AMENDED IN ASSEMBLY AUGUST 18, 2014

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 change initially requested.~~ *revise the aggregate information required to be provided with the rate filing described above, including, among other things, total earned premiums, total incurred claims, and average rate of increase for the rate year. The bill would require a plan or insurer to disclose the methodologies used to develop base rates and other specified information, including, among other things, all of the base rates used for groups in the large group market and all of the factors used to adjust the base rates. The bill would also require a plan or insurer to provide additional aggregate information regarding rate changes for the large group market, including, among other things, the average monthly rate implemented during the prior year and the average rate change initially requested, as specified.* The bill would require a plan or ~~insurer~~ *insurer, under certain circumstances,* 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~~ *changes*.

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

1374.8. (a) A health care service plan shall not release 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. An insurer that has, pursuant to an agreement, assumed the responsibility to pay compensation pursuant to Article 3 (commencing with Section 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall not be considered an employer for the purposes of this section.

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

(c) Nothing in this section prohibits a health care service plan from releasing relevant information described in this section for the purposes set forth in subdivision ~~(f)~~ *(h)* of Section 1385.04.

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

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

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

(1) Company name 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.

(10) Annual rate.

(11) Total earned premiums in each plan contract form.

(12) Total incurred claims in each plan contract form.

(13) Average rate change initially requested.

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

(15) Average rate of change.

(16) Effective date of rate change.

(17) Number of subscribers or enrollees affected by each plan contract form.

(18) 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 plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost changes in specific benefit categories in the geographic regions listed in Sections 1357.512 and 1399.855. 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 service categories that are, to the maximum extent possible, the same or similar to the benefit categories used by other

plans. For this purpose, benefit categories shall be those specified in ~~subdivision (e)~~ *subparagraph (A) of paragraph (1) of subdivision (g)* of Section 1385.04.

(19) 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 service category, using service categories that are, to the maximum extent possible, the same or similar to those used by other plans. For this purpose, benefit categories shall be those specified in ~~subdivision (e)~~ *subparagraph (A) of paragraph (1) of subdivision (g)* of Section 1385.04.

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

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

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

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

(24) Any changes in administrative costs.

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

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

(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) The plan’s average rate change by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) 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.

(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.

(e) 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. 3. 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 at least 60 days prior to implementing any rate change all required rate information for *unreasonable* rate ~~increases that exceed 5 percent of the prior year's rate~~ *increases*. This filing shall be concurrent with the written notice described in subdivision (a) of Section 1374.21.

(b) 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.

(c) A health care service plan ~~subject to subdivision (a)~~ shall disclose ~~for each rate filing that exceeds 5 percent of the prior year's rate for that group all of the following:~~ *the following aggregate information for rates in the large group market:*

(1) Company name and contact information.

(2) Number of plan ~~contract forms~~ *contracts* covered by the filing.

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

~~(4)~~

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

~~(5)~~

(4) Segment type.

~~(6)~~

(5) Type of plan involved, such as for profit or not for profit.

~~(7)~~

(6) Whether the products are opened or closed.

~~(8) Enrollment in each plan contract and rating form.~~

~~(9) Enrollee months in each plan contract form.~~

~~(10) Annual rate.~~

~~(11)~~

(7) Total earned premiums~~ in each plan contract form~~.

~~(12)~~

(8) Total incurred claims~~ in each plan contract form~~.

~~(13) Average rate change initially requested.~~

~~(14) Review category: initial filing for new product, filing for existing product, or resubmission.~~

~~(15) Average rate of change.~~

~~(16) Effective date of rate change.~~

(9) Average rate of increase for the rate year.

~~(17)~~

(10) Number of subscribers or enrollees affected~~ by each plan contract form~~.

(d) A health care service plan shall disclose the methodology or methodologies used to develop the base rate or rates and all of the following information:

(1) The base rate for the groups in the large group market. If more than one base rate is used by the plan, all of the base rates shall be disclosed, as well as the types of groups to which different base rates are applied.

(2) All factors used to adjust the base rate or rates including, but not limited to, the following:

(A) Industry or occupation, if either is applicable.

(B) Age.

(C) Health status, medical condition, or claims experience.

(D) Tobacco use, if applicable.

(E) Alcohol use, if applicable.

(F) Any other factor used to adjust the base rate or rates, with a description of the factor and an objective and scientifically valid explanation, based on up-to-date statistical or actuarial data.

(3) Any variation in rate or rates based on geographic regions, along with a description of the geographic regions used by the plan. The description shall specify the applicable counties or, if counties are split, the ZIP Codes, in each region.

(4) Any variation due to benefits covered in addition to basic health care services as defined in subdivision (b) of Section 1345, as well as a description of the benefits covered, such as prescription drugs, durable medical equipment, or infertility treatment, using the format specified in paragraph (3) of subdivision (b) of Section 1363.

(5) Variations due to differences in benefit design arising from differences in cost sharing, including copays, coinsurance, deductibles, annual out-of-pocket limitations, or any other cost sharing, using the format specified in paragraph (3) of subdivision (b) of Section 1363.

(6) The actuarial value of products, including the number of enrolled lives by the actuarial value tiers specified in paragraph (2) of subdivision (e).

(7) Any other factors affecting the base rate not described here.

(8) The amount or proportion that each factor contributes to the base rate. If the proportions do not add up to 100 percent, an explanation of how the remaining portion of the base rate or rates are derived.

(9) If a plan uses modified community rating for any segment of the large group, such as new business or groups of a certain size, the plan shall describe the modifications to community rating and the market segments to which modified community rating applies.

(10) Any change from the prior year in methodology, factors, or assumptions used to develop a base rate or rates.

(e) (1) The plan shall also provide the following aggregate information regarding rate changes for the large group market:

(A) Average rate change during the prior year.

(B) Average monthly rate implemented during the prior year.

(C) Average rate change initially requested.

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

(E) Any changes in enrollee cost sharing over the prior year, including the range of changes and the number and proportion of enrollees affected.

(F) Any changes in enrollee benefits over the prior year, including the number and proportion of enrollees affected.

(G) Any changes in administrative costs.

(2) The information described in paragraph (1) shall be categorized by family composition, such as single, single plus one, and family, or any other family composition as the plan may use. If the plan uses an alternative family composition, it shall provide a description of that family composition.

(3) The information described in paragraph (1) shall also be categorized by actuarial value tier, using the following actuarial value tiers:

(A) 90 to 100 percent.

(B) 80 to 89 percent.

(C) 70 to 79 percent.

(D) 60 to 69 percent.

(E) Under 60 percent, if any.

(f) The plan shall provide the following aggregate information regarding trend factors used to develop the change in rate:

~~(18) The~~

(1) (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 plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost changes in specific benefit categories in major geographic regions of the state if rates vary by region. If rates vary by region, the plan shall provide a description of the regions used by the plan. A~~

(B) 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 service categories that are, to the maximum extent possible, the same or similar to the benefit categories used by other plans. For this

purpose, benefit categories shall be those specified in ~~subdivision (e)~~ *subparagraph (A) of paragraph (1) of subdivision (g)*.

~~(19)~~

(2) (A) 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~~

(B) 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 service category, using service categories that are, to the maximum extent possible, the same or similar to those used by other plans. For this purpose, benefit categories shall be those specified in ~~subdivision (e)~~ *subparagraph (A) of paragraph (1) of subdivision (g)*.

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

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

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

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

~~(24) Any changes in administrative costs.~~

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

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

~~(1) Plan year.~~

~~(2) Segment type.~~

~~(3) Product type.~~

~~(4) Number of subscribers.~~

~~(5) Number of covered lives affected.~~

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

~~(A) Plan year.~~

~~(B) Segment type.~~

~~(C) Product type.~~

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

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

~~(e) A~~

(g) In addition to the other information required under this section, a health care service plan that is unable to provide information on rate ~~increases~~ *change* by benefit categories, as defined in subdivision (d) of Section 1385.07, including, but not limited to, hospital, outpatient medical, and mental health, or information on trend attributable to cost and trend attributable to utilization by benefit category pursuant to subdivision (d) *of Section 1385.07*, shall annually disclose all of the following aggregate data for its large group health care service plan contracts:

(1) (A) The plan's overall aggregate data demonstrating or reasonably estimating year-to-year cost ~~increases~~ *change* in the aggregate for large group rates by major service category. The plan shall distinguish between the ~~increase~~ *change* ascribed to the volume of services provided and the increase ascribed to the cost of services provided for those assumptions that shall include the following categories:

(i) Hospital inpatient.

(ii) Outpatient visits.

(iii) Outpatient surgical or other procedures.

(iv) Professional medical.

(v) Mental health.

(vi) Substance abuse.

(vii) Skilled nursing facility, if covered.

(viii) Prescription drugs.

(ix) Other ancillary services.

(x) Laboratory.

(xi) Radiology or imaging.

(B) A plan may provide ~~aggregated~~ additional *aggregated* data that ~~demonstrate~~ *demonstrates* or reasonably ~~estimate~~ *estimates* year-to-year cost ~~increases~~ *change* in each of the specific service categories specified in subparagraph (A) for each of the major geographic regions of the state if any.

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

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

(B) Capital investment.

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

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

~~(f)~~

(h) (1) A health care service plan shall annually provide claims data at no charge to a large group purchaser if the large group purchaser requests the information. The health care service plan shall provide claims data that a qualified statistician has determined ~~are~~ *is* deidentified so that the claims data ~~do~~ *does* not identify or ~~do not~~ provide a reasonable basis from which to identify an individual.

(2) Information provided to a large group purchaser under this subdivision is not subject to Section 1385.07.

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

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

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

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

(B) The health care service plan shall obtain a formal determination from a qualified statistician that the data provided pursuant to this paragraph ~~have~~ *has* been deidentified so that the data ~~do~~ *does* not identify or ~~do not~~ provide a reasonable basis from which to identify an individual. The statistician shall certify the

formal determination in writing and shall, upon request, provide the protocol used for deidentification to the department.

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

(A) ~~Is~~ *The large group purchaser is* able to demonstrate its ability to comply with state and federal privacy laws.

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

~~(g)~~

(i) 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. 4. Section 791.27 of the Insurance Code is amended to read:

791.27. (a) A disability insurer that provides coverage for hospital, medical, or surgical expenses shall not release 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. An insurer that has, pursuant to an agreement, assumed the responsibility to pay compensation pursuant to Article 3 (commencing with Section 3750) of Chapter 4 of Part 1 of Division 4 of the Labor Code, shall not be considered an employer for the purposes of this section.

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

(c) Nothing in this section prohibits a health insurer from releasing relevant information described in this section for the purposes set forth in subdivision ~~(f)~~ *(h)* of Section 10181.4.

SEC. 5. 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 at least 60 days prior

to implementing any rate change all required rate information for *unreasonable* rate ~~increases that exceed 5 percent of the prior year's rate~~ *increases*. This filing shall be concurrent with the written notice described in Section 10199.1.

(b) 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.

(c) A health insurer ~~subject to subdivision (a)~~ shall disclose ~~for each rate filing that exceeds 5 percent of the prior year's rate for that group all of the following:~~ *the following aggregate information for rates in the large group market:*

(1) Company name and contact information.

(2) Number of ~~policy forms~~ *policies* covered by the filing.

~~(3) Policy form numbers covered by the filing.~~

~~(4)~~

(3) Product type, such as indemnity or preferred provider organization.

~~(5)~~

(4) Segment type.

~~(6)~~

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

~~(7)~~

(6) Whether the products are opened or closed.

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

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

~~(10) Annual rate.~~

~~(11)~~

(7) Total earned premiums ~~in each policy form~~.

~~(12)~~

(8) Total incurred claims ~~in each policy form~~.

~~(13) Average rate change initially requested.~~

~~(14) Review category: initial filing for new product, filing for existing product, or resubmission.~~

~~(15) Average rate of change.~~

~~(16) Effective date of rate change.~~

(9) Average rate of increase for the rate year.

~~(17)~~

(10) Number of policyholders or insureds affected by each policy form.

(d) A health insurer shall disclose the methodology or methodologies used to develop the base rate or rates and all of the following information:

(1) The base rate for the groups in the large group market. If more than one base rate is used by the insurer, all of the base rates shall be disclosed, as well as the types of groups to which different base rates are applied.

(2) All factors used to adjust the base rate or rates including, but not limited to, the following:

(A) Industry or occupation, if either is applicable.

(B) Age.

(C) Health status, medical condition, or claims experience.

(D) Tobacco use, if applicable.

(E) Alcohol use, if applicable.

(F) Any other factor used to adjust the base rate or rates, with a description of the factor and an objective and scientifically valid explanation, based on up-to-date statistical or actuarial data.

(3) Any variation in rate or rates based on geographic regions, along with a description of the geographic regions used by the insurer. The description shall specify the applicable counties or, if counties are split, the ZIP Codes, in each region.

(4) Any variation due to benefits covered in addition to basic health care services, as well as a description of the benefits covered, such as prescription drugs, durable medical equipment, or infertility treatment, using the format specified in paragraph (2) of subdivision (a) of Section 10603.

(5) Variations due to differences in benefit design arising from differences in cost sharing, including copays, coinsurance, deductibles, annual out-of-pocket limitations, or any other cost sharing, using the format specified in paragraph (2) of subdivision (a) of Section 10603.

(6) The actuarial value of products, including the number of enrolled lives by the actuarial value tiers specified in paragraph (3) of subdivision (e).

(7) Any other factors affecting the base rate not described here.

(8) The amount or proportion that each factor contributes to the base rate. If the proportions do not add up to 100 percent, an explanation of how the remaining portion of the base rate or rates are derived.

(9) If an insurer uses modified community rating for any segment of the large group, such as new business or groups of a certain size, the insurer shall describe the modifications to community rating and the market segments to which modified community rating applies.

(10) Any change from the prior year in methodology, factors, or assumptions used to develop a base rate or rates.

(e) (1) The insurer shall also provide the following aggregate information regarding rate changes for the large group market:

(A) Average rate change during the prior year.

(B) Average monthly rate implemented during the prior year.

(C) Average rate change initially requested.

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

(E) Any changes in insured cost sharing over the prior year, including the range of changes and the number and proportion of insureds affected.

(F) Any changes in insured benefits over the prior year, including the number and proportion of insureds affected.

(G) Any changes in administrative costs.

(2) The information described in paragraph (1) shall be categorized by family composition, such as single, single plus one, and family, or any other family composition as the insurer may use. If the insurer uses an alternative family composition, it shall provide a description of that family composition.

(3) The information described in paragraph (1) shall also be categorized by actuarial value tier, using the following actuarial value tiers:

(A) 90 to 100 percent.

(B) 80 to 89 percent.

(C) 70 to 79 percent.

(D) 60 to 69 percent.

(E) Under 60 percent, if any.

(f) The insurer shall provide the following aggregate information regarding trend factors used to develop the change in rate:

~~(18)~~

(1) (A) The 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. ~~An insurer may provide aggregated~~

~~additional data that demonstrates or reasonably estimates year-to-year cost changes in specific benefit categories in major geographic regions of the state if rates vary by region. If rates vary by region, the insurer shall provide a description of the regions used by the insurer.~~

(B) An insurer that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for its insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate benefit category, using service categories that are, to the maximum extent possible, the same or similar to the benefit categories used by other plans. For this purpose, benefit categories shall be those specified in subparagraph (A) of paragraph (1) of subdivision (g).

~~(19)~~

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

(B) 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 its insureds shall instead disclose the amount of its actual trend experience for the prior contract year by aggregate service category, using service categories that are, to the maximum extent possible, the same or similar to those used by other plans. For this purpose, benefit categories shall be those specified in subparagraph (A) of paragraph (1) of subdivision (g).

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

~~(21) Any changes in insured cost-sharing over the prior year associated with the submitted rate filing.~~

~~(22) Any changes in insured benefits over the prior year associated with the submitted rate filing.~~

~~(23) The certification described in subdivision (b) of Section 10181.6.~~

~~(24) Any changes in administrative costs.~~

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

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

~~(1) Policy year.~~

~~(2) Segment type.~~

~~(3) Product type.~~

~~(4) Number of policyholders.~~

~~(5) Number of covered lives affected.~~

~~(6) The insurer's average rate change by the following:~~

~~(A) Policy year.~~

~~(B) Segment type.~~

~~(C) Product type.~~

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

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

~~(e) A~~

(g) In addition to the other information required under this section, a health insurer that is unable to provide information on rate ~~increases~~ *change* by benefit categories, as defined in subdivision (d) of Section ~~10181.7~~ *10181.7*, including, but not limited to, hospital, outpatient medical, and mental health, or information on trend attributable to cost and trend attributable to utilization by benefit category pursuant to subdivision ~~(d),~~ *(d) of Section 10181.7*, shall annually disclose all of the following aggregate data for its large group health insurance policies:

(1) (A) The insurer's overall aggregate data demonstrating or reasonably estimating year-to-year cost ~~increases~~ *change* in the aggregate for large group rates by major service category. The insurer shall distinguish between the ~~increase~~ *change* ascribed to the volume of services provided and the increase ascribed to the cost of services provided for those assumptions that shall include the following categories:

(i) Hospital inpatient.

(ii) Outpatient visits.

(iii) Outpatient surgical or other procedures.

(iv) Professional medical.

(v) Mental health.

(vi) Substance abuse.

(vii) Skilled nursing facility, if covered.

(viii) Prescription drugs.

(ix) Other ancillary services.

(x) Laboratory.

(xi) Radiology or imaging.

(B) An insurer may provide ~~aggregated~~ additional *aggregated* data that ~~demonstrate~~ *demonstrates* or reasonably ~~estimate~~ *estimates* year-to-year cost ~~increases~~ *change* in each of the specific service categories specified in subparagraph (A) for each of the major geographic regions of the state if any.

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

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

(B) Capital investment.

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

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

~~(f)~~

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

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

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

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

(ii) Deidentified patient-level data on demographics, prescribing, encounters, inpatient services, outpatient services, and any other data as may be required of the health insurer to comply with risk adjustment, reinsurance, or risk corridors pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148),

as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued ~~thereunder~~ *pursuant to these acts*.

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

(B) The health insurer shall obtain a formal determination from a qualified statistician that the data provided pursuant to this paragraph ~~have~~ *has* been deidentified so that the data ~~do~~ *does* not identify or ~~do not~~ provide a reasonable basis from which to identify an individual. The statistician shall certify the formal determination in writing and shall, upon request, provide the protocol used for deidentification to the department.

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

(A) ~~Is~~ *The large group purchaser is* able to demonstrate its ability to comply with state and federal privacy laws.

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

~~(g)~~

(i) 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. 6. 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.

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