

AMENDED IN ASSEMBLY JUNE 30, 2014

AMENDED IN SENATE APRIL 10, 2014

SENATE BILL

No. 1182

Introduced by Senator Leno

February 20, 2014

An act to amend Sections 1374.8, 1385.03, and 1385.04 of the Health and Safety Code, and to amend Sections 791.27 and 10181.4 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1182, as amended, 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 specified data for each rate filing that exceeds 5% of the prior year's rate for that group, including, but not limited to, company name and contact information, annual rate, and average rate-increase *change* initially requested. 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.

Existing law prohibits, with exceptions, a health care service plan or health insurer from releasing any information to an employer that would directly or indirectly indicate to the employer that an employee is receiving or has received services from a health care provider covered by the plan unless authorized to do so by the employee.

This bill would exempt from the prohibition the release of relevant information for the purposes set forth in the provisions regarding the review of rate increases.

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 1374.8 of the Health and Safety Code is
2 amended to read:

3 1374.8. (a) A health care service plan shall not release any
4 information to an employer that would directly or indirectly
5 indicate to the employer that an employee is receiving or has
6 received services from a health care provider covered by the plan
7 unless authorized to do so by the employee. An insurer that has,
8 pursuant to an agreement, assumed the responsibility to pay
9 compensation pursuant to Article 3 (commencing with Section
10 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall
11 not be considered an employer for the purposes of this section.

12 (b) Nothing in this section prohibits a health care service plan
13 from releasing relevant information described in this section for
14 the purposes set forth in Chapter 12 (commencing with Section
15 1871) of Part 2 of Division 1 of the Insurance Code.

16 (c) Nothing in this section prohibits a health care service plan
17 from releasing relevant information described in this section for
18 the purposes set forth in ~~Article 6.2 (commencing with Section~~
19 ~~1385.01)~~ *subdivision (f) of Section 1385.04.*

20 SEC. 2. Section 1385.03 of the Health and Safety Code is
21 amended to read:

22 1385.03. (a) ~~(1)~~ All health care service plans shall file with
23 the department all required rate information for individual and
24 small group health care service plan contracts at least 60 days prior
25 to implementing any rate change.

26 ~~(2) For individual health care service plan contracts, the filing~~
27 ~~shall be concurrent with the notice required under Section 1389.25.~~

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

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

33 (1) Company name and contact information.

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

35 (3) Plan contract form numbers covered by the filing.

- 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 in each plan contract and rating form.
- 7 (9) Enrollee months in each plan contract form.
- 8 (10) Annual rate.
- 9 (11) Total earned premiums in each plan contract form.
- 10 (12) Total incurred claims in each plan contract form.
- 11 (13) Average rate ~~increase~~ *change* initially requested.
- 12 (14) Review category: initial filing for new product, filing for
13 existing product, or resubmission.
- 14 (15) Average rate of ~~increase~~ *change*.
- 15 (16) Effective date of rate ~~increase~~ *change*.
- 16 (17) Number of subscribers or enrollees affected by each plan
17 contract form.
- 18 (18) The plan's overall annual medical trend factor assumptions
19 in each rate filing for all benefits and by aggregate benefit category,
20 including hospital inpatient, hospital outpatient, physician services,
21 prescription drugs and other ancillary services, laboratory, and
22 radiology. A plan may provide aggregated additional data that
23 demonstrates or reasonably estimates year-to-year cost ~~increases~~
24 *changes* in specific benefit categories in ~~major geographic regions~~
25 ~~of the state. For purposes of this paragraph, "major geographic~~
26 ~~region" shall be defined by the department and shall include no~~
27 ~~more than nine regions~~ *the geographic regions listed in Sections*
28 *1357.512 and 1399.855.* A health plan that exclusively contracts
29 with no more than two medical groups in the state to provide or
30 arrange for professional medical services for the enrollees of the
31 plan shall instead disclose the amount of its actual trend experience
32 for the prior contract year by aggregate benefit category, using
33 service categories that are, to the maximum extent possible, the
34 same or similar to the benefit categories used by other plans. For
35 this purpose, benefit categories shall be those specified in
36 subdivision (e) of Section 1385.04.
- 37 (19) The amount of the projected trend attributable to the use
38 of services, price inflation, or fees and risk for annual plan contract
39 trends by aggregate benefit category, such as hospital inpatient,
40 hospital outpatient, physician services, prescription drugs and other

1 ancillary services, laboratory, and radiology. A health plan that
2 exclusively contracts with no more than two medical groups in the
3 state to provide or arrange for professional medical services for
4 the enrollees of the plan shall instead disclose the amount of its
5 actual trend experience for the prior contract year by aggregate
6 service category, using service categories that are, to the maximum
7 extent possible, the same or similar to those used by other plans.
8 For this purpose, benefit categories shall be those specified in
9 subdivision (e) of Section 1385.04.

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

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

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

15 (23) The certification described in subdivision (b) of Section
16 1385.06.

17 (24) Any changes in administrative costs.

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

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

24 (1) Number and percentage of rate filings reviewed by the
25 following:

26 (A) Plan year.

27 (B) Segment type.

28 (C) Product type.

29 (D) Number of subscribers.

30 (E) Number of covered lives affected.

31 (2) The plan's average rate ~~increase~~ *change* by the following
32 categories:

33 (A) Plan year.

34 (B) Segment type.

35 (C) Product type.

36 (3) Any cost containment and quality improvement efforts since
37 the plan's last rate filing for the same category of health benefit
38 plan. To the extent possible, the plan shall describe any significant
39 new health care cost containment and quality improvement efforts

1 and provide an estimate of potential savings together with an
2 estimated cost or savings for the projection period.

3 (d) The department may require all health care service plans to
4 submit all rate filings to the National Association of Insurance
5 Commissioners’ System for Electronic Rate and Form Filing
6 (SERFF). Submission of the required rate filings to SERFF shall
7 be deemed to be filing with the department for purposes of
8 compliance with this section.

9 (e) A plan shall submit any other information required under
10 PPACA. A plan shall also submit any other information required
11 pursuant to any regulation adopted by the department to comply
12 with this article.

13 SEC. 3. Section 1385.04 of the Health and Safety Code is
14 amended to read:

15 1385.04. (a) For large group health care service plan contracts,
16 all health plans shall file with the department at least 60 days prior
17 to implementing any rate change all required rate information for
18 rate increases that exceed 5 percent of the prior year’s rate. This
19 filing shall be concurrent with the written notice described in
20 subdivision (a) of Section 1374.21.

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

25 (c) A health care service plan subject to subdivision (a) shall
26 disclose for each rate filing that exceeds 5 percent of the prior
27 year’s rate for that group all of the following:

- 28 (1) Company name and contact information.
- 29 (2) Number of plan contract forms covered by the filing.
- 30 (3) Plan contract form numbers covered by the filing.
- 31 (4) Product type, such as a preferred provider organization or
32 health maintenance organization.
- 33 (5) Segment type.
- 34 (6) Type of plan involved, such as for profit or not for profit.
- 35 (7) Whether the products are opened or closed.
- 36 (8) Enrollment in each plan contract and rating form.
- 37 (9) Enrollee months in each plan contract form.
- 38 (10) Annual rate.
- 39 (11) Total earned premiums in each plan contract form.
- 40 (12) Total incurred claims in each plan contract form.

- 1 (13) Average rate ~~increase~~ *change* initially requested.
- 2 (14) Review category: initial filing for new product, filing for
3 existing product, or resubmission.
- 4 (15) Average rate of ~~increase~~ *change*.
- 5 (16) Effective date of rate ~~increase~~ *change*.
- 6 (17) Number of subscribers or enrollees affected by each plan
7 contract form.
- 8 (18) The plan’s overall annual medical trend factor assumptions
9 in each rate filing for all benefits and by aggregate benefit category,
10 including hospital inpatient, hospital outpatient, physician services,
11 prescription drugs and other ancillary services, laboratory, and
12 radiology. A plan may provide aggregated additional data that
13 demonstrates or reasonably estimates year-to-year cost ~~increases~~
14 *changes* in specific benefit categories in major geographic regions
15 of the state. ~~For purposes of this paragraph, “major geographic~~
16 ~~region” shall be defined by the department and shall include no~~
17 ~~more than nine regions~~ *state if rates vary by region. If rates vary*
18 *by region, the plan shall provide a description of the regions used*
19 *by the plan.* A health plan that exclusively contracts with no more
20 than two medical groups in the state to provide or arrange for
21 professional medical services for the enrollees of the plan shall
22 instead disclose the amount of its actual trend experience for the
23 prior contract year by aggregate benefit category, using service
24 categories that are, to the maximum extent possible, the same or
25 similar to the benefit categories used by other plans. For this
26 purpose, benefit categories shall be those specified in subdivision
27 (e).
- 28 (19) The amount of the projected trend attributable to the use
29 of services, price inflation, or fees and risk for annual plan contract
30 trends by aggregate benefit category, such as hospital inpatient,
31 hospital outpatient, physician services, prescription drugs and other
32 ancillary services, laboratory, and radiology. A health plan that
33 exclusively contracts with no more than two medical groups in the
34 state to provide or arrange for professional medical services for
35 the enrollees of the plan shall instead disclose the amount of its
36 actual trend experience for the prior contract year by aggregate
37 service category, using service categories that are, to the maximum
38 extent possible, the same or similar to those used by other plans.
39 For this purpose, benefit categories shall be those specified in
40 subdivision (e).

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

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

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

6 (23) The certification described in subdivision (b) of Section
7 1385.06.

8 (24) Any changes in administrative costs.

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

11 (d) Except as provided in subdivision (e), a health care service
12 plan shall annually disclose the following aggregate data for all
13 products sold in the large group market:

14 (1) Plan year.

15 (2) Segment type.

16 (3) Product type.

17 (4) Number of subscribers.

18 (5) Number of covered lives affected.

19 (6) The plan's average rate ~~increase~~ *change* by the following:

20 (A) Plan year.

21 (B) Segment type.

22 (C) Product type.

23 (D) Benefit category, including, but not limited to, hospital,
24 medical, ancillary, and other benefit categories reported publicly
25 for individual and small employer rate filings.

26 (E) Trend attributable to cost and trend attributable to utilization
27 by benefit category.

28 (e) A health care service plan that is unable to provide
29 information on rate increases by benefit categories, as defined in
30 subdivision (d) of Section 1385.07, including, but not limited to,
31 hospital, outpatient medical, and mental health, or information on
32 trend attributable to cost and trend attributable to utilization by
33 benefit category pursuant to subdivision (d), shall annually disclose
34 all of the following aggregate data for its large group health care
35 service plan contracts:

36 (1) (A) The plan's overall aggregate data demonstrating or
37 reasonably estimating year-to-year cost increases in the aggregate
38 for large group rates by major service category. The plan shall
39 distinguish between the increase ascribed to the volume of services

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

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

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

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

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

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

24 (B) Is a large group purchaser that is either an employer with
25 an enrollment of greater than 1,000 covered lives or a
26 multiemployer trust.

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

33 SEC. 4. Section 791.27 of the Insurance Code is amended to
34 read:

35 791.27. (a) A disability insurer that provides coverage for
36 hospital, medical, or surgical expenses shall not release any
37 information to an employer that would directly or indirectly
38 indicate to the employer that an employee is receiving or has
39 received services from a health care provider covered by the plan
40 unless authorized to do so by the employee. An insurer that has,

1 pursuant to an agreement, assumed the responsibility to pay
2 compensation pursuant to Article 3 (commencing with Section
3 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall
4 not be considered an employer for the purposes of this section.

5 (b) Nothing in this section prohibits a disability insurer from
6 releasing relevant information described in this section for the
7 purposes set forth in Chapter 12 (commencing with Section 1871)
8 of Part 2 of Division 1.

9 (c) Nothing in this section prohibits a health insurer from
10 releasing relevant information described in this section for the
11 purposes set forth in ~~Article 4.5 (commencing with Section 10181)~~
12 ~~of Chapter 1 of Part 2 of Division 2 subdivision (f) of Section~~
13 ~~10181.4.~~

14 SEC. 5. Section 10181.4 of the Insurance Code is amended to
15 read:

16 10181.4. (a) For large group health insurance policies, all
17 health insurers shall file with the department at least 60 days prior
18 to implementing any rate change all required rate information for
19 rate increases that exceed 5 percent of the prior year's rate. This
20 filing shall be concurrent with the written notice described in
21 Section 10199.1.

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

26 (c) A health insurer subject to subdivision (a) shall disclose for
27 each rate filing that exceeds 5 percent of the prior year's rate for
28 that group all of the following:

- 29 (1) Company name and contact information.
- 30 (2) Number of policy forms covered by the filing.
- 31 (3) Policy form numbers covered by the filing.
- 32 (4) Product type, such as indemnity or preferred provider
33 organization.
- 34 (5) Segment type.
- 35 (6) Type of insurer involved, such as for profit or not for profit.
- 36 (7) Whether the products are opened or closed.
- 37 (8) Enrollment in each policy and rating form.
- 38 (9) Insured months in each policy form.
- 39 (10) Annual rate.
- 40 (11) Total earned premiums in each policy form.

- 1 (12) Total incurred claims in each policy form.
- 2 (13) Average rate ~~increase~~ *change* initially requested.
- 3 (14) Review category: initial filing for new product, filing for
4 existing product, or resubmission.
- 5 (15) Average rate of ~~increase~~ *change*.
- 6 (16) Effective date of rate ~~increase~~ *change*.
- 7 (17) Number of policyholders or insureds affected by each
8 policy form.
- 9 (18) The insurer's overall annual medical trend factor
10 assumptions in each rate filing for all benefits and by aggregate
11 benefit category, including hospital inpatient, hospital outpatient,
12 physician services, prescription drugs and other ancillary services,
13 laboratory, and radiology. An insurer may provide aggregated
14 additional data that demonstrates or reasonably estimates
15 year-to-year cost ~~increases~~ *changes* in specific benefit categories
16 in major geographic regions of the ~~state~~. ~~For purposes of this~~
17 ~~paragraph, "major geographic region" shall be defined by the~~
18 ~~department and shall include no more than nine regions state if~~
19 *rates vary by region. If rates vary by region, the insurer shall*
20 *provide a description of the regions used by the insurer.*
- 21 (19) The amount of the projected trend attributable to the use
22 of services, price inflation, or fees and risk for annual policy trends
23 by aggregate benefit category, such as hospital inpatient, hospital
24 outpatient, physician services, prescription drugs and other
25 ancillary services, laboratory, and radiology.
- 26 (20) A comparison of claims cost and rate of changes over time.
- 27 (21) Any changes in insured cost-sharing over the prior year
28 associated with the submitted rate filing.
- 29 (22) Any changes in insured benefits over the prior year
30 associated with the submitted rate filing.
- 31 (23) The certification described in subdivision (b) of Section
32 10181.6.
- 33 (24) Any changes in administrative costs.
- 34 (25) Any other information required for rate review under
35 PPACA.
- 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~~ *change* 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 utilization
 - 12 by benefit category.
- 13 (e) A health insurer that is unable to provide information on
- 14 rate increases by benefit categories, as defined in subdivision (d)
- 15 of Section 10181.7 including, but not limited to, hospital, outpatient
- 16 medical, and mental health, or information on trend attributable
- 17 to cost and trend attributable to utilization by benefit category
- 18 pursuant to subdivision (d), shall annually disclose all of the
- 19 following aggregate data for its large group health insurance
- 20 policies:
 - 21 (1) (A) The insurer's overall aggregate data demonstrating or
 - 22 reasonably estimating year-to-year cost increases in the aggregate
 - 23 for large group rates by major service category. The insurer shall
 - 24 distinguish between the increase ascribed to the volume of services
 - 25 provided and the increase ascribed to the cost of services provided
 - 26 for those assumptions that shall include the following categories:
 - 27 (i) Hospital inpatient.
 - 28 (ii) Outpatient visits.
 - 29 (iii) Outpatient surgical or other procedures.
 - 30 (iv) Professional medical.
 - 31 (v) Mental health.
 - 32 (vi) Substance abuse.
 - 33 (vii) Skilled nursing facility, if covered.
 - 34 (viii) Prescription drugs.
 - 35 (ix) Other ancillary services.
 - 36 (x) Laboratory.
 - 37 (xi) Radiology or imaging.
 - 38 (B) An insurer may provide aggregated additional data that
 - 39 demonstrate or reasonably estimate year-to-year cost increases in

1 each of the specific service categories specified in subparagraph
2 (A) for each of the major geographic regions of the state *if any*.
3 (2) The amount of projected trend attributable to the following
4 categories:
5 (A) Use of services by service and disease category.
6 (B) Capital investment.
7 (C) Community benefit expenditures, excluding bad debt and
8 valued at cost.
9 (3) The amount and proportion of costs attributed to contracting
10 medical groups that would not have been attributable as medical
11 losses if incurred by the health insurer rather than the medical
12 group.
13 (f) (1) A health insurer shall annually provide claims data at
14 no charge to a large group purchaser if the large group purchaser
15 requests the information. The health insurer shall provide claims
16 data that a qualified statistician has determined are deidentified so
17 that the claims data do not identify or do not provide a reasonable
18 basis from which to identify an individual.
19 (2) Information provided to a large group purchaser under this
20 subdivision is not subject to Section 10181.7.
21 (3) (A) If claims data are not available, the insurer shall provide,
22 at no charge to the purchaser, all of the following:
23 (i) Deidentified data sufficient for the large group purchaser to
24 calculate the cost of obtaining similar services from other health
25 insurers and plans and evaluate cost-effectiveness by service and
26 disease category.
27 (ii) Deidentified patient-level data on demographics, prescribing,
28 encounters, inpatient services, outpatient services, and any other
29 data as may be required of the health insurer to comply with risk
30 adjustment, reinsurance, or risk corridors pursuant to the federal
31 Patient Protection and Affordable Care Act (Public Law 111-148),
32 as amended by the federal Health Care and Education
33 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
34 regulations, or guidance issued thereunder.
35 (iii) Deidentified patient-level data used to experience rate the
36 large group, including diagnostic and procedure coding and costs
37 assigned to each service.
38 (B) The health insurer shall obtain a formal determination from
39 a qualified statistician that the data provided pursuant to this
40 paragraph have been deidentified so that the data do not identify

1 or do not provide a reasonable basis from which to identify an
2 individual. The statistician shall certify the formal determination
3 in writing and shall, upon request, provide the protocol used for
4 deidentification to the department.

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

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

10 (B) Is a large group purchaser that is either an employer with
11 an enrollment of greater than 1,000 covered lives or a
12 multiemployer trust.

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

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

O