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

Introduced by Senator Leno

February 22, 2013

An act to amend Section 1385.04 of the Health and Safety 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 requires health care service plans, for large group plan contracts, at least 60 days in advance of a rate change, to file with the department all specified rate information for unreasonable rate increases and, with that filing, to disclose specified aggregate data.

This bill would instead require the plans 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 that exclusively contracts with no more than 2 medical groups in the state to annually disclose certain information with respect to its large group plan contracts to the department, including the plan's overall

annual medical trend factor assumptions by major service category ~~and the amount of the projected aggregate trend in the large group market attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by each major service category, as specified,~~ and 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. The bill would require a health care service plan to use only deidentified data in its 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:

SECTION 1. 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. 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 annually the following aggregate data for all rate filings submitted under this section:

(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.
(D) Benefit category.
(E) Number of covered lives affected.
(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) A health care service plan shall ~~also~~ disclose annually 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 increase by the following:
(A) Plan year.
(B) Segment type.
(C) Product type.
(D) Benefit ~~category.~~ *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 health care service 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 ~~also~~ disclose annually all of the following *aggregate data* for its large group health care service plan contracts:
(1) The plan's overall annual medical trend factor assumptions in the aggregate for large group rates by major service category. The plan shall distinguish between the trend ascribed to the volume of services provided and the trend ascribed to the cost of services

provided, for those assumptions that shall include the following categories:

(A) Hospital inpatient.

(B) Outpatient visits.

(C) Outpatient surgical or other procedures.

(D) Professional medical.

(E) Mental health.

(F) Substance abuse.

(G) Skilled nursing facility, if covered.

(H) Prescription drugs.

(I) Other ancillary services.

(J) Laboratory.

(K) Radiology or imaging.

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

~~(3) The amount of the projected aggregate trend in the large group market attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by each major service category specified in paragraph (1).~~

~~(4)~~

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

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

~~(B) Cost changes in administrative costs for the health plan.~~

~~(C) Cost changes in administrative costs for each of the two contracting medical groups with an exclusive contract with the plan.~~

~~(D)~~

(B) Capital ~~investment for care locations, including, but not limited to, hospitals and medical office buildings.~~ *investment.*

~~(E) Other capital investments.~~

~~(F)~~

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

~~(5)~~

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

(f) (1) A health care service 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 provide claims data at no charge to a large group purchaser *annually* if the large group purchaser requests the information. 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.

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

(3) If claims data are not available, the plan shall provide, at no charge, 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 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 as required by the PPACA.

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

(D) The health care service plan shall obtain a formal determination from a qualified statistician that the data have been deidentified so that the data do 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 subdivision (e) shall only be provided to a large group purchaser that meets both of the following conditions:

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

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

(g) 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. 2. 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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