# CAHP LEGISLATIVE INFORMATION

## AB 731 (Kalra)
## Chapter 807, Statutes of 2019

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**HEALTH CARE COVERAGE: RATE REVIEW**

## BACKGROUND

Assembly Bill 731 was introduced by Assemblymember Ash Kalra and was sponsored by the California Labor Federation, the California Teamsters and Health Access, California. AB 731 relates to large group premiums and rate review. The author of this bill stated that his intent was to build upon California's "proven rate review policy" for individual and small group insurance that, according to supporters, has saved consumers over $226 million.

AB 731 represents the latest bill in a long standing legislative battle over large group premiums. This bill has several components but the main portions are as follows: 1) All rate review filings (individual, small, large) are required to include more information, 2) health plans methodologies for large group premium calculation will be reviewed for reasonableness, and 3) specified large groups can request a full rate review from regulators.

In its original form the measure would have applied rate review to all large products; an impossible task considering that there were roughly 18,000 large group renewals in 2018. At each point in the legislative process the bill was reduced in scope. The final product, nevertheless, contains several problematic components. The bill still allows state regulators to deem large group rate methodologies, if not the exact rate, as unreasonable or not justified. The bill also triggers a full blown rate review if requested by a large group. consisting of more than 2000 employees, or if the health plans does not submit all of the required information.

CAHP strongly opposed AB 731 along with a large coalition of organizations representing large employers. Regrettably the constant amendments to the bill gave its proponents rhetorical cover to argue that the bill was less and less burdensome. The vote for this bill was interesting, with some majority Democrats abstaining or voting No. Most Republicans voted No. However, the opposition was not enough to stop the measure.

## REQUIREMENTS

AB 731 amends Sections 1374.21, 1385.01, 1385.02, 1385.045, and 1385.07 of, to amend, repeal, and add Section 1385.03 of, and to add Section 1385.046 to, the Health and Safety Code, relating to health care coverage.

Specifically, AB 731 does the following:

1374.21. (c) (1) Requires health plans to notify the contract holder if a large group contract rate has been determined unreasonable by DMHC or CDI.

1385.03. (a) (3) Requires, beginning July 1, 2020, for large group products that are either experience rated, in whole or blended, or community rated, a plan to file specified information 120 days before any change in the methodology, factors, or assumptions that would affect the rates paid by a large group.

Deletes exemptions in existing law for a health plan that exclusively contracts with no more than two medical groups to arrange for professional services from specified reporting requirements and alternative applicable disclosure requirements.

1385.03. (b) Requires a large group plan to disclose the same information as required in existing law for each individual and small group rate filings.

1385.03. (c) (1) Requires nongrandfathered individual, small and large group plans to disclose by geographic region, 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; and,
(2) aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories.

1385.03. (c) (3) Requires, in addition to 1385.03. (c) above, variation in trend, by geographic region, if plan or insurer serves more than one geographic region; and, information by benefit category that demonstrates the price paid compared to the price paid by Medicare for the same service.

1385.03. (e) Requires any individual, small, or large group plan that fails to file specified information for each benefit category to also disclose specified information for individual, grandfathered group, and nongrandfathered group contracts and policies by market and geographic regions.

1385.03. (i) Permits DMHC and CDI to require additional schedules or documents if California-specific information is required. Establishes time frames for response for further information and when the departments must make a determination.

1385.03. (k) (4) Permits DMHC and CDI to contract with consultants to assist with the review, and permits the departments to adopt emergency regulations.

1385.045. (b) (2) Changes the time frame for an existing public meeting requirement related to the large group market from annual to every even numbered year for DMHC.

1385.046. (e) (1) Allows a large group contract holder to apply for a review of a rate change, if the contractholder has more than 2,000 total enrollees; or, the plan failed to provide information specified in this bill and existing law.

1385.046. (f) Permits DMHC or CDI to group appeals that apply to the same plan and that raise similar questions about rates, methodology, assumptions, or factors.

1385.07. (b) (2) Makes contracted rates between a health plan and a large group, confidential information exempt from disclosure under the California Public Records Act.

1385.02. Exempts a Mexican prepaid health plan from rate review requirements and states that this article does not limit, impair, or interfere with the authority of the California Public Employees' Retirement System, as specified.

## COMPLIANCE DATES

July 1, 2020 – new requirements for grandfathered individual, grandfathered and non-grandfathered small group and all large group rate filings go into effect.

## IMPLEMENTATION ISSUES

This law applies to all grandfathered individual and small group, all large group and non-grandfathered individual and small group plans in the Commercial market.

This law will impose additional rate reporting requirements to the large group and grandfathered individual and small group rate reporting information. DMHC is very likely to create new reporting templates for these rate filings.

Wherein the law will require DMHC to conduct their rate reviews on newly created rating regions, health plans may need to make updates to product development or market research methodologies to assess comparative rates within the regions.

Any changes to underwriting methodologies for large group products will now need to be filed annually and at least 120 days before any change in the methodology. Health plans may need to build in additional lead time for large group renewal periods to account for this new filing requirement.

This law will also allow any large group that is experience-rated with more than 2,000 total enrollees to ask DMHC to conduct an ad-hoc rate review. DMHC must notify a health plan of this request and the health plan must submit all required information for DMHC to conduct its review within five (5) business days of DMHC's request. While the law does allow DMHC to have 60 days to reasonably conduct their review, there is no language in the law that would prohibit a renewal from effectuating if DMHC takes more than 60 days to conduct their review.