HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] *(Division 2 enacted by Stats. 1939, Ch. 60.)*

CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874] *(Chapter 2.2 added by Stats. 1975, Ch. 941.)*

ARTICLE 6.2. Review of Rate Increases [1385.01 - 1385.14] *(Article 6.2 added by Stats. 2010, Ch. 661, Sec. 4.)*

1385.01. For purposes of this article, the following definitions shall apply:

(a) (1) “Blended” means a rating method that combines community rating and experience rating methods.

(2) “Community rated” means a rating method in the large group market that bases rates on the expected costs to a health care service plan of providing covered benefits to all enrollees, including both low-risk and high-risk enrollees. Premiums may vary according to the factors in this article.

(3) “Experience rated” means a rating method in the large group market under which a health care service plan calculates the premiums for a large group in whole or blended based on the group’s prior experience.

(b) (1) For individual and small group market products, “geographic region” has the same meaning as in Sections 1357.512 and 1399.855.

(2) For large group market products, “geographic region” means one of the following areas composed of the regions defined in Sections 1357.512 and 1399.855:

(A) An area composed of regions 2, 4, 5, 6, 7, and 8, which consist of the Counties of Alameda, Contra Costa, Marin, Napa, San Mateo, Santa Clara, Solano, and Sonoma and the City and County of San Francisco.

(B) An area composed of regions 1 and 3, which consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

(C) An area composed of regions 9 and 12, which consist of the Counties of Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura.

(D) An area composed of regions 10, 11, and 14, which consist of the Counties of Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(E) An area composed of regions 13 and 17, which consist of the Counties of Imperial, Inyo, Mono, Riverside, and San Bernardino.

(F) An area composed of regions 15 and 16, which consist of the County of Los Angeles.

(G) An area composed of regions 18 and 19, which consist of the Counties of Orange and San Diego.

(c) “Large group health care service plan contract” means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(d) “Small group health care service plan contract” means a group health care service plan contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(e) “PPACA” means Section 2794 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal Patient Protection and Affordable Care Act (Public Law (111-148)), and any subsequent rules, regulations, or guidance issued under

that section.

(f) “Unreasonable rate increase” has the same meaning as that term is defined in PPACA.

(Amended by Stats. 2019, Ch. 807, Sec. 2. (AB 731) Effective January 1, 2020.)

1385.02. This article shall apply to a health care service plan contract offered in the individual or group market in California, including a health care service plan contract covering dental services and a specialized health care service plan contract covering dental services. However, this article shall not apply to a nondental specialized health care service plan contract, a Medicare supplement contract subject to Article 3.5 (commencing with Section 1358.1), a health care service plan contract offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan contract offered in the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article 10.5 (commencing with Section 1399.801), or a Mexican prepaid health plan subject to Section 1351.2. This article does not limit, impair, or interfere with the authority of the California Public Employees’ Retirement System, as set forth in Section 22794 of the Government Code and Article 6 (commencing with Section 22850) of Part 5 of Division 5 of Title 2 of the Government Code.

(Amended by Stats. 2023, Ch. 557, Sec. 2. (AB 1048) Effective January 1, 2024.)

1385.026. The Legislature finds and declares that Sections 19 and 29 of this act, which add Sections 1385.0011 and 1385.0021, respectively, to the Health and Safety Code, impose a limitation on the public’s right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

To balance the public’s right to access records with the need to protect proprietary information received from pharmacy benefit managers, it is necessary that the information be kept confidential.

(Added by Stats. 2025, Ch. 21, Sec. 34. (AB 116) Effective June 30, 2025.)

1385.03. (a) (1) A health care service plan shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered group health care service plan contracts at least 120 days before implementing any rate change.

(2) A health care service plan shall file with the department all required rate information for nongrandfathered individual health care service plan contracts on the earlier of the following dates:

(A) One hundred days before the commencement of the annual enrollment period of the preceding policy year.

(B) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(3) For large group products that are either experience rated, in whole or blended, or community rated, a health care service plan shall file the information required by this article at least annually and shall file 120 days before any change in the methodology, factors, or assumptions that would affect the rates paid by a large group.

(b) A plan shall disclose to the department all of the following for each rate filing for products in the individual, small group, community-rated segment of the large group market, and experience-rated segment, in whole or blended, in the large group market:

(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 increase initially requested.

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

(15) Average rate of increase.

(16) Effective date of rate increase.

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

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

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

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

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

(22) Any changes in administrative costs.

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

(c) A health care service plan subject to subdivision (a) shall disclose the following by geographic region for individual, grandfathered group, and nongrandfathered group contracts:

(1) 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. The plan shall also disclose integrated care management fees or other similar fees, as well as reclassification of services from one benefit category to another, such as from inpatient to outpatient.

(2) Aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories.

(3) Information by benefit category that demonstrates the price paid compared to the price paid by the Medicare Program for the same services.

(4) Variation in trend, by geographic region, if the plan serves more than one geographic region.

(d) A health care service plan subject to subdivision (a) shall disclose, by geographic region for individual, grandfathered group, and nongrandfathered group contracts, 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.

(e) A health care service plan subject to subdivision (a) that fails to file the information required by subdivisions (c), (d), (g), and (h) for each benefit category shall also disclose the following for individual, grandfathered group, and nongrandfathered group contracts by market and by geographic region:

(1) The amount spent in the prior two years, the amount projected to be spent in the current year, and the amount projected to be spent for the subsequent year for each of the following:

(A) Physician services.

(B) Inpatient hospital services.

(C) Outpatient hospital services, including emergency department services.

(D) Laboratory services.

(E) Imaging and radiology services.

(F) Other ancillary services.

(G) Prescription drugs.

(H) Integrated care management fees or other similar fees.

(I) Reclassification of services from one benefit category to another, such as from inpatient to outpatient.

(2) Utilization of services for the prior two years, current year, and subsequent year, as measured by the plan for the following:

(A) Physician services.

(B) Inpatient hospital services.

(C) Outpatient hospital services, including emergency department services.

(D) Laboratory services.

(E) Imaging and radiology services.

(F) Other ancillary services.

(G) Prescription drugs.

(f) 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 group health care service 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 increase 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. If rate filings in a prior year or years included a description of cost containment or quality improvement efforts, the plan shall document the effects of those efforts, if any, including the impact on rates and documented improvements in quality, such as reduction of readmissions, reduction of emergency room use, or other recognized measures of quality improvement.

(g) For large group experience-rated, in whole or blended, and community-rated filings, the plan shall also submit the following:

(1) The geographic regions used.

(2) Age, including age rating factors.

(3) Industry or occupation adjustments.

(4) Family composition.

(5) Enrollee cost sharing.

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

(7) The base rate or rates and the factors used to determine the base rate or rates.

(8) Whether benefits, including prescription drugs, dental, and vision, are separately contracted.

(9) Variations in covered benefits, including durable medical equipment, infertility, and other similar benefits.

(10) Cost-sharing variations, described with actuarial value ranges and any expected impact on rates.

(11) Any other factor that affects the community rating.

(h) For large group filings that are experience rated, either in whole or blended, the plan shall submit the methodology for modifying the rate based on experience.

(i) (1) 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.

(2) If California-specific information is required, the department may require additional schedules or documents.

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

(k) (1) A plan shall respond to the department's request for any additional information necessary for the department to complete its review of the plan's rate filing for individual and group health care service plan contracts under this article within five business days of the department's request or as otherwise required by the department.

(2) Except as provided in paragraph (3), the department shall determine whether a plan's rate change for individual and small group health care service plan contracts is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to makes its determination. For both experience-rated, in whole or blended, and community-rated large groups, the department shall determine whether the methodology, factors, and assumptions used to determine rates are unreasonable or not justified no later than 60 days following receipt of all the information the department requires to make its determination.

(3) For all nongrandfathered individual health care service plan contracts, the department shall issue a determination that the plan's rate change is unreasonable or not justified no later than 15 days before the start of the next annual enrollment period. If a health care service plan fails to provide all the information the department requires in order for the department to make its determination, the department may determine that a plan's rate change is unreasonable or not justified.

(4) The department may contract with a consultant or consultants with expertise to assist the department in its review. Contracts entered into pursuant to the authority in this article shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and the State Contract Act (Chapter 1 (commencing with Section 10100) of Part 2 of Division 2 of the Public Contract Code).

(l) If the department determines that a plan's rate change for individual or group health care service plan contracts is unreasonable or not justified consistent with this article, the health care service plan shall provide notice of that determination to an individual or group applicant. For experience-rated, in whole or blended, and community-rated large groups, the determination by the department shall apply to methodology, factors, and assumptions used to determine rates. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 1389.25. The notice provided to a group applicant shall be consistent with the notice described in Section 1374.21.

(m) Failure to provide the information required by subdivision (b), (c), (d), (e), (g), or (h) shall constitute an unjustified rate.

(n) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 1399.845.

(o) (1) The department may adopt emergency regulations implementing this section. The department may, on a one-time basis, readopt an emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(p) This section shall become operative on July 1, 2020.

(Repealed (in Sec. 4) and added by Stats. 2019, Ch. 807, Sec. 5. (AB 731) Effective January 1, 2020. Section operative July 1, 2020, by its own provisions.)

1385.035. (a) It is the intent of the Legislature in enacting this section to ensure that enrollees and subscribers benefit from reductions in the rate of growth in health care costs as a result of the establishment of the Office of Health Care Affordability.

(b) In submitting rates for review consistent with this article, a health care service plan shall demonstrate the impact of any changes in the rate of growth in health care costs resulting from the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

(c) In determining whether a rate is unreasonable or not justified, the director shall consider the impact on changes in health care costs as a result of the health care cost targets set pursuant to Chapter 2.6 (commencing with Section 127500) of Part 2 of Division 107.

(Added by Stats. 2022, Ch. 47, Sec. 7. (SB 184) Effective June 30, 2022.)

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. 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 also disclose the following aggregate data for all rate filings 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) The plan's average rate increase 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.

(Added by Stats. 2010, Ch. 661, Sec. 4. (SB 1163) Effective January 1, 2011.)

1385.043. (a) A health care service plan, not including a specialized health care service plan, shall annually report to the department the information described in subdivision (c) for all grandfathered and nongrandfathered products that the plan offers and sells in the individual market, including both on-exchange and off-exchange enrollment, for rates effective during the 12-month period ending January 1 of the following year.

(b) A health care service plan, not including a specialized health care service plan, shall annually report to the department the information described in subdivision (c) for all grandfathered and nongrandfathered products that the plan offers and sells in the small group market, including both on-exchange and off-exchange enrollment, for products with rates effective during that 12-month period ending January 1 of the following year.

(c) (1) Information on premiums, including share of premium, if applicable, average premium weighted by enrollment, and weighted average rate change.

(2) Cost sharing, including deductibles, maximum out-of-pocket limit, copayments, coinsurance, and any other cost sharing for covered benefits as well as high deductible health plans.

(3) (A) For nongrandfathered plans, benefits, including essential health benefits or basic health care services.

(B) For grandfathered plans, basic health care services and mandates.

(4) Standard and nonstandard benefit designs, including on-exchange and off-exchange nonstandard benefit designs.

(5) Enrollment by actuarial value tier, product, benefit design and premiums, including both of the following:

(A) Enrollment in products with zero deductibles, high deductibles as defined in this section, and deductibles between zero and high.

(B) (i) Enrollment by premium.

(ii) For small group products, enrollment by share of premium.

(6) Trend factors as reported in individual and small group rate filings for the health care service plan, including both price and utilization, as required in Section 1385.03.

(d) By October 1, 2021, and annually thereafter, a health care service plan shall submit the annual report, as described under subdivision (a), to the department in a form and manner determined by the department.

(e) Beginning in 2022, the department shall annually present the information reported under this section in the meeting specified in Section 1385.045, a meeting of the Financial Solvency Standards Board, or at any other public meeting the department deems appropriate. The department also shall post the information reported under this section on its internet website no later than December 15 of each year.

(f) The following definitions apply for purposes of this section:

(1) “Average premium weighted by enrollment” means the following:

(A) For the individual market, the average premium shall be weighted by the number of individual enrollees in the plan’s individual market during the 12-month period.

(B) For the small group market, the average premium shall be weighted by the number of enrollees in each small group benefit design in the plan’s small group market during the 12-month period.

(2) “Benefit design” means the cost sharing for covered benefits.

(3) “High deductible” has the same meaning as defined in Section 223(c)(2)(A) of Title 26 of the United States Code.

(4) “Nonstandard benefit design” means a benefit design other than the standard benefit design.

(5) “Share of premium” means the share of premium paid by the enrollee on behalf of the enrollee and any dependents, not the subscriber.

(6) “Standard benefit design” means the standardized products approved by the executive board of the California Health Benefit Exchange pursuant to subdivision (c) of Section 100504 of the Government Code.

(g) Until January 1, 2023, a health care service plan shall not be required to report either of the following information:

(1) Share of premium paid by enrollee.

(2) Enrollment by benefit design, deductible, or share of premium.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters, forms, or similar instructions, without taking regulatory action until January 1, 2024.

(Added by Stats. 2020, Ch. 277, Sec. 1. (AB 2118) Effective January 1, 2021.)

1385.045. (a) For large group health care service plan contracts, a health care service 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 a public meeting in every even-numbered year regarding large group rates within four 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, including cost sharing for prescription drugs.

(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.

(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.

(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 care service plan.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health care service plan spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The plan shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2018, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

(Amended by Stats. 2020, Ch. 370, Sec. 195. (SB 1371) Effective January 1, 2021.)

1385.046. (a) Upon receiving notice of a rate change, a large group contractholder that has coverage that is experience rated in whole or blended and that meets the criteria in subdivision (e) may apply within 60 days to have the department review the rate change to determine whether the rate change is unreasonable or not justified, consistent with this article.

(b) Upon receiving an application, the department shall notify the health care service plan of the application, and the plan shall provide the information required by the department to complete the department's review of the proposed rate within five business days of the department's request or as otherwise required by the department.

(c) The department shall use all reasonable efforts to complete its review of the rate change within 60 days of receiving all the information the department requires to make its determination, and shall notify the health care service plan and the large group contractholder of its determination.

(d) A rate change under review by the department shall not be imposed before a determination is made by the department pursuant to subdivision (c) or within 60 days following receipt by the department of all information the department requires to make its determination, whichever occurs earlier.

(e) To apply for a review of a rate change for a particular group, at least one of the following shall apply:

(1) The contractholder has more than 2,000 total enrollees.

(2) The plan failed to provide the information required by this article or Section 1385.10.

(f) To facilitate review, the department may group appeals that apply to the same health care service plan and that raise similar questions about rates, methodology, assumptions, or factors.

(g) The department may contract with a consultant or consultants with expertise to assist the department in its review. Contracts entered into pursuant to the authority in this article shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and the State Contract Act (Chapter 1 (commencing with Section 10100) of Part 2 of Division 2 of the Public Contract Code).

(h) This section shall become operative on July 1, 2021.

(Added by Stats. 2019, Ch. 807, Sec. 7. (AB 731) Effective January 1, 2020. Operative July 1, 2021, by its own provisions.)

1385.05. Notwithstanding any provision in a contract between a health care service plan and a provider, the department may request from a health care service plan any information required under this article or PPACA.

(Added by Stats. 2010, Ch. 661, Sec. 4. (SB 1163) Effective January 1, 2011.)

1385.06. (a) A filing submitted under this article shall be actuarially sound.

(b) (1) The plan shall contract with an independent actuary or actuaries consistent with this section.

(2) A filing submitted under this article shall include a certification by an independent actuary or actuarial firm that the rate increase is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies. Unless PPACA requires a certification of actuarial soundness for each large group contract, a filing submitted under Section 1385.04 shall include a certification by an independent actuary, as described in this section, that the aggregate or average rate increase is based on accurate and sound actuarial assumptions and methodologies.

(3) The actuary or actuarial firm acting under paragraph (2) shall not be an affiliate or a subsidiary of, nor in any way owned or controlled by, a health care service plan or a trade association of health care service plans. A board member, director, officer, or employee of the actuary or actuarial firm shall not serve as a board member, director, or employee of a health care service plan. A board member, director, or officer of a health care service plan or a trade association of health care service plans shall not serve as a board member, director, officer, or employee of the actuary or actuarial firm.

(c) Nothing in this article shall be construed to permit the director to establish the rates charged subscribers and enrollees for covered health care services.

(Added by Stats. 2010, Ch. 661, Sec. 4. (SB 1163) Effective January 1, 2011.)

1385.07. (a) Notwithstanding Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) (1) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code). The contracted rates between a health care service plan and a provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10.

(2) The contracted rates between a health care service plan, including those submitted to the department pursuant to Section 1385.046, and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 1385.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their internet websites in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health care service plan contracts, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care service plan contracts, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health care service plan's actual costs, by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) 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.

(Amended by Stats. 2021, Ch. 615, Sec. 228. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

1385.08. (a) On or before July 1, 2012, the director may issue guidance to health care service plans regarding compliance with this article. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) The department shall consult with the Department of Insurance in issuing guidance under subdivision (a), in adopting necessary regulations, in posting information on its Internet Web site under this article, and in taking any other action for the purpose of implementing this article.

(Added by Stats. 2010, Ch. 661, Sec. 4. (SB 1163) Effective January 1, 2011.)

1385.09. A health care service plan contract subject to Section 1385.03 or 1385.04 shall file a separate schedule documenting the cost savings associated with Section 1367.016 and the impact on rates.

(Added by Stats. 2019, Ch. 862, Sec. 4. (AB 290) Effective January 1, 2020.)

1385.10. (a) (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 and otherwise meets the requirements of this section.

(2) The health care service plan shall provide claims data that a qualified statistician has determined are deidentified so that the claims data do not identify or do not provide a reasonable basis from which to identify an individual. If the statistician is unable to determine that the data has been deidentified, then the data that cannot be deidentified shall not be provided by the health care service plan to the large group purchaser. A health care service plan may provide the claims data in an aggregated form as necessary to comply with subdivisions (e) and (f).

(b) (1) As an alternative to providing claims data required pursuant to subdivision (a), the plan shall provide, at no charge to a large group purchaser, all of the following:

(A) 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.

(B) Deidentified aggregated patient-level data on demographics, prescribing, encounters, inpatient services, outpatient services, and any other data that is comparable to what is 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.

(C) Deidentified aggregated patient-level data used to experience rate the large group, including diagnostic and procedure coding and costs assigned to each service that the plan has available.

(2) The health care service plan shall obtain a formal determination from a qualified statistician that the data provided pursuant to this subdivision have been deidentified so that the data do not identify or do not provide a reasonable basis from which to identify an individual. If the statistician is unable to determine that the data has been deidentified, the health care service plan shall not

provide the data that cannot be deidentified to the large group purchaser. The statistician shall document the formal determination in writing and shall, upon request, provide the protocol used for deidentification to the department.

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

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

(2) Is a large group purchaser that is either an employer with an enrollment of greater than 1,000 covered lives and at least 500 covered lives enrolled with the health care service plan providing the information or a multiemployer trust with an enrollment of greater than 500 covered lives and at least 250 covered lives enrolled with the health care service plan providing the information.

(d) Nothing in this section shall be construed to prohibit a plan and purchaser from negotiating the release of additional information not described in this section.

(e) All disclosures of data to the large group purchaser made pursuant to this section shall comply with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

(f) All disclosures of data to the large group purchaser made pursuant to this section shall comply with the Confidentiality of Medical Information Act (Chapter 1 (commencing with Section 56) of Part 2.6 of Division 1 of the Civil Code).

(Added by Stats. 2014, Ch. 577, Sec. 3. (SB 1182) Effective January 1, 2015.)

1385.11. (a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, including the filing of inaccurate or unjustified rates or inaccurate or unjustified rate information, the department may review the rate filing to ensure compliance with the law.

(b) The department may review other filings.

(c) The department shall accept and post to its Internet Web site any public comment on a rate increase submitted to the department during the applicable period described in subdivision (d) of Section 1385.07.

(d) The department shall report to the Legislature at least quarterly on all unreasonable rate filings.

(e) The department shall post on its Internet Web site any changes submitted by the plan to the proposed rate increase, including any documentation submitted by the plan supporting those changes.

(f) If the director makes a decision that an unreasonable rate increase is not justified or that a rate filing contains inaccurate information, the department shall post that decision on its Internet Web site.

(g) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this chapter.

(Amended by Stats. 2016, Ch. 498, Sec. 4. (SB 908) Effective January 1, 2017.)

1385.13. The department shall do all of the following in a manner consistent with applicable federal laws, rules, and regulations:

(a) Provide data to the United States Secretary of Health and Human Services on health care service plan rate trends in premium rating areas.

(b) Commencing with the creation of the Exchange, provide to the Exchange such information as may be necessary to allow compliance with federal law, rules, regulations, and guidance.

(Added by Stats. 2010, Ch. 661, Sec. 4. (SB 1163) Effective January 1, 2011.)

1385.14. (a) This section shall apply only to a health care service plan covering dental services and a specialized health care service plan covering dental services, as defined in Section 1374.194.

(b) On or after January 1, 2025, and at least annually thereafter, a plan shall file with the department the information required by this article, as applicable, including, but not limited to, all of the following:

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

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

(3) Whether the products are opened or closed.

(4) Annual rate.

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

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

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

(8) Average rate of increase.

(9) Effective date of rate increase.

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

(11) A comparison of claims cost and rate 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) Any changes in administrative costs.

(15) Variation in trend, by geographic region, if the plan serves more than one geographic region.

(16) The loss ratio for the plan contract as described in Section 1367.004.

(17) Proposed and effective rates for all products.

(18) A rating manual that outlines the methodology used in the development of the premium rates, along with a description of how rates were determined.

(19) The base rate or rates and the factors used to determine the base rate or rates.

(20) Trend, including overall average, and by-product, if different.

(21) Any other factors affecting dental premium rates.

(22) An actuarial certification signed by a qualified actuary.

(23) Any other information required for the department to make its determination.

(c) (1) The plan shall file with the department the required information at least 120 days before any change in the methodology, factors, or assumptions that would affect rates.

(2) A plan shall respond to the department's request for any additional information necessary for the department to complete its review of the plan's rate filing for individual and group plan contracts within five business days of the department's request or as otherwise required by the department.

(3) If a plan fails to provide all the information the department requires in order for the department to make its determination, the department may determine that a plan's rate change is unreasonable or not justified.

(4) If the department determines that a plan's rate change for individual or group plan contracts is unreasonable or not justified consistent with this article, the plan shall provide notice of that determination to an individual or group applicant or subscriber.

(5) The department may contract with a consultant or consultants with expertise to assist the department in its review. Contracts entered into pursuant to the authority in this article shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and the State Contract Act (Chapter 1 (commencing with Section 10100) of Part 2 of Division 2 of the Public Contract Code).

(d) For all plans covering dental services, the department shall issue a determination that the plan's rate change is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to make its determination. The determination by the department shall also apply to the methodology, factors, and assumptions used to determine rates.

(e) The department may review the rate filings to ensure compliance with the law, as described in Section 1385.11, excluding subdivision (c).

(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) (1) The department may adopt emergency regulations implementing this section. The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(2) On or before July 1, 2024, the director may issue guidance to plans regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(3) The department shall consult with the Department of Insurance when issuing guidance on adopting necessary regulations pursuant to this subdivision.

(Added by Stats. 2023, Ch. 557, Sec. 3. (AB 1048) Effective January 1, 2024.)