Assembly Bill No. 731

CHAPTER 807

An act to amend 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, and to amend Sections 10181, 10181.2, 10181.3, 10181.7, and 10199.1 of, and to add Section 10181.31 to, the Insurance Code, relating to health care coverage.

[Approved by Governor October 12, 2019. Filed with Secretary of State October 12, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 731, Kalra. Health care coverage: rate review.

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 a health care service plan or health insurer offering a contract or policy in the individual or small group market to file specified information, including total earned premiums and total incurred claims for each contract or policy form, with the appropriate department at least 120 days before implementing a rate change. Existing law requires a health plan that exclusively contracts with no more than 2 medical groups in the state to disclose actual trend experience information in lieu of disclosing specified annual medical trend factor assumptions and projected trends, as specified. Existing law requires the Department of Managed Health Care to conduct an annual public meeting regarding large group rates.

This bill, commencing July 1, 2020, would expand those requirements to apply to large group health care service plan contracts and health insurance policies, and would impose additional rate filing requirements on large group contracts and policies. On and after July 1, 2020, the bill would require a plan or insurer to disclose with a rate filing specified information by geographic region for individual, grandfathered group, and nongrandfathered group contracts and policies, including the price paid compared to the price paid by the Medicare Program for the same services in each benefit category. The bill would eliminate separate reporting and disclosure requirements for a health plan that exclusively contracts with no more than 2 medical groups in the state. On and after July 1, 2020, the bill would require a health care service plan that fails to file specified information to disclose other information by market and by geographic region. If a plan or insurer fails to provide all the information required, the bill would specify that the filing is an unjustified rate on and after July 1, 2020. The bill would authorize a

large group contractholder that has experience-rated or blended coverage and meets specified criteria to apply to the Department of Managed Health Care or Department of Insurance, as appropriate, within 60 days of receiving notice of a rate change to review a rate change and determine if it is unreasonable or not justified, and would require the appropriate department to use reasonable efforts to complete the review within 60 days of receiving all the information required to make a determination. The bill would require the Department of Managed Health Care to conduct a public meeting regarding large group rates in every even-numbered year. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the 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.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.21 of the Health and Safety Code is amended to read:

1374.21. (a) (1) A change in premium rates or changes in coverage stated in a small group health care service plan contract shall not become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.

(2) A change on premium rates or changes in coverage stated in a large group health care service plan contract shall not become effective unless the plan has delivered a written notice indicating the change or changes at least 120 days before the contract renewal effective date. The notice for large group health plans shall include the following information:

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final or greater than the average rate increase for coverage offered in the large group market, as filed pursuant to Section 1385.045.

(C) Whether the rate change includes any portion of the excise tax paid by the health plan.

(D) How to obtain the rate filing required under Article 6.2 (commencing with Section 1385.01).

(E) How to apply to the department to have the proposed rate reviewed by the department if a request is made within 30 days of the notice.

(b) A health care service plan that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(c) (1) For group health care service plan contracts, if the department determines that a rate is unreasonable or not justified consistent with Article 6.2 (commencing with Section 1385.01), the plan shall notify the contractholder of this determination. This notification may be included in the notice required in subdivision (a).

(2) The notification to the contractholder shall be developed by the department and shall include the following statements in 14-point type:

(A) The Department of Managed Health Care has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the plan.

(B) The contractholder has the option to obtain other coverage from this plan or another plan, or to keep this coverage.

(C) Small business purchasers may want to contact Covered California at www.coveredca.com for help in understanding available options.

(3) In developing the notification, the department shall take into consideration that this notice is required to be provided to a small group applicant pursuant to subdivision (g) of Section 1385.03.

(4) The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(5) The plan may include in the notification to the contractholder the internet website address at which the plan's final justification for implementing an increase that has been determined to be unreasonable by the director may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(6) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

SEC. 2. Section 1385.01 of the Health and Safety Code is amended to read:

1385.01. For purposes of this article, the following definitions shall apply:

(a) (1) "Blended" means a rating method that combines community rating and experience rating methods.

(2) "Community rated" means a rating method in the large group market that bases rates on the expected costs to a health care service plan of providing covered benefits to all enrollees, including both low-risk and high-risk enrollees. Premiums may vary according to the factors in this article.

(3) "Experience rated" means a rating method in the large group market under which a health care service plan calculates the premiums for a large group in whole or blended based on the group's prior experience.

(b) (1) For individual and small group market products, "geographic region" has the same meaning as in Sections 1357.512 and 1399.855.

(2) For large group market products, "geographic region" means one of the following areas composed of the regions defined in Sections 1357.512 and 1399.855:

(A) An area composed of regions 2, 4, 5, 6, 7, and 8, which consist of the Counties of Alameda, Contra Costa, Marin, Napa, San Mateo, Santa Clara, Solano, and Sonoma and the City and County of San Francisco.

(B) An area composed of regions 1 and 3, which consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

(C) An area composed of regions 9 and 12, which consist of the Counties of Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura.

(D) An area composed of regions 10, 11, and 14, which consist of the Counties of Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(E) An area composed of regions 13 and 17, which consist of the Counties of Imperial, Inyo, Mono, Riverside, and San Bernardino.

(F) An area composed of regions 15 and 16, which consist of the County of Los Angeles.

(G) An area composed of regions 18 and 19, which consist of the Counties of Orange and San Diego.

(c) "Large group health care service plan contract" means a group health care service plan contract other than a contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(d) "Small group health care service plan contract" means a group health care service plan contract issued to a small employer, as defined in Section 1357, 1357.500, or 1357.600.

(e) "PPACA" means Section 2794 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal Patient Protection and Affordable Care Act (Public Law (111-148)), and any subsequent rules, regulations, or guidance issued under that section.

(f) "Unreasonable rate increase" has the same meaning as that term is defined in PPACA.

SEC. 3. Section 1385.02 of the Health and Safety Code is amended to read:

1385.02. This article shall apply to a health care service plan contract offered in the individual or group market in California. However, this article shall not apply to a specialized health care service plan contract, a Medicare supplement contract subject to Article 3.5 (commencing with Section 1358.1), a health care service plan contract offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan contract offered in the California Major Risk Medical Insurance Program (Part 6.5

(commencing with Section 12700) of Division 2 of the Insurance Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article 10.5 (commencing with Section 1399.801), or a Mexican prepaid health plan subject to Section 1351.2. This article does not limit, impair, or interfere with the authority of the California Public Employees' Retirement System, as set forth in Section 22794 of the Government Code and Article 6 (commencing with Section 22850) of Part 5 of Division 5 of Title 2 of the Government Code.

SEC. 4. Section 1385.03 of the Health and Safety Code is amended to read:

1385.03. (a) A health care service plan shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered small group health care service plan contracts at least 120 days prior to implementing a rate change. 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:

(1) One hundred days before October 15 of the preceding policy year.

(2) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(b) A plan shall disclose to the department all of the following for each individual and small group rate filing:

(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) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs

and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in the geographic regions listed in Sections 1357.512 and 1399.855.

(19) 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.

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 1385.06.

(24) Any changes in administrative costs.

(25) Any other information required for rate review under the federal Patient Protection and Affordable Care Act (PPACA).

(c) 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 small 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.

(d) 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.

(e) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(f) (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 small 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 increase 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 make its determination.

(3) For all nongrandfathered individual health care service plan contracts, the department shall issue a determination that the plan's rate increase is unreasonable or not justified no later than 15 days before October 15 of the preceding policy year. 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 increase is unreasonable or not justified.

(g) If the department determines that a plan's rate increase for individual or small 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 any individual or small group applicant. 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 small group applicant shall be consistent with the notice described in subdivision (c) of Section 1374.21.

(h) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 1399.845.

(i) This section shall become inoperative on July 1, 2020, and, as of January 1, 2021, is repealed.

SEC. 5. Section 1385.03 is added to the Health and Safety Code, to read:

1385.03. (a) (1) A health care service plan shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered 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.

SEC. 6. Section 1385.045 of the Health and Safety Code is amended to read:

1385.045. (a) For large group health care service plan contracts, a health care service plan shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of enrollees in each large group benefit design in the plan's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct a public meeting in every even-numbered year regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of enrollees.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Enrollees' share of premiums.

(H) Enrollees' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) 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 for the applicable 12-month period ending January 1 of the following year.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual plan contract trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(C) A comparison of the aggregate per enrollee per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of enrollees.

(E) Any changes in enrollee benefits over the prior year, including a description of benefits added or eliminated, as well as any aggregate changes, as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts since the plan's prior year's information pursuant to this section 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.

(G) The number of products covered by the information that incurred the excise tax paid by the health care service plan.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health care service plan spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The plan shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2018, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 7. Section 1385.046 is added to the Health and Safety Code, to read:

1385.046. (a) Upon receiving notice of a rate change, a large group contractholder that has coverage that is experience rated in whole or blended and that meets the criteria in subdivision (e) may apply within 60 days to have the department review the rate change to determine whether the rate change is unreasonable or not justified, consistent with this article.

(b) Upon receiving an application, the department shall notify the health care service plan of the application, and the plan shall provide the information required by the department to complete the department's review of the proposed rate within five business days of the department's request or as otherwise required by the department.

(c) The department shall use all reasonable efforts to complete its review of the rate change within 60 days of receiving all the information the

department requires to make its determination, and shall notify the health care service plan and the large group contractholder of its determination.

(d) A rate change under review by the department shall not be imposed before a determination is made by the department pursuant to subdivision (c) or within 60 days following receipt by the department of all information the department requires to make its determination, whichever occurs earlier.

(e) To apply for a review of a rate change for a particular group, at least one of the following shall apply:

(1) The contractholder has more than 2,000 total enrollees.

(2) The plan failed to provide the information required by this article or Section 1385.10.

(f) To facilitate review, the department may group appeals that apply to the same health care service plan and that raise similar questions about rates, methodology, assumptions, or factors.

(g) 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).

(h) This section shall become operative on July 1, 2021.

SEC. 8. Section 1385.07 of the Health and Safety Code is amended to read:

1385.07. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) (1) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health care service plan and a provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10.

(2) The contracted rates between a health care service plan, including those submitted to the department pursuant to Section 1385.046, and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 1385.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records

Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their internet websites in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health care service plan contracts, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care service plan contracts, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health care service plan's actual costs, by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) 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.

SEC. 9. Section 10181 of the Insurance Code is amended to read:

10181. For purposes of this article, the following definitions shall apply:

(a) (1) "Blended" means a rating method that combines community rating and experience rating methods.

(2) "Community rated" means a rating method in the large group market that bases rates on the expected costs to a health insurer of providing covered benefits to all insureds, including both low-risk and high-risk insureds. Premiums may vary according to the factors in this article.

(3) "Experience rated" means a rating method in the large group market under which a health insurer calculates the premiums for a large group in whole or blended based on the group's prior experience.

(b) (1) For individual and small group market products, "geographic region" has the same meaning as in Sections 10753.14 and 10965.9.

(2) For large group market products, "geographic region" means one of the following areas, composed of the regions defined in Sections 10753.14 and 10965.9:

(A) An area composed of regions 2, 4, 5, 6, 7, and 8, which consist of the Counties of Alameda, Contra Costa, Marin, Napa, San Mateo, Santa Clara, Solano, and Sonoma and the City and County of San Francisco.

(B) An area composed of regions 1 and 3, which consist of the Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

(C) An area composed of regions 9 and 12, which consist of the Counties of Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura.

(D) An area composed of regions 10, 11, and 14, which consist of the Counties of Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.

(E) An area composed of regions 13 and 17, which consist of the Counties of Imperial, Inyo, Mono, Riverside, and San Bernardino.

(F) An area composed of regions 15 and 16, which consist of the County of Los Angeles.

(G) An area composed of regions 18 and 19, which consist of the Counties of Orange and San Diego.

(c) "Large group health insurance policy" means a group health insurance policy other than a policy issued to a small employer, as defined in Section 10700, 10753, or 10755.

(d) "Small group health insurance policy" means a group health insurance policy issued to a small employer, as defined in Section 10700, 10753, or 10755.

(e) "PPACA" means Section 2794 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-94), as amended by the federal Patient Protection and Affordable Care Act (Public Law 111-148), and any subsequent rules, regulations, or guidance issued pursuant to that law.

(f) "Unreasonable rate increase" has the same meaning as that term is defined in PPACA.

SEC. 10. Section 10181.2 of the Insurance Code is amended to read:

10181.2. This article shall apply to a health insurance policy offered in the individual or group market in California. However, this article shall not apply to a specialized health insurance policy, a Medicare supplement policy subject to Article 6 (commencing with Section 10192.05), a health insurance policy offered in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health insurance policy offered in the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)), a health insurance conversion policy offered pursuant to Section 12682.1, a health insurance policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900), or a Mexican prepaid health plan subject to Section 1351.2 of the Health and Safety Code.

SEC. 11. Section 10181.3 of the Insurance Code is amended to read:

10181.3. (a) (1) A health insurer shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered group health insurance policies at least 120 days before implementing any rate change.

(2) A health insurer shall file with the department all required rate information for nongrandfathered individual health insurance policies 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 insurer 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) An insurer 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 policy forms covered by the filing.

(3) Policy form numbers covered by the filing.

(4) Product type, such as indemnity or preferred provider organization.

(5) Segment type.

(6) Type of insurer involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each policy and rating form.

(9) Insured months in each policy form.

(10) Annual rate.

(11) Total earned premiums in each policy form.

(12) Total incurred claims in each policy 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 policyholders or insureds affected by each policy form.

(18) A comparison of claims cost and rate of changes over time.

(19) Any changes in insured cost sharing over the prior year associated with the submitted rate filing.

(20) Any changes in insured benefits over the prior year associated with the submitted rate filing.

(21) The certification described in subdivision (b) of Section 10181.6.

(22) Any changes in administrative costs.

(23) Any other information required for rate review under PPACA.

(c) A health insurer subject to subdivision (a) shall disclose the following by geographic region for individual, grandfathered group, and nongrandfathered group policies:

(1) The insurer’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 insurer 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 insurer serves more than one geographic region.

(d) A health insurer subject to subdivision (a) shall disclose, by geographic region for individual, grandfathered group, and nongrandfathered group policies, the amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual policy trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(e) An insurer 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 insurance markets:

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

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of policyholders.

(E) Number of covered lives affected.

(2) The insurer'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 insurer's last rate filing for the same category of health benefit plan. To the extent possible, the insurer 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 insurer 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.

(f) For large group experience-rated, in whole or blended, and community-rated filings, the insurer 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) Insured cost sharing.

(6) Covered benefits in addition to basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, 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.

(g) For large group filings that are experience rated, either in whole or blended, the insurer shall submit the methodology for modifying the rate based on experience.

(h) (1) The department may require all health insurers 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.

(i) A health insurer shall submit any other information required under PPACA. A health insurer shall also submit any other information required pursuant to a regulation adopted by the department to comply with this article.

(j) (1) A health insurer shall respond to the department's request for any additional information necessary for the department to complete its review of the health insurer's rate filing for individual and group health insurance policies 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 health insurer's rate change for individual and small group insurance policies is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to make 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 insurance policies, the department shall issue a determination that the health insurer'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 insurer fails to provide all the information the department requires in order for the department to make its

determination, the department may determine that a health insurer'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).

(k) If the department determines that a health insurer's rate change for individual or group health insurance policies is unreasonable or not justified consistent with this article, the health insurer shall provide notice of that determination to any individual or group applicant. For both 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 10113.9. The notice provided to a group applicant shall be consistent with the notice described in subdivision (d) of Section 10199.1.

(*l*) Failure to provide the information required by subdivision (b), (c), (d), (e), (f), or (g) shall constitute an unjustified rate.

(m) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 10965.

(n) (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.

(o) The amendments made to this section by Assembly Bill 731 of the 2019–20 Regular Session shall become operative on July 1, 2020.

SEC. 12. Section 10181.31 is added to the Insurance Code, immediately following Section 10181.3, to read:

10181.31. (a) Upon receiving notice of a rate change, a large group contractholder that has coverage that is experience rated in whole or blended and that meets the criteria in subdivision (e), may apply within 60 days to have the department review the rate change to determine whether the rate change is unreasonable or not justified, consistent with this article.

(b) Upon receiving an application, the department shall notify the health insurer of the application, and the insurer shall provide the information required by the department to complete the department's review of the proposed rate within five business days of the department's request or as otherwise required by the department.

(c) The department shall use reasonable efforts to complete its review of the rate change within 60 days of receiving all the information the department requires to make its determination, and shall notify the health insurer and the large group contractholder of its determination.

(d) A rate change under review by the department shall not be imposed before a determination is made by the department pursuant to subdivision (c) or within 60 days following receipt by the department of all information the department requires to make its determination, whichever occurs earlier.

(e) To apply for a review of a rate change for a particular group, at least one of the following shall apply:

(1) The contractholder has more than 2,000 total insureds.

(2) The insurer failed to provide the information required by this article or Section 10181.10.

(f) To facilitate review, the department may group appeals that apply to the same health insurer and that raise similar questions about rates, methodology, assumptions, or factors.

(g) 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).

(h) This section shall become operative on July 1, 2021.

SEC. 13. Section 10181.7 of the Insurance Code is amended to read:

10181.7. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) (1) The contracted rates between a health insurer and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health insurer and a provider shall not be disclosed by a health insurer to a large group purchaser that receives information pursuant to Section 10181.10.

(2) The contracted rates between a health insurer, including those submitted to the department pursuant to Section 10181.31, and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7

of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 10181.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health insurer shall, at a minimum, make the following information readily available to the public on their internet websites in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health insurance policies, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care insurance policies, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) An insurer's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) An insurer's actual costs, by aggregate benefit category to include, hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual policy trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

SEC. 14. Section 10199.1 of the Insurance Code is amended to read:

10199.1. (a) (1) An insurer or nonprofit hospital service plan or administrator acting on its behalf shall not terminate a group master policy or contract providing hospital, medical, or surgical benefits, increase premiums or charges therefor, reduce or eliminate benefits thereunder, or restrict eligibility for coverage thereunder without providing prior notice of that action. The action shall not become effective unless written notice of the action was delivered by mail to the last known address of the appropriate insurance producer and the appropriate administrator, if any, at least 45 days prior to the effective date of the action and to the last known address of the group policyholder or group contractholder at least 60 days prior to the effective date of the action. If nonemployee certificate holders or employees of more than one employer are covered under the policy or contract, written notice shall also be delivered by mail to the last known address of each nonemployee certificate holder or affected employer or, if the action does not affect all employees and dependents of one or more

employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

(2) The notice delivered pursuant to paragraph (1) for large group health insurance policies shall also include the following information:

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final.

(C) Whether the rate change includes any portion of the excise tax paid by the health insurer.

(D) How to obtain the rate filing required under Article 4.5 (commencing with Section 10181), including whether the rate change is attributable to changes in medical trend, utilization, or other factors.

(E) How to apply to the department to have the proposed rate reviewed by the department if a request is made within 30 days of the notice.

(b) A holder of a master group policy or a master group nonprofit hospital service plan contract or administrator acting on its behalf shall not terminate the coverage of, increase premiums or charges for, or reduce or eliminate benefits available to, or restrict eligibility for coverage of a covered person, employer unit, or class of certificate holders covered under the policy or contract for hospital, medical, or surgical benefits without first providing prior notice of the action. The action shall not become effective unless written notice was delivered by mail to the last known address of each affected nonemployee certificate holder or employer, or if the action does not affect all employees and dependents of one or more employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

(c) A health insurer that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(d) (1) For group health insurance policies, if the department determines that a rate is unreasonable or not justified consistent with Article 4.5 (commencing with Section 10181), the insurer shall notify the policyholder of this determination. This notification may be included in the notice required in subdivision (a) or (b).

(2) The notification to the policyholder shall be developed by the department and shall include the following statements in 14-point type:

(A) The Department of Insurance has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the insurer.

(B) The policyholder has the option to obtain other coverage from this insurer or another insurer, or to keep this coverage.

(C) Small business purchasers may want to contact Covered California at www.coveredca.com for help in understanding available options.

(3) The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(4) The insurer may include in the notification to the policyholder the internet website address at which the insurer's final justification for implementing an increase that has been determined to be unreasonable by the commissioner may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(5) The notice shall also be provided to the agent of record for the policyholder, if any, so that the agent may assist the purchaser in finding other coverage.

(6) In developing the notification, the department shall take into consideration that this notice is required to be provided to a small group applicant pursuant to subdivision (g) of Section 10181.3.

SEC. 15. 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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