§ 1385.03. Filing of rate information for health care service plan contracts prior to implementing any rate change; Disclosure of infor- mation

(a)(1) A health care service plan shall file with the department all required rate information for grandfathered individual and grandfathered and non-grandfathered 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.

HISTORY:

Added Stats 2019 ch 807 § 5 (AB 731), effective January 1, 2020, operative July 1, 2020.