

§ 1367.003. Rebate on pro rata basis; Conditions; Minimum medical loss ratios; Total amount of rebate; Adoption of regulations; Applicability

(a) A health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, but not including specialized health care service

plan contracts that provide only dental or vision services, shall provide an annual rebate to each enrollee under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health care service plan on the costs for reimbursement for clinical services provided to enrollees under that coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(b) A health care service plan that issues, sells, renews, or offers health care service plan contracts for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health care service plan offering coverage in the large group market, 85 percent.

(2) With respect to a health care service plan offering coverage in the small group market or in the individual market, 80 percent.

(c)(1) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or

(2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health care service plan shall provide a rebate owing to an enrollee no later than September 30 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(d) The director may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(e) The requirements of this section shall be implemented as described in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections as in effect on January 1, 2017.

(f) This section does not apply to provisions of this chapter pertaining to financial statements, assets, liabilities, and other accounting items to which subdivision (s) of Section 1345 applies.

(g) This section does not apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

HISTORY:

Added Stats 2011 ch 644 § 2 (SB 51), effective January 1, 2012. Amended Stats 2018 ch 678 § 1 (AB 2499), effective January 1, 2019.

§ 1367.004. Plans covering dental services; MLR annual report requirement; Examination by director; Use of data by Legislature; Compliance guidance exempt from APA

(a) A health care service plan that issues, sells, renews, or offers a contract covering dental services shall file a report with the department by July 31 of each year, which shall be known as the MLR annual report. The MLR annual report shall be organized by market and product type and shall contain the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The department shall post a health care service plan's MLR annual report on its Internet Web site within 45 days after receiving the report.

(b) The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. As applicable, all terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with Section 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

(c) If the director decides to conduct a financial examination, as described in Section 1382, because the director finds it necessary to verify the health care service plan's representations in the MLR annual report, the department shall provide the health care service plan with a notification 30 days before the commencement of the financial examination.

(d) The health care service plan shall have 30 days from the date of notification to electronically submit to the department all requested records, books, and papers specified in subdivision (a) of Section 1381. The director may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.

(e) The department shall make available to the public all of the data provided to the department pursuant to this section.

(f) This section does not apply to a health care service plan contract issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or 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), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(g) The department may issue guidance to specialized health care service plans subject to this section regarding compliance with this section. The guidance shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), and shall be effective only until the department adopts regulations pursuant to that act. The department shall consult with the Department of Insurance in issuing the guidance specified in this section.

HISTORY:

Added Stats 2014 ch 567 § 1 (AB 1962), effective January 1, 2015. Amended Stats 2015 ch 303 § 252 (AB 731), effective January 1, 2016; Stats 2018 ch 933 § 3 (SB 1008), effective January 1, 2019.