AMENDED IN ASSEMBLY AUGUST 31, 2015

AMENDED IN SENATE JUNE 2, 2015

AMENDED IN SENATE APRIL 30, 2015

SENATE BILL No. 546

Introduced by Senator Leno

February 26, 2015

An act to amend ~~Sections 1374.21 and 1385.04~~ *Section 1374.21* of, and to add Section 1385.045 to, the Health and Safety Code, and to amend ~~Sections 10181.4 and~~ *Section* 10199.1 of, and to add Section 10181.45 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 546, 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. The PPACA imposes an excise tax on a provider of applicable employer-sponsored health care coverage, if the aggregate cost of that coverage provided to an employee exceeds a specified dollar limit.

Existing state 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 large group plan contracts and policies, existing law requires a plan or insurer to file rate information with the respective 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. Existing law authorizes the respective department to review those filings, to report to the Legislature at least quarterly on all unreasonable rate filings, and to post on its Internet Web site a decision that an unreasonable rate increase is not justified or that a rate filing contains inaccurate information. Existing law requires prior notice, as specified, of changes to premium rates or coverage in order for those changes to be effective.

This bill would ~~recast the~~ *add to the existing* rate information requirement to *further* require large group health care service plans and health insurers to file with the respective ~~department, at least 60 days prior to implementing any rate increase, all required rate information for any product with a rate increase if any of certain conditions apply. The bill would require the respective department to review that information and finalize a decision as to whether the rate is reasonable or unreasonable within 60 days after receiving the information.~~ *department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year.* The bill would require the notice of changes to premium rates or coverage *for large group health plans and insurance policies* to provide additional information regarding whether the rate change is greater than average rate increases approved by the California Health Benefit Exchange or by the Board of Administration of the Public Employees' Retirement System, or would be subject to the excise tax described above. The bill would require the plan or insurer to file additional aggregate rate information with the respective department on or before October 1, 2016, and annually thereafter. The bill would require the respective department to conduct a public meeting regarding large group rate changes. The bill would require these meetings to occur annually after the respective department has reviewed the large group rate information required to be submitted annually by the plan or insurer, as specified. The bill would authorize a health care service plan or health insurer that exclusively contracts with no more than 2 medical groups

to provide or arrange for professional medical services for enrollees or insureds 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 or health insurers.

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:

SECTION 1. Section 1374.21 of the Health and Safety Code is amended to read:

1374.21. (a) (1) A change in premium rates or changes in coverage stated in a group health care service plan contract shall not become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.

(2) The notice delivered pursuant to paragraph (1) for large group health plans shall also include the following information:

~~(A) The amount by which the rate change for the majority of months the rate is proposed to be in effect is greater than the average rate increase for individual market products approved by the California Health Benefit Exchange for the calendar year.~~

~~(B) The amount by which the rate change for the majority of months the rate is proposed to be in effect is greater than the average rate increase approved by the Board of Administration of the Public Employees' Retirement System for the calendar year.~~

~~(C) Whether the rate change would cause the health plan for the large group purchaser to incur the excise tax for any part of the period the rate increase is proposed to be in effect.~~

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated

by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final.

(C) Whether the rate change includes any portion of the excise tax paid by the health plan.

(b) A health care service plan that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

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

~~1385.04. (a) For large group health care service plan contracts, all health plans shall file with the department all required rate information for rate changes aggregated for the entire large group market. This information shall be submitted on or before October 1, 2016, and on or before October 1, annually thereafter.~~

~~(b) (1) For large group rate filings, health plans shall submit all information that is required by PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.~~

~~(2) For each health plan that offers coverage in the large group market, the department shall conduct a public meeting regarding large group rate changes. The public meeting shall occur after the department has reviewed the information required in subdivision (a). The department shall schedule the public meeting between November 1, 2016, and March 1, 2017, and annually thereafter between November 1, and March 1, of the subsequent year. The department shall schedule the public meeting based on the number of covered lives for the health plan in the large group market, with the largest health plan first, and the smallest health plan last.~~

~~(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate filing for the large group market submitted under this section in the large group health plan market:~~

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

~~(A) Plan year.~~
~~(B) Segment type.~~
~~(C) Product type.~~
~~(D) Number of subscribers.~~
~~(E) Number of covered lives affected.~~
~~(2) Any factors affecting the rate, and the actuarial basis for those factors, including:~~
~~(A) Geographic region.~~
~~(B) Age, including age rating factors.~~
~~(C) Occupation.~~
~~(D) Industry.~~
~~(E) Health status, including health status factors considered.~~
~~(F) Employee, employee and dependents, including a description of the family composition used.~~
~~(G) Enrollee share of premiums.~~
~~(H) Enrollee cost sharing.~~
~~(I) Covered benefits in addition to basic health care services, as defined in subdivision (b) of Section 1345, and other benefits mandated under this article.~~
~~(J) Any other factors that affect the rate that are not otherwise specified.~~
~~(3) (A) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.~~
~~(B) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its~~

~~actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.~~

~~(C) A comparison of claims cost and rate of changes over time.~~

~~(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.~~

~~(E) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.~~

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

~~(G) The average rate increase for the large group market enrollees covered in the filing with the average rate weighted by the number of covered lives.~~

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

~~SEC. 3. Section 1385.045 is added to the Health and Safety Code, to read:~~

~~1385.045. (a) (1) For large group health care service plan contracts, all health plans shall file with the department at least 60 days prior to implementing any rate increase all required rate information for any product with a rate increase if either of the following apply:~~

~~(A) The rate increase is greater than 150 percent of the average rate increase determined under Section 1385.04.~~

~~(B) The rate increase would cause the health plan for the large group purchaser to incur the excise tax for any part of the period the rate increase is proposed to be in effect.~~

~~(2) This filing shall be concurrent with the written notice described in subdivision (a) of Section 1374.21.~~

~~(b) A plan shall disclose to the department all of the following for each large group rate filing described in subdivision (a):~~

~~(1) Company name of plan and contact information.~~

~~(2) Number of plan contract forms covered by the filing.~~
~~(3) Plan contract form numbers covered by the filing.~~
~~(4) Product type, such as a preferred provider organization or health maintenance organization.~~
~~(5) Segment type.~~
~~(6) Type of plan involved, such as for profit or not for profit.~~
~~(7) Whether the products are opened or closed.~~
~~(8) Enrollment in each plan contract and rating form.~~
~~(9) Enrollee months in each plan contract form.~~
~~(c) Any factors affecting the rate, and the actuarial basis for the factor, including, but not limited to:~~
~~(1) Geographic region.~~
~~(2) Age, including age rating factors.~~
~~(3) Occupation.~~
~~(4) Industry.~~
~~(5) Health status, including health status factors considered.~~
~~(6) Employee, employee and dependents, including a description of the family composition used.~~
~~(7) Enrollee share of premiums.~~
~~(8) Enrollee cost sharing.~~
~~(9) Covered benefits in addition to basic health care services, as defined in subdivision (b) of Section 1345, and other benefits mandated under this article.~~
~~(10) Any other factor that affects the rate that is not otherwise specified.~~
~~(d) The plan shall also disclose the following:~~
~~(1) Annual rate.~~
~~(2) Total earned premiums in each plan contract form.~~
~~(3) Total incurred claims in each plan contract form.~~
~~(4) Average rate increase initially requested.~~
~~(5) Review category: initial filing for new product, filing for existing product, or resubmission.~~
~~(6) Average rate of increase.~~
~~(7) Effective date of rate increase.~~
~~(8) Number of subscribers or enrollees affected by each plan contract form.~~
~~(9) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and~~

~~radiology. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other plans.~~

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

~~(11) A comparison of claims cost and rate of changes over time.~~

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

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

~~(14) The certification described in subdivision (b) of Section 1385.06.~~

~~(15) Any changes in administrative costs.~~

~~(16) Any other information required for rate review under PPACA.~~

~~(17) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health care service plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.~~

~~(e) Within 60 days after receiving complete information from the plan consistent with this section, the department shall complete its review and finalize a decision as to whether the rate is reasonable or unreasonable.~~

~~(f) The department may require all health care service plans to submit all rate filings to the National Association of Insurance~~

~~Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.~~

~~(g) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.~~

~~SEC. 4. Section 10181.4 of the Insurance Code is amended to read:~~

~~10181.4. (a) For large group health insurance policies, all health insurers shall file with the department all required rate information for rate changes aggregated for the entire large group market. This information shall be submitted on or before October 1, 2016, and on or before October 1, annually thereafter.~~

~~(b) (1) For large group rate filings, health insurers shall submit all information that is required by PPACA. A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.~~

~~(2) For each health insurer that offers coverage in the large group market, the department shall conduct a public meeting regarding large group rate changes. The public meeting shall occur after the department has reviewed the information required in subdivision (a). The department shall schedule the public meeting between November 1, 2016, and March 1, 2017, and annually thereafter between November 1, and March 1, of the subsequent year. The department shall schedule the public meeting based on the number of covered lives for the health insurer in the large group market, with the largest health insurer first, and the smallest health insurer last.~~

~~(c) A health insurer subject to subdivision (a) shall also disclose the following for the aggregate rate filing for the large group market submitted under this section in the large group health insurance market:~~

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

~~(A) Plan year.~~

~~(B) Segment type.~~

~~(C) Product type.~~

~~(D) Number of insureds.~~

~~(E) Number of covered lives affected.~~

~~(2) Any factors affecting the rate, and the actuarial basis for those factors, including:~~

~~(A) Geographic region.~~

~~(B) Age, including age rating factor.~~

~~(C) Occupation.~~

~~(D) Industry.~~

~~(E) Health status, including health status factors considered.~~

~~(F) Employee, employee and dependents, including a description of the family composition used.~~

~~(G) Insured share of premiums.~~

~~(H) Insured cost sharing.~~

~~(I) Covered benefits in addition to basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, and other benefits mandated under this article.~~

~~(J) Any other factors that affect the rate that are not otherwise specified.~~

~~(3) (A) The health insurer's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds of the health insurer shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other health insurers.~~

~~(B) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual health insurer contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds of the health insurer shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other health insurers.~~

~~(C) A comparison of claims cost and rate of changes over time.~~

~~(D) Any changes in insured cost sharing over the prior year associated with the submitted rate filing.~~

~~(E) Any changes in insured benefits over the prior year associated with the submitted rate filing.~~

~~(F) Any cost containment and quality improvement efforts since the health insurer's last rate filing for the same category of health insurance policy. To the extent possible, the health insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.~~

~~(G) The average rate increase for the large group market insureds covered in the filing with the average rate weighted by the number of covered lives.~~

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

~~SEC. 5. Section 10181.45 is added to the Insurance Code, to read:~~

~~10181.45. (a) (1) For large group health insurance policies, all health insurers shall file with the department at least 60 days prior to implementing any rate increase all required rate information for any product with a rate increase if either of the following apply:~~

~~(A) The rate increase is greater than 150 percent of the average rate increase determined under Section 10181.4.~~

~~(B) The rate increase would cause the health insurer for the large group purchaser to incur the excise tax for any part of the period the rate increase is proposed to be in effect.~~

~~(2) This filing shall be concurrent with the written notice described in subdivision (a) of Section 10199.1.~~

~~(b) A health insurer shall disclose to the department all of the following for each large group rate filing described in subdivision (a):~~

~~(1) Company name of the health insurer and contact information.~~

~~(2) Number of health insurance policies covered by the filing.~~

~~(3) Health insurance policy form numbers covered by the filing.~~

~~(4) Product type, such as a preferred provider organization or health maintenance organization.~~

~~(5) Segment type.~~

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

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

~~(8) Enrollment in each health insurance policy and rating form.~~

~~(9) Insured months in each health insurance policy form.~~

~~(c) Any factors affecting the rate, and the actuarial basis for the factor, including, but not limited to:~~

~~(1) Geographic region.~~

~~(2) Age, including age rating factors.~~

~~(3) Occupation.~~

~~(4) Industry.~~

~~(5) Health status, including health status factors considered.~~

~~(6) Employee, employee and dependents, including a description of the family composition used.~~

~~(7) Insured share of premiums.~~

~~(8) Insured cost sharing.~~

~~(9) Covered benefits in addition to basic health care services, as defined in subdivision (b) of Section 1345, and other benefits mandated under this article.~~

~~(10) Any other factor that affects the rate that is not otherwise specified.~~

~~(d) The health insurer shall also disclose the following:~~

~~(1) Annual rate.~~

~~(2) Total earned premiums in each health insurance policy form.~~

~~(3) Total incurred claims in each health insurance policy form.~~

~~(4) Average rate increase initially requested.~~

~~(5) Review category: initial filing for new product, filing for existing product, or resubmission.~~

~~(6) Average rate of increase.~~

~~(7) Effective date of rate increase.~~

~~(8) Number of insureds affected by each health insurance policy form.~~

~~(9) The health insurer's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services,~~

~~laboratory, and radiology. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds of the health insurer shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other health insurers.~~

~~(10) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual health insurance policy trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds of the health insurer shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other health insurers.~~

~~(11) A comparison of claims cost and rate of changes over time.~~

~~(12) Any changes in insured cost sharing over the prior year associated with the submitted rate filing.~~

~~(13) Any changes in insured benefits over the prior year associated with the submitted rate filing.~~

~~(14) The certification described in subdivision (b) of Section 10181.6.~~

~~(15) Any changes in administrative costs.~~

~~(16) Any other information required for rate review under PPACA.~~

~~(17) Any cost containment and quality improvement efforts since the health insurer's last rate filing for the same category of health insurance policy. To the extent possible, the health insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.~~

~~(e) Within 60 days after receiving complete information from the insurer consistent with this section, the department shall complete its review and finalize a decision as to whether the rate is reasonable or unreasonable.~~

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

~~(g) A health insurer shall submit any other information required under PPACA. A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.~~

SEC. 2. Section 1385.045 is added to the Health and Safety Code, to read:

1385.045. (a) For large group health care service plan contracts, each health plan shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of enrollees in each large group benefit design in the plan's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within three months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of enrollees.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Enrollees' share of premiums.

(H) Enrollees' cost sharing.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. A health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan shall

instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same as, or similar to, those used by other plans.

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

(C) A comparison of the aggregate per enrollee per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of enrollees.

(E) Any changes in enrollee benefits over the prior year, including a description of benefits added or eliminated, as well as any aggregate changes, as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts since the plan's prior year's information pursuant to this section for the same category of health benefit plan. To the extent possible, the

plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health plan.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2016, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

SEC. 3. Section 10181.45 is added to the Insurance Code, to read:

10181.45. (a) For large group health insurance policies, each health insurer shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of insureds in each large group benefit design in the insurer's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within three months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health insurer subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of insureds.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Insureds' share of premiums.

(H) Insureds' cost sharing.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345 of the Health and Safety Code, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The insurer's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the health insurer's

insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories, to the maximum extent possible, that are the same or similar to those used by other insurers.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual policy trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A health insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are, to the maximum extent possible, the same or similar to those used by other insurers.

(C) A comparison of the aggregate per insured per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in insured cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in insured cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of insureds.

(E) Any changes in insured benefits over the prior year, including a description of benefits added or eliminated as well as any aggregate changes as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts made since the insurer's prior year's information pursuant to this section for the same category of health insurer. To the extent possible, the

insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health insurer.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2016, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 10181.7.

~~SEC. 6.~~

SEC. 4. Section 10199.1 of the Insurance Code is amended to read:

10199.1. (a) (1) An insurer or nonprofit hospital service plan or administrator acting on its behalf shall not terminate a group master policy or contract providing hospital, medical, or surgical benefits, increase premiums or charges therefor, reduce or eliminate benefits thereunder, or restrict eligibility for coverage thereunder without providing prior notice of that action. The action shall not become effective unless written notice of the action was delivered by mail to the last known address of the appropriate insurance producer and the appropriate administrator, if any, at least 45 days prior to the effective date of the action and to the last known address of the group policyholder or group contractholder at least 60 days prior to the effective date of the action. If nonemployee certificate holders or employees of more than one employer are covered under the policy or contract, written notice shall also be delivered by mail to the last known address of each nonemployee certificate holder or affected employer or, if the action does not affect all employees and dependents of one or more employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

(2) The notice delivered pursuant to paragraph (1) for large group health insurance policies shall also include the following information:

~~(A) The amount by which the rate change for the majority of months the rate is proposed to be in effect is greater than the average rate increase for individual market products approved by the California Health Benefit Exchange for the calendar year.~~

~~(B) The amount by which the rate change for the majority of months the rate is proposed to be in effect is greater than the average rate increase approved by the Board of Administration of the Public Employees' Retirement System for the calendar year.~~

~~(C) Whether the rate change would cause the insurer for the large group purchaser to incur the excise tax for any part of the period the rate increase is proposed to be in effect.~~

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final.

(C) Whether the rate change includes any portion of the excise tax paid by the health insurer.

(b) A holder of a master group policy or a master group nonprofit hospital service plan contract or administrator acting on its behalf shall not terminate the coverage of, increase premiums or charges for, or reduce or eliminate benefits available to, or restrict eligibility for coverage of a covered person, employer unit, or class of certificate holders covered under the policy or contract for hospital, medical, or surgical benefits without first providing prior notice of the action. The action shall not become effective unless written notice was delivered by mail to the last known address of each affected nonemployee certificate holder or employer, or if the action does not affect all employees and dependents of one or more employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

(c) A health insurer that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

~~SEC. 7.~~

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school

district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O