

AMENDED IN ASSEMBLY SEPTEMBER 4, 2013

AMENDED IN ASSEMBLY AUGUST 6, 2013

AMENDED IN ASSEMBLY JUNE 25, 2013

AMENDED IN ASSEMBLY JUNE 17, 2013

AMENDED IN SENATE APRIL 30, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 9, 2013

**SENATE BILL**

**No. 746**

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**Introduced by Senator Leno**

February 22, 2013

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An act to amend Section 1385.04 of the Health and Safety Code, *and to amend Section 10181.4 of the Insurance Code*, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 746, as amended, Leno. Health care coverage: premium rates.

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 provides for the regulation of health insurers by the Department of Insurance.* Existing law requires health care service plans, for large group plan contracts, *and health insurers, for large group health insurance policies*, at least 60 days in advance of a rate change, to file with the ~~department~~ *respective departments* all specified rate information for unreasonable rate increases and, with that filing, to disclose specified aggregate data.

This bill would instead require the plans *and insurers* to disclose specified aggregate data for products and for rate filings, as specified, in the large group market on an annual basis. The bill would also require a health plan *or health insurer* that exclusively contracts with no more than 2 medical groups in the state to provide claims or other data to large group purchasers that request the data and demonstrate the ability to comply with privacy laws, as specified, and would require the health care service plan *or health insurer* to use only deidentified data in those disclosures, as specified, to protect the privacy rights of individuals.

Because a willful violation of the bill’s requirements would be a crime, this 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:*

- 1 SECTION 1. Section 1385.04 of the Health and Safety Code
- 2 is amended to read:
- 3 1385.04. (a) For large group health care service plan contracts,
- 4 all health plans shall file with the department at least 60 days prior
- 5 to implementing any rate change all required rate information for
- 6 unreasonable rate increases. This filing shall be concurrent with
- 7 the written notice described in subdivision (a) of Section 1374.21.
- 8 (b) For large group rate filings, health plans shall submit all
- 9 information that is required by PPACA. A plan shall also submit
- 10 any other information required pursuant to any regulation adopted
- 11 by the department to comply with this article.
- 12 (c) A health care service plan subject to subdivision (a) shall
- 13 also disclose annually the following aggregate data for all rate
- 14 filings submitted under this section:
- 15 (1) Number and percentage of rate filings reviewed by the
- 16 following:
- 17 (A) Plan year.
- 18 (B) Segment type.
- 19 (C) Product type.

- 1 (D) Number of subscribers.
- 2 (E) Number of covered lives affected.
- 3 (2) The plan's average rate increase by the following categories:
- 4 (A) Plan year.
- 5 (B) Segment type.
- 6 (C) Product type.
- 7 (D) Benefit category.
- 8 (E) Number of covered lives affected.
- 9 (3) Any cost containment and quality improvement efforts since
- 10 the plan's last rate filing for the same category of health benefit
- 11 plan. To the extent possible, the plan shall describe any significant
- 12 new health care cost containment and quality improvement efforts
- 13 and provide an estimate of potential savings together with an
- 14 estimated cost or savings for the projection period.
- 15 (d) Except as provided in subdivision (e), a health care service
- 16 plan shall disclose annually the following aggregate data for all
- 17 products sold in the large group market:
- 18 (1) Plan year.
- 19 (2) Segment type.
- 20 (3) Product type.
- 21 (4) Number of subscribers.
- 22 (5) Number of covered lives affected.
- 23 (6) The plan's average rate increase by the following:
- 24 (A) Plan year.
- 25 (B) Segment type.
- 26 (C) Product type.
- 27 (D) Benefit category, including, but not limited to, hospital,
- 28 medical, ancillary, and other benefit categories reported publicly
- 29 for individual and small employer rate filings.
- 30 (E) Trend attributable to cost and trend attributable to utilization
- 31 by benefit category.
- 32 (e) A health care service plan that is unable to provide
- 33 information on rate increases by benefit categories, including, but
- 34 not limited to, hospital, outpatient medical, and mental health, or
- 35 information on trend attributable to cost and trend attributable to
- 36 utilization by benefit category pursuant to subdivision (d) shall
- 37 disclose annually all of the following aggregate data for its large
- 38 group health care service plan contracts:
- 39 (1) The plan's overall aggregate data demonstrating or
- 40 reasonably estimating year-to-year cost increases in the aggregate

1 for large group rates by major service category. The plan shall  
2 distinguish between the increase ascribed to the volume of services  
3 provided and the increase ascribed to the cost of services provided,  
4 for those assumptions that shall include the following categories:

- 5 (A) Hospital inpatient.
- 6 (B) Outpatient visits.
- 7 (C) Outpatient surgical or other procedures.
- 8 (D) Professional medical.
- 9 (E) Mental health.
- 10 (F) Substance abuse.
- 11 (G) Skilled nursing facility, if covered.
- 12 (H) Prescription drugs.
- 13 (I) Other ancillary services.
- 14 (J) Laboratory.
- 15 (K) Radiology or imaging.

16 (2) A plan may provide aggregated additional data that  
17 demonstrate or reasonably estimate year-to-year cost increases in  
18 each of the specific service categories specified in paragraph (1)  
19 for each of the major geographic regions of the state.

20 (3) The amount of projected trend attributable to the following  
21 categories:

- 22 (A) Use of services by service and disease category.
- 23 (B) Capital investment.
- 24 (C) Community benefit expenditures, excluding bad debt and  
25 valued at cost.

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

29 (f) (1) A health care service plan that exclusively contracts with  
30 no more than two medical groups in the state to provide or arrange  
31 for professional medical services for the enrollees of the plan shall  
32 provide claims data at no charge to a large group purchaser  
33 annually if the large group purchaser requests the information. The  
34 health care service plan shall provide claims data that a qualified  
35 statistician has determined are deidentified so that the claims data  
36 do not identify or do not provide a reasonable basis from which  
37 to identify an individual.

38 (2) Information provided to a large group purchaser under this  
39 subdivision shall not be subject to the public disclosure  
40 requirements in subdivision (a) of Section 1385.07.

1 (3) If claims data are not available, the plan shall provide, at no  
2 charge, all of the following:

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

7 (B) Deidentified patient-level data on demographics, prescribing,  
8 encounters, inpatient services, outpatient services, and any other  
9 data as may be required of the health plan to comply with risk  
10 adjustment, reinsurance, or risk corridors as required by the  
11 PPACA.

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

15 (D) The health care service plan shall obtain a formal  
16 determination from a qualified statistician that the data have been  
17 deidentified so that the data do not identify or do not provide a  
18 reasonable basis from which to identify an individual. The  
19 statistician shall certify the formal determination in writing and  
20 shall, upon request, provide the protocol used for deidentification  
21 to the department.

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

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

27 (B) Is a large group purchaser that is either an  
28 employer-sponsored plan with an enrollment of greater than 1,000  
29 covered lives or a multiemployer trust.

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

36 *SEC. 2. Section 10181.4 of the Insurance Code is amended to*  
37 *read:*

38 10181.4. (a) For large group health insurance policies, all  
39 health insurers shall file with the department at least 60 days prior  
40 to implementing any rate change all required rate information for

1 unreasonable rate increases. This filing shall be concurrent with  
2 the written notice described in Section 10199.1.

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

7 (c) A health insurer subject to subdivision (a) shall also disclose  
8 *annually* the following aggregate data for all rate filings submitted  
9 ~~under this section in the large group health insurance market:~~  
10 *section:*

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

13 (A) ~~Plan~~-*Policy* year.

14 (B) Segment type.

15 (C) Product type.

16 (D) Number of insureds.

17 (E) Number of covered lives affected.

18 (2) The insurer's average rate increase by the following  
19 categories:

20 (A) ~~Plan~~-*Policy* year.

21 (B) Segment type.

22 (C) Product type.

23 (D) *Benefit category*.

24 (E) *Number of covered lives affected*.

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

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

35 (1) *Policy year.*

36 (2) *Segment type.*

37 (3) *Product type.*

38 (4) *Number of policyholders.*

39 (5) *Number of covered lives affected.*

40 (6) *The insurer's average rate increase by the following:*

- 1 (A) *Policy year.*
- 2 (B) *Segment type.*
- 3 (C) *Product type.*
- 4 (D) *Benefit category, including, but not limited to, hospital,*
- 5 *medical, ancillary, and other benefit categories reported publicly*
- 6 *for individual and small employer rate filings.*
- 7 (E) *Trend attributable to cost and trend attributable to*
- 8 *utilization by benefit category.*
- 9 (e) *A health insurer that is unable to provide information on*
- 10 *rate increases by benefit categories, including, but not limited to,*
- 11 *hospital, outpatient medical, and mental health, or information*
- 12 *on trend attributable to cost and trend attributable to utilization*
- 13 *by benefit category pursuant to subdivision (d), shall disclose*
- 14 *annually all of the following aggregate data for its large group*
- 15 *health insurance policies:*
- 16 (1) *The insurer's overall aggregate data demonstrating or*
- 17 *reasonably estimating year-to-year cost increases in the aggregate*
- 18 *for large group rates by major service category. The insurer shall*
- 19 *distinguish between the increase ascribed to the volume of services*
- 20 *provided and the increase ascribed to the cost of services provided,*
- 21 *for those assumptions that shall include the following categories:*
- 22 (A) *Hospital inpatient.*
- 23 (B) *Outpatient visits.*
- 24 (C) *Outpatient surgical or other procedures.*
- 25 (D) *Professional medical.*
- 26 (E) *Mental health.*
- 27 (F) *Substance abuse.*
- 28 (G) *Skilled nursing facility, if covered.*
- 29 (H) *Prescription drugs.*
- 30 (I) *Other ancillary services.*
- 31 (J) *Laboratory.*
- 32 (K) *Radiology or imaging.*
- 33 (2) *An insurer may provide aggregated additional data that*
- 34 *demonstrate or reasonably estimate year-to-year cost increases*
- 35 *in each of the specific service categories specified in paragraph*
- 36 *(1) for each of the major geographic regions of the state.*
- 37 (3) *The amount of projected trend attributable to the following*
- 38 *categories:*
- 39 (A) *Use of services by service and disease category.*
- 40 (B) *Capital investment.*

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

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

7 (f) (1) A health insurer that exclusively contracts with no more  
8 than two medical groups in the state to provide or arrange for  
9 professional medical services for the insureds of the insurer shall  
10 provide claims data at no charge to a large group purchaser  
11 annually if the large group purchaser requests the information.  
12 The health insurer shall provide claims data that a qualified  
13 statistician has determined are deidentified so that the claims data  
14 do not identify or do not provide a reasonable basis from which  
15 to identify an individual.

16 (2) Information provided to a large group purchaser under this  
17 subdivision shall not be subject to the public disclosure  
18 requirements in subdivision (a) of Section 10181.7.

19 (3) If claims data are not available, the insurer shall provide,  
20 at no charge, all of the following:

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

25 (B) Deidentified patient-level data on demographics,  
26 prescribing, encounters, inpatient services, outpatient services,  
27 and any other data as may be required of the health insurer to  
28 comply with risk adjustment, reinsurance, or risk corridors as  
29 required by PPACA.

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

33 (D) The health insurer shall obtain a formal determination from  
34 a qualified statistician that the data have been deidentified so that  
35 the data do not identify or do not provide a reasonable basis from  
36 which to identify an individual. The statistician shall certify the  
37 formal determination in writing and shall, upon request, provide  
38 the protocol used for deidentification to the department.

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

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

6 (B) Is a large group purchaser that is either an  
7 employer-sponsored plan with an enrollment of greater than 1,000  
8 covered lives or a multiemployer trust.

9 ~~(d)~~

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

16 ~~SEC. 2.~~

17 SEC. 3. No reimbursement is required by this act pursuant to  
18 Section 6 of Article XIII B of the California Constitution because  
19 the only costs that may be incurred by a local agency or school  
20 district will be incurred because this act creates a new crime or  
21 infraction, eliminates a crime or infraction, or changes the penalty  
22 for a crime or infraction, within the meaning of Section 17556 of  
23 the Government Code, or changes the definition of a crime within  
24 the meaning of Section 6 of Article XIII B of the California  
25 Constitution.