

**Introduced by Senator Leno**February 20, 2014

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An act to amend Sections 1385.03 and 1385.04 of the Health and Safety Code, and to amend Section 10181.4 of the Insurance Code, relating to health care coverage.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1182, as introduced, Leno. Health care coverage: rate review.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), requires the United States Secretary of Health and Human Services to establish a process for the annual review of unreasonable increases in premiums for health insurance coverage in which health insurance issuers submit to the secretary and the relevant state a justification for an unreasonable premium increase prior to implementation of the increase. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer in the individual, small group, or large group markets to file rate information with the Department of Managed Health Care or the Department of Insurance. For individual and small group contracts and policies, existing law requires a plan or insurer to file rate information at least 60 days prior to implementing a rate change and requires a plan or insurer to disclose with each filing specified information by aggregate benefit category. Existing law allows a health care service plan that exclusively contracts with no more than 2 medical groups to provide or arrange for professional medical services for enrollees of the plan to

meet this requirement by disclosing its actual trend experience for the prior year using benefit categories that are the same or similar to those used by other plans.

This bill would specify the benefit categories to be used for that purpose and would make other related changes.

For large group plan contracts and policies, existing law requires a plan or insurer to file rate information with the department at least 60 days prior to implementing an unreasonable rate increase, as defined in PPACA. Existing law requires the plan or insurer to also disclose specified aggregate data with that rate filing.

This bill would instead require the plan or insurer to file rate information with the department at least 60 days prior to implementing a rate increase that exceeds 5% of the prior year's rate. The bill would also require that the plan or insurer disclose the aggregate data for all rate filings submitted under these provisions on an annual basis. The bill would require a plan or insurer to annually disclose additional aggregate data for all products sold in the large group market and to provide deidentified claims data at no charge to a large group purchaser that requests the information and meets specified conditions.

Because a willful violation of the bill's requirements 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. Section 1385.03 of the Health and Safety Code
- 2 is amended to read:
- 3 1385.03. (a) (1) All health care service plans shall file with
- 4 the department all required rate information for individual and
- 5 small group health care service plan contracts at least 60 days prior
- 6 to implementing any rate change.
- 7 (2) For individual health care service plan contracts, the filing
- 8 shall be concurrent with the notice required under Section 1389.25.

1 (3) For small group health care service plan contracts, the filing  
2 shall be concurrent with the notice required under subdivision (a)  
3 of Section 1374.21.

4 (b) A plan shall disclose to the department all of the following  
5 for each individual and small group rate filing:

- 6 (1) Company name and contact information.
- 7 (2) Number of plan contract forms covered by the filing.
- 8 (3) Plan contract form numbers covered by the filing.
- 9 (4) Product type, such as a preferred provider organization or  
10 health maintenance organization.
- 11 (5) Segment type.
- 12 (6) Type of plan involved, such as for profit or not for profit.
- 13 (7) Whether the products are opened or closed.
- 14 (8) Enrollment in each plan contract and rating form.
- 15 (9) Enrollee months in each plan contract form.
- 16 (10) Annual rate.
- 17 (11) Total earned premiums in each plan contract form.
- 18 (12) Total incurred claims in each plan contract form.
- 19 (13) Average rate increase initially requested.
- 20 (14) Review category: initial filing for new product, filing for  
21 existing product, or resubmission.
- 22 (15) Average rate of increase.
- 23 (16) Effective date of rate increase.
- 24 (17) Number of subscribers or enrollees affected by each plan  
25 contract form.
- 26 (18) The plan's overall annual medical trend factor assumptions  
27 in each rate filing for all benefits and by aggregate benefit category,  
28 including hospital inpatient, hospital outpatient, physician services,  
29 prescription drugs and other ancillary services, laboratory, and  
30 radiology. A plan may provide aggregated additional data that  
31 demonstrates or reasonably estimates year-to-year cost increases  
32 in specific benefit categories in major geographic regions of the  
33 state. For purposes of this paragraph, "major geographic region"  
34 shall be defined by the department and shall include no more than  
35 nine regions. A health plan that exclusively contracts with no more  
36 than two medical groups in the state to provide or arrange for  
37 professional medical services for the enrollees of the plan shall  
38 instead disclose the amount of its actual trend experience for the  
39 prior contract year by aggregate benefit category, using ~~benefit~~  
40 *service* categories that are, to the maximum extent possible, the

1 same or similar to ~~those~~ *the benefit categories* used by other plans.  
2 *For this purpose, benefit categories shall be those specified in*  
3 *subdivision (e) of Section 1385.04.*

4 (19) The amount of the projected trend attributable to the use  
5 of services, price inflation, or fees and risk for annual plan contract  
6 trends by aggregate benefit category, such as hospital inpatient,  
7 hospital outpatient, physician services, prescription drugs and other  
8 ancillary services, laboratory, and radiology. A health plan that  
9 exclusively contracts with no more than two medical groups in the  
10 state to provide or arrange for professional medical services for  
11 the enrollees of the plan shall instead disclose the amount of its  
12 actual trend experience for the prior contract year by aggregate  
13 ~~benefit service~~ category, using ~~benefit service~~ categories that are,  
14 to the maximum extent possible, the same or similar to those used  
15 by other plans. *For this purpose, benefit categories shall be those*  
16 *specified in subdivision (e) of Section 1385.04.*

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

18 (21) Any changes in enrollee cost-sharing over the prior year  
19 associated with the submitted rate filing.

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

22 (23) The certification described in subdivision (b) of Section  
23 1385.06.

24 (24) Any changes in administrative costs.

25 (25) Any other information required for rate review under  
26 PPACA.

27 (c) A health care service plan subject to subdivision (a) shall  
28 also disclose the following aggregate data for all rate filings  
29 submitted under this section in the individual and small group  
30 health plan markets:

31 (1) Number and percentage of rate filings reviewed by the  
32 following:

33 (A) Plan year.

34 (B) Segment type.

35 (C) Product type.

36 (D) Number of subscribers.

37 (E) Number of covered lives affected.

38 (2) The plan's average rate increase by the following categories:

39 (A) Plan year.

40 (B) Segment type.

1 (C) Product type.

2 (3) Any cost containment and quality improvement efforts since  
3 the plan's last rate filing for the same category of health benefit  
4 plan. To the extent possible, the plan shall describe any significant  
5 new health care cost containment and quality improvement efforts  
6 and provide an estimate of potential savings together with an  
7 estimated cost or savings for the projection period.

8 (d) The department may require all health care service plans to  
9 submit all rate filings to the National Association of Insurance  
10 Commissioners' System for Electronic Rate and Form Filing  
11 (SERFF). Submission of the required rate filings to SERFF shall  
12 be deemed to be filing with the department for purposes of  
13 compliance with this section.

14 (e) A plan shall submit any other information required under  
15 PPACA. A plan shall also submit any other information required  
16 pursuant to any regulation adopted by the department to comply  
17 with this article.

18 SEC. 2. Section 1385.04 of the Health and Safety Code is  
19 amended to read:

20 1385.04. (a) For large group health care service plan contracts,  
21 all health plans shall file with the department at least 60 days prior  
22 to implementing any rate change all required rate information for  
23 ~~unreasonable~~ rate increases *that exceed 5 percent of the prior*  
24 *year's rate*. This filing shall be concurrent with the written notice  
25 described in subdivision (a) of Section 1374.21.

26 (b) For large group rate filings, health plans shall submit all  
27 information that is required by PPACA. A plan shall also submit  
28 any other information required pursuant to any regulation adopted  
29 by the department to comply with this article.

30 (c) A health care service plan subject to subdivision (a) shall  
31 also *annually* disclose the following aggregate data for all rate  
32 filings submitted under this section ~~in the large group health plan~~  
33 ~~market~~:

34 (1) Number and percentage of rate filings reviewed by the  
35 following:

36 (A) Plan year.

37 (B) Segment type.

38 (C) Product type.

39 (D) Number of subscribers.

40 (E) Number of covered lives affected.

- 1 (2) The plan's average rate increase by the following categories:  
2 (A) Plan year.  
3 (B) Segment type.  
4 (C) Product type.  
5 (D) *Benefit category*.  
6 (E) *Number of covered lives affected*.
- 7 (3) Any cost containment and quality improvement efforts since  
8 the plan's last rate filing for the same category of health benefit  
9 plan. To the extent possible, the plan shall describe any significant  
10 new health care cost containment and quality improvement efforts  
11 and provide an estimate of potential savings together with an  
12 estimated cost or savings for the projection period, *including an*  
13 *estimate of any reduction in the rate within the next five years of*  
14 *implementation of those efforts*.
- 15 (d) *Except as provided in subdivision (e), a health care service*  
16 *plan shall annually disclose the following aggregate data for all*  
17 *products sold in the large group market:*
- 18 (1) *Plan year*.  
19 (2) *Segment type*.  
20 (3) *Product type*.  
21 (4) *Number of subscribers*.  
22 (5) *Number of covered lives affected*.  
23 (6) *The plan's average rate increase by the following:*
- 24 (A) *Plan year*.  
25 (B) *Segment type*.  
26 (C) *Product type*.  
27 (D) *Benefit category, including, but not limited to, hospital,*  
28 *medical, ancillary, and other benefit categories reported publicly*  
29 *for individual and small employer rate filings*.  
30 (E) *Trend attributable to cost and trend attributable to*  
31 *utilization by benefit category*.
- 32 (e) *A health care service plan that is unable to provide*  
33 *information on rate increases by benefit categories, including, but*  
34 *not limited to, hospital, outpatient medical, and mental health, or*  
35 *information on trend attributable to cost and trend attributable to*  
36 *utilization by benefit category pursuant to subdivision (d), shall*  
37 *annually disclose all of the following aggregate data for its large*  
38 *group health care service plan contracts:*
- 39 (1) (A) *The plan's overall aggregate data demonstrating or*  
40 *reasonably estimating year-to-year cost increases in the aggregate*

1 *for large group rates by major service category. The plan shall*  
2 *distinguish between the increase ascribed to the volume of services*  
3 *provided and the increase ascribed to the cost of services provided*  
4 *for those assumptions that shall include the following categories:*  
5 *(i) Hospital inpatient.*  
6 *(ii) Outpatient visits.*  
7 *(iii) Outpatient surgical or other procedures.*  
8 *(iv) Professional medical.*  
9 *(v) Mental health.*  
10 *(vi) Substance abuse.*  
11 *(vii) Skilled nursing facility, if covered.*  
12 *(viii) Prescription drugs.*  
13 *(ix) Other ancillary services.*  
14 *(x) Laboratory.*  
15 *(xi) Radiology or imaging.*  
16 *(B) A plan may provide aggregated additional data that*  
17 *demonstrate or reasonably estimate year-to-year cost increases*  
18 *in each of the specific service categories specified in subparagraph*  
19 *(A) for each of the major geographic regions of the state.*  
20 *(2) The amount of projected trend attributable to the following*  
21 *categories:*  
22 *(A) Use of services by service and disease category.*  
23 *(B) Capital investment.*  
24 *(C) Community benefit expenditures, excluding bad debt and*  
25 *valued at cost.*  
26 *(3) The amount and proportion of costs attributed to contracting*  
27 *medical groups that would not have been attributable as medical*  
28 *losses if incurred by the health plan rather than the medical group.*  
29 *(f) (1) A health care service plan shall annually provide claims*  
30 *data at no charge to a large group purchaser if the large group*  
31 *purchaser requests the information. The health care service plan*  
32 *shall provide claims data that a qualified statistician has*  
33 *determined are deidentified so that the claims data do not identify*  
34 *or do not provide a reasonable basis from which to identify an*  
35 *individual.*  
36 *(2) Information provided to a large group purchaser under this*  
37 *subdivision is not subject to Section 1385.07.*  
38 *(3) (A) If claims data are not available, the plan shall provide,*  
39 *at no charge to the purchaser, all of the following:*

1 (i) Deidentified data sufficient for the large group purchaser to  
2 calculate the cost of obtaining similar services from other health  
3 plans and evaluate cost-effectiveness by service and disease  
4 category.

5 (ii) Deidentified patient-level data on demographics,  
6 prescribing, encounters, inpatient services, outpatient services,  
7 and any other data as may be required of the health plan to comply  
8 with risk adjustment, reinsurance, or risk corridors pursuant to  
9 the federal Patient Protection and Affordable Care Act (Public  
10 Law 111-148), as amended by the federal Health Care and  
11 Education Reconciliation Act of 2010 (Public Law 111-152), and  
12 any rules, regulations, or guidance issued thereunder.

13 (iii) Deidentified patient-level data used to experience rate the  
14 large group, including diagnostic and procedure coding and costs  
15 assigned to each service.

16 (B) The health care service plan shall obtain a formal  
17 determination from a qualified statistician that the data provided  
18 pursuant to this paragraph have been deidentified so that the data  
19 do not identify or do not provide a reasonable basis from which  
20 to identify an individual. The statistician shall certify the formal  
21 determination in writing and shall, upon request, provide the  
22 protocol used for deidentification to the department.

23 (4) Data provided pursuant to this subdivision shall only be  
24 provided to a large group purchaser that meets both of the  
25 following conditions:

26 (A) Is able to demonstrate its ability to comply with state and  
27 federal privacy laws.

28 (B) Is a large group purchaser that is either an  
29 employer-sponsored plan with an enrollment of greater than 1,000  
30 covered lives or a multiemployer trust.

31 ~~(d)~~

32 (g) The department may require all health care service plans to  
33 submit all rate filings to the National Association of Insurance  
34 Commissioners' System for Electronic Rate and Form Filing  
35 (SERFF). Submission of the required rate filings to SERFF shall  
36 be deemed to be filing with the department for purposes of  
37 compliance with this section.

38 SEC. 3. Section 10181.4 of the Insurance Code is amended to  
39 read:

1 10181.4. (a) For large group health insurance policies, all  
2 health insurers shall file with the department at least 60 days prior  
3 to implementing any rate change all required rate information for  
4 ~~unreasonable~~ rate increases *that exceed 5 percent of the prior*  
5 *year's rate*. This filing shall be concurrent with the written notice  
6 described in Section 10199.1.

7 (b) For large group rate filings, health insurers shall submit all  
8 information that is required by PPACA. A health insurer shall also  
9 submit any other information required pursuant to any regulation  
10 adopted by the department to comply with this article.

11 (c) A health insurer subject to subdivision (a) shall also *annually*  
12 disclose the following aggregate data for all rate filings submitted  
13 under this section ~~in the large group health insurance market~~:

14 (1) Number and percentage of rate filings reviewed by the  
15 following:

16 (A) ~~Plan~~-*Policy* year.

17 (B) Segment type.

18 (C) Product type.

19 (D) Number of insureds.

20 (E) Number of covered lives affected.

21 (2) The insurer's average rate increase by the following  
22 categories:

23 (A) ~~Plan~~-*Policy* year.

24 (B) Segment type.

25 (C) Product type.

26 (D) *Benefit category*.

27 (E) *Number of covered lives affected*.

28 (3) Any cost containment and quality improvement efforts since  
29 the health insurer's last rate filing for the same category of health  
30 insurance policy. To the extent possible, the health insurer shall  
31 describe any significant new health care cost containment and  
32 quality improvement efforts and provide an estimate of potential  
33 savings together with an estimated cost or savings for the projection  
34 period, *including an estimate of any reduction in the rate within*  
35 *the next five years of implementation of those efforts*.

36 (d) *Except as provided in subdivision (e), a health insurer shall*  
37 *annually disclose the following aggregate data for all products*  
38 *sold in the large group market*:

39 (1) *Policy year*.

40 (2) *Segment type*.

- 1 (3) *Product type.*  
2 (4) *Number of policyholders.*  
3 (5) *Number of covered lives affected.*  
4 (6) *The insurer's average rate increase by the following:*  
5 (A) *Policy year.*  
6 (B) *Segment type.*  
7 (C) *Product type.*  
8 (D) *Benefit category, including, but not limited to, hospital,*  
9 *medical, ancillary, and other benefit categories reported publicly*  
10 *for individual and small employer rate filings.*  
11 (E) *Trend attributable to cost and trend attributable to*  
12 *utilization by benefit category.*  
13 (e) *A health insurer that is unable to provide information on*  
14 *rate increases by benefit categories, including, but not limited to,*  
15 *hospital, outpatient medical, and mental health, or information*  
16 *on trend attributable to cost and trend attributable to utilization*  
17 *by benefit category pursuant to subdivision (d), shall annually*  
18 *disclose all of the following aggregate data for its large group*  
19 *health insurance policies:*  
20 (1) (A) *The insurer's overall aggregate data demonstrating or*  
21 *reasonably estimating year-to-year cost increases in the aggregate*  
22 *for large group rates by major service category. The insurer shall*  
23 *distinguish between the increase ascribed to the volume of services*  
24 *provided and the increase ascribed to the cost of services provided*  
25 *for those assumptions that shall include the following categories:*  
26 (i) *Hospital inpatient.*  
27 (ii) *Outpatient visits.*  
28 (iii) *Outpatient surgical or other procedures.*  
29 (iv) *Professional medical.*  
30 (v) *Mental health.*  
31 (vi) *Substance abuse.*  
32 (vii) *Skilled nursing facility, if covered.*  
33 (viii) *Prescription drugs.*  
34 (ix) *Other ancillary services.*  
35 (x) *Laboratory.*  
36 (xi) *Radiology or imaging.*  
37 (B) *An insurer may provide aggregated additional data that*  
38 *demonstrate or reasonably estimate year-to-year cost increases*  
39 *in each of the specific service categories specified in subparagraph*  
40 (A) *for each of the major geographic regions of the state.*

1 (2) *The amount of projected trend attributable to the following*  
2 *categories:*

3 (A) *Use of services by service and disease category.*

4 (B) *Capital investment.*

5 (C) *Community benefit expenditures, excluding bad debt and*  
6 *valued at cost.*

7 (3) *The amount and proportion of costs attributed to contracting*  
8 *medical groups that would not have been attributable as medical*  
9 *losses if incurred by the health insurer rather than the medical*  
10 *group.*

11 (f) (1) *A health insurer shall annually provide claims data at*  
12 *no charge to a large group purchaser if the large group purchaser*  
13 *requests the information. The health insurer shall provide claims*  
14 *data that a qualified statistician has determined are deidentified*  
15 *so that the claims data do not identify or do not provide a*  
16 *reasonable basis from which to identify an individual.*

17 (2) *Information provided to a large group purchaser under this*  
18 *subdivision is not subject to Section 10181.7.*

19 (3) (A) *If claims data are not available, the insurer shall*  
20 *provide, at no charge to the purchaser, all of the following:*

21 (i) *Deidentified data sufficient for the large group purchaser to*  
22 *calculate the cost of obtaining similar services from other health*  
23 *insurers and plans and evaluate cost-effectiveness by service and*  
24 *disease category.*

25 (ii) *Deidentified patient-level data on demographics,*  
26 *prescribing, encounters, inpatient services, outpatient services,*  
27 *and any other data as may be required of the health insurer to*  
28 *comply with risk adjustment, reinsurance, or risk corridors*  
29 *pursuant to the federal Patient Protection and Affordable Care*  
30 *Act (Public Law 111-148), as amended by the federal Health Care*  
31 *and Education Reconciliation Act of 2010 (Public Law 111-152),*  
32 *and any rules, regulations, or guidance issued thereunder.*

33 (iii) *Deidentified patient-level data used to experience rate the*  
34 *large group, including diagnostic and procedure coding and costs*  
35 *assigned to each service.*

36 (B) *The health insurer shall obtain a formal determination from*  
37 *a qualified statistician that the data provided pursuant to this*  
38 *paragraph have been deidentified so that the data do not identify*  
39 *or do not provide a reasonable basis from which to identify an*  
40 *individual. The statistician shall certify the formal determination*

1 *in writing and shall, upon request, provide the protocol used for*  
2 *deidentification to the department.*

3 *(4) Data provided pursuant to this subdivision shall only be*  
4 *provided to a large group purchaser that meets both of the*  
5 *following conditions:*

6 *(A) Is able to demonstrate its ability to comply with state and*  
7 *federal privacy laws.*

8 *(B) Is a large group purchaser that is either an*  
9 *employer-sponsored plan with an enrollment of greater than 1,000*  
10 *covered lives or a multiemployer trust.*

11 ~~(d)~~

12 *(g) The department may require all health insurers to submit all*  
13 *rate filings to the National Association of Insurance*  
14 *Commissioners' System for Electronic Rate and Form Filing*  
15 *(SERFF). Submission of the required rate filings to SERFF shall*  
16 *be deemed to be filing with the department for purposes of*  
17 *compliance with this section.*

18 SEC. 4. No reimbursement is required by this act pursuant to  
19 Section 6 of Article XIII B of the California Constitution because  
20 the only costs that may be incurred by a local agency or school  
21 district will be incurred because this act creates a new crime or  
22 infraction, eliminates a crime or infraction, or changes the penalty  
23 for a crime or infraction, within the meaning of Section 17556 of  
24 the Government Code, or changes the definition of a crime within  
25 the meaning of Section 6 of Article XIII B of the California  
26 Constitution.