, these rates shall
34 not be disclosed to the public.
- 35 (44) Any other information deemed necessary by the
36 commissioner.
- 37 (d) An insurer shall also submit any other information required
38 pursuant to any regulation adopted by the department to comply
39 with this article and related regulations.

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

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

10 10180.6. Notwithstanding any provision in a contract between
11 a health insurer and a provider, the department may request from
12 a health insurer, and the health insurer shall provide, any
13 information required under this article or the federal Patient
14 Protection and Affordable Care Act (Public Law 111-148).

15 10180.7. A rate change by a health insurer that became effective
16 during the period January 1, 2011, to December 31, 2011, inclusive,
17 shall be subject to review by the department for compliance with
18 this article. The department shall order the refund of payments
19 made pursuant to any such rate, to the extent the department finds
20 the rate to be excessive, inadequate, or unfairly discriminatory.

21 10180.8. (a) Notwithstanding Chapter 3.5 (commencing with
22 Section 6250) of Division 7 of Title 1 of the Government Code,
23 all information submitted under this article shall be made publicly
24 available by the department, except as provided in subdivision (b).
25 Subdivision (d) of Section 6254 of the Government Code shall not
26 apply to a public record under this article.

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

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

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

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

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

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

15 (e) The department shall accept and post to its Internet Web site
16 any public comment on a proposed rate submitted to the department
17 during the 60-day period described in subdivision (a) of Section
18 10180.4 or subdivision (a) of Section 10180.5.

19 10180.9. (a) The department shall notify the public of any rate
20 application by a health insurer.

21 (b) If the application process in Section 10180.4 or 10180.5 has
22 been followed, the department shall issue a decision within 60
23 days after the date of the public notice provided under subdivision
24 (a), unless the department and the applicant agree to waive the
25 60-day period or the department notices a public hearing on the
26 application. If the department holds a hearing on the application,
27 the department shall issue a decision and findings within—
28 ~~reasonable time~~ *100 days* after the hearing. The department shall
29 hold a hearing on any of the following grounds:

30 (1) A consumer, or his or her representative, requests a hearing
31 within 45 days of the date of the public notice, and the department
32 grants the request for a hearing. If the department denies the request
33 for a hearing, it shall issue written findings in support of that
34 decision.

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

37 (3) The proposed change would exceed 10 percent of the amount
38 of the current rate under the plan contract, or would exceed 15
39 percent for any individual insured subject to the rate increase, in

1 which case the department shall hold a hearing upon a timely
2 request for a hearing.

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

8 10180.10. All hearings under this article shall be conducted
9 pursuant to the provisions of Chapter 5 (commencing with Section
10 11500) of Part 1 of Division 3 of Title 2 of the Government Code,
11 with the following exceptions:

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

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

18 (c) The commissioner shall adopt, amend, or reject a decision
19 only under Section 11518.5 of the Government Code and
20 subdivisions (b) and (c) of Section 11517 of the Government Code
21 and solely on the basis of the record as provided in Section
22 11425.50 of the Government Code.

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

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

32 10180.11. (a) A person may initiate or intervene in any
33 proceeding permitted or established pursuant to this article,
34 challenge any action of the department under this article, and
35 enforce any provision of this article on behalf of himself or herself
36 or members of the public.

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

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

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

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

7 10180.12. (a) A violation of this article is subject to the
8 penalties set forth in Section 1859.1. The commissioner may also
9 suspend or revoke in whole or in part the certificate of authority
10 of a health insurer for a violation of this article.

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

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

24 10180.13. (a) The department may charge a health insurer a
25 fee for the actual and reasonable costs related to filing and
26 reviewing an application under this article.

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

32 10180.14. (a) On or before July 1, 2012, the commissioner
33 may issue guidance to health insurers regarding compliance with
34 this article. This guidance shall not be subject to the Administrative
35 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
36 Part 1 of Division 3 of Title 2 of the Government Code).

37 (b) The department shall consult with the Department of
38 Managed Health Care in issuing guidance under subdivision (a),
39 in adopting necessary regulations, in posting information on its

1 Internet Web site under this article, and in taking any other action
2 for the purpose of implementing this article.

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

7 10180.15. (a) Whenever it appears to the department that any
8 person has engaged, or is about to engage, in any act or practice
9 constituting a violation of this article, the department may review
10 any rate to ensure compliance with this article.

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

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

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

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

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

30 SEC. 5. No reimbursement is required by this act pursuant to
31 Section 6 of Article XIII B of the California Constitution because
32 the only costs that may be incurred by a local agency or school
33 district will be incurred because this act creates a new crime or
34 infraction, eliminates a crime or infraction, or changes the penalty
35 for a crime or infraction, within the meaning of Section 17556 of
36 the Government Code, or changes the definition of a crime within
37 the meaning of Section 6 of Article XIII B of the California
38 Constitution.

O