

## **SB890: Transitioning to a More Transparent & Standardized Individual Insurance Market**

Introduced by Senators Elaine Alquist (Dem-Dist. 13-San Jose) and Steinberg (Dem-Dist 5.-Sacramento)  
Coauthors: Assembly Members De La Torre (Dem.-Dist. 50-SE Los Angeles) and Jones (Dem.-Dist. 9-Sacramento)

**Summary of Bill:** This bill standardizes and simplifies the individual insurance market, so that consumers can understand their coverage choices, make apples-to-apples comparisons, and have the security that coverage does not have hidden loopholes, or lifetime and/or annual caps on coverage. It sets a standard of basic health care services for products at both the Department of Insurance as well as the Department of Managed Health Care products. It will also allow consumers to switch to a different individual health plan or insurer on the annual renewal date, puts limits on insurance premium rate variation for adults, and requires a minimum health plan medical loss ratio of 85% for large group policies and 80% for individual or small group policies.

### ***Why UULM Should Advocate for SB890:***

- ◆ *As a faith community UULM should support legislation that demands fair dealing and full disclosure of information from the insurance companies.* SB890 will empower all Californians purchasing individual plans to make good purchasing choices by ensuring they receive essential information. Such a bill upholds a key UU principal of “justice, equity and compassion in human relations.”
- ◆ *This bill aligns California law with recently passed Federal healthcare reform law.*

### ***Bill Details:***

#### **1. Limited Number of Standard Benefit Plan Designs by July 1, 2011**

This bill would require plans and insurers issuing individual coverage to make certain standard benefit plan designs available to individuals, would require that these designs be offered in five different coverage choice categories (five preferred provider organization [PPO] products and five health maintenance organization [HMO] products) as specified, and would require a plan or insurer to offer and market one standard benefit plan design in each category. The bill would require plans to, on and after July 1, 2011, discontinue offering and selling benefit plan designs other than standard benefit plan designs, but would require plans and insurers to renew benefit plan designs issued prior to that date until July 1, 2012.

Designates the five coverage choice categories as platinum, gold, silver, bronze and catastrophic, and specifies the cost-sharing requirements (deductibles, co-payments, and out-of-pocket maximums) for services covered under each coverage choice category, for individuals, and for families. The plan design in the catastrophic choice category must have cost-sharing and an out-of-pocket maximum that enables it to be offered with a health savings account.

#### **2. Consumers Can Change Plans Annually**

The bill would allow a subscriber or policyholder of an individual contract or policy, on the annual renewal date of that contract or policy, to transfer on a guarantee issue basis to another benefit plan design issued by his or her plan or insurer or a benefit plan design issued by another plan or insurer, provided that the new plan design is in the same or a lower coverage choice category or has an equal or lower actuarial value, as specified. The bill would require plans and insurers to provide notice of these transfer rights in their evidence of coverage and in notices regarding changes to premiums or coverage.

#### **3. Insurance Market Reform Commission (IMRC) Created**

The bill would create the Individual Insurance Market Reform Commission, which would consist of 9 voting members, appointed by the Legislature and the Governor, as specified, and 3 nonvoting members. The bill would require the commission to review and suggest changes to the standard benefit plan designs described above within six months after the date of this bill's passage and would require the Department of Managed Health Care and the Department of Insurance to jointly adopt regulations based on those suggestions.

a. IMRC Must Standardize Enrollment Questionnaires & Limits on Disclosure Required

The bill would require the commission to develop a standardized enrollment questionnaire to be used by all plans and insurers when offering and selling individual coverage, but would prohibit plans and insurers from requesting or obtaining health information from applicants eligible for guaranteed issuance of coverage on and after January 1, 2014.

b. IMRC Must Develop Methodology for Risk Assessment of Insurers in Individual Market.

The bill would also require the commission to establish a methodology for the graduation of risk into three specified categories ("higher risk," "standard risk," and "preferred risk") and would require plans and insurers in the individual market to set rates consistent with this methodology. The bill would place limits on the annualized premium rate increase for a contract and the variation between the highest standard premium rate and the lowest.

**4. Limits on Medical-Loss Ratio**

This bill would require full service health care service plans and health insurers to expend no less than 85 percent (for large group products), and 80 percent (for individual and small group products) of the aggregate fees, premiums, and other periodic payments they receive on health care benefits. It would require plans and insurers to provide for rebates to enrollees and insured if they fail to meet that percentage, as specified. The bill would authorize plans and insurers to assess compliance with this requirement by averaging their total costs across all plan contracts or insurance policies issued, amended, or renewed by them and their affiliated plans and insurers in California, as specified. The bill would require the departments to jointly adopt and amend regulations to implement these provisions.

**5. Increased Disclosure Requirements for Insurance Companies**

The bill requires specified health plan disclosure material, including the uniform benefits and coverage matrix, to be made available on the health plan's internet Website.

It also requires health plans, health insurers and disability insurers to disclose additional information related to this bill, including provisions relating to an individual's right to apply for any benefit plan design written by the plan/insurer at the time of application for a new health plan/insurance contract, or at the time of renewal of a health plan contract, and to provide information concerning the availability of a listing of all the plan's contracts and benefit plan designs offered to individuals, including the rates for each contract. For health insurers, this additional information that must be disclosed includes a uniform health plan benefits and coverage matrix.

**6. Insurance Policies Must Provide for Medically Necessary Basic Health Care Services by Jan. 2011**

To create a level playing field and ensure coverage of basic health care services, this bill would require health insurance policies issued, amended, or renewed on or after January 1, 2011, to provide coverage for medically necessary care with no annual or lifetime limits. Sen. Alquist argues allowing insurers to exclude services, such as maternity, means only people who want to have children buy maternity coverage, which defeats the purpose of insurance where you have a large pool of people whose health costs are spread across the group.

**7. Annual and Lifetime Insurance Caps Prohibited**

The bill would also prohibit health insurance policies and health care service plan contracts issued, amended, or renewed on or after January 1, 2011, from imposing annual or lifetime limits on basic health care services.

SB890 received broad support from a range of stakeholders, including Health Access California, Kaiser Permanente, Congress of California Seniors, California Medical Association, California Hospital Association, and many others. Insurers and brokers raised concerns with both bills. A common refrain was to wait until the federal government issued more clarifying regulations. An ongoing issue spotlighted by the insurers was about any provision that went beyond the federal law.

This bill has been amended and passed by the Senate Health Committee and is now being re-referred to the Senate Appropriations Committee for a hearing on May 10, 2010. Senators Alquist, Leno, Negrete, McLeod, Pavley, and Romero voted for the bill while Strickland, Aanestad, Cedillo and Cox abstained from voting on the bill.

The Senate categorizes the bill as:

- ◆ Active
- ◆ Non-Urgency
- ◆ Non-Appropriations
- ◆ Majority Vote Required
- ◆ State-Mandated Local Program
- ◆ Fiscal
- ◆ Non-Tax Levy

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