STATE OF CALIFORNIA
LEGISLATIVE COUNSEL BUREAU
AUTHENTICATED
ELECTRONIC LEGAL MATERIAL

Assembly Bill No. 2118

CHAPTER 277

An act to add Section 1385.043 to the Health and Safety Code, and to add Section 10181.46 to the Insurance Code, relating to health care coverage.

[Approved by Governor September 29, 2020. Filed with Secretary of State September 29, 2020.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2118, Kalra. Health care service plans and health insurers: reporting requirements.

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, small, and large group markets 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 large group market health care service plan or insurer to report additional information relating to cost sharing and specified aggregate rate information. Existing law requires the Department of Managed Health Care and the Department of Insurance to conduct an annual public meeting regarding large group rates.

This bill would require a health care service plan and health insurer, excluding for a specialized health care service plan or specialized health care policy, to report to the Department of Managed Health Care and the Department of Insurance, respectively, by October 1, 2021, and annually thereafter, for products in the individual and small group markets, and for rates effective during the 12-month period ending January 1 of the following year, on specified information, including premiums, cost sharing, benefits, enrollment, and trend factors, and would exclude prescribed information from the reporting requirements until January 1, 2023. The bill would also require a health care service plan and health insurer, excluding a specialized health care service plan or specialized health care policy, to annually report to the Department of Managed Health Care and the Department of Insurance, respectively, the above-described information for all grandfathered and nongrandfathered products, as specified. The bill would require each department, beginning in 2022, to annually present the reported information at various meetings, as specified. The bill would also require each department to post the information reported under this section on its internet website no later than December 15 of each year. The bill would also authorize the

Department of Managed Health Care to implement, interpret, or make specific these provisions by means of all-plan letters, forms, or similar instructions, without taking regulatory action until January 1, 2024. The bill would exempt the Department of Insurance from the Administrative Procedure Act in order to issue guidance to health insurers regarding compliance with these provisions until January 1, 2024.

Because a violation of the bill by a health care service plan 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 1385.043 is added to the Health and Safety Code, to read:

1385.043. (a) A health care service plan, not including a specialized health care service plan, shall annually report to the department the information described in subdivision (c) for all grandfathered and nongrandfathered products that the plan offers and sells in the individual market, including both on-exchange and off-exchange enrollment, for rates effective during the 12-month period ending January 1 of the following year.

(b) A health care service plan, not including a specialized health care service plan, shall annually report to the department the information described in subdivision (c) for all grandfathered and nongrandfathered products that the plan offers and sells in the small group market, including both on-exchange and off-exchange enrollment, for products with rates effective during that 12-month period ending January 1 of the following year.

(c) (1) Information on premiums, including share of premium, if applicable, average premium weighted by enrollment, and weighted average rate change.

(2) Cost sharing, including deductibles, maximum out-of-pocket limit, copayments, coinsurance, and any other cost sharing for covered benefits as well as high deductible health plans.

(3) (A) For nongrandfathered plans, benefits, including essential health benefits or basic health care services.

(B) For grandfathered plans, basic health care services and mandates.

(4) Standard and nonstandard benefit designs, including on-exchange and off-exchange nonstandard benefit designs.

(5) Enrollment by actuarial value tier, product, benefit design and premiums, including both of the following:

(A) Enrollment in products with zero deductibles, high deductibles as defined in this section, and deductibles between zero and high.

(B) (i) Enrollment by premium.

(ii) For small group products, enrollment by share of premium.

(6) Trend factors as reported in individual and small group rate filings for the health care service plan, including both price and utilization, as required in Section 1385.03.

(d) By October 1, 2021, and annually thereafter, a health care service plan shall submit the annual report, as described under subdivision (a), to the department in a form and manner determined by the department.

(e) Beginning in 2022, the department shall annually present the information reported under this section in the meeting specified in Section 1385.045, a meeting of the Financial Solvency Standards Board, or at any other public meeting the department deems appropriate. The department also shall post the information reported under this section on its internet website no later than December 15 of each year.

(f) The following definitions apply for purposes of this section:

(1) "Average premium weighted by enrollment" means the following:

(A) For the individual market, the average premium shall be weighted by the number of individual enrollees in the plan's individual market during the 12-month period.

(B) For the small group market, the average premium shall be weighted by the number of enrollees in each small group benefit design in the plan's small group market during the 12-month period.

(2) "Benefit design" means the cost sharing for covered benefits.

(3) "High deductible" has the same meaning as defined in Section 223(c)(2)(A) of Title 26 of the United States Code.

(4) "Nonstandard benefit design" means a benefit design other than the standard benefit design.

(5) "Share of premium" means the share of premium paid by the enrollee on behalf of the enrollee and any dependents, not the subscriber.

(6) "Standard benefit design" means the standardized products approved by the executive board of the California Health Benefit Exchange pursuant to subdivision (c) of Section 100504 of the Government Code.

(g) Until January 1, 2023, a health care service plan shall not be required to report either of the following information:

(1) Share of premium paid by enrollee.

(2) Enrollment by benefit design, deductible, or share of premium.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters, forms, or similar instructions, without taking regulatory action until January 1, 2024.

SEC. 2. Section 10181.46 is added to the Insurance Code, to read:

10181.46. (a) A health insurer, not including a specialized health insurance policy, shall annually report to the department the information described in subdivision (c) for all grandfathered and nongrandfathered

products that the insurer offers and sells in the individual market, including both on-exchange and off-exchange enrollment, for rates effective during the 12-month period ending January 1 of the following year.

(b) A health insurer, not including a specialized health insurance policy, shall annually report to the department the information described in subdivision (c) for all grandfathered and nongrandfathered products that the insurer offers and sells in the small group market, including both on-exchange and off-exchange enrollment, for products with rates effective during that 12-month period ending January 1 of the following year.

(c) (1) Information on premiums, including share of premium, if applicable, average premium weighted by enrollment, and weighted average rate change.

(2) Cost sharing, including deductibles, maximum out-of-pocket limit, copayments, coinsurance and any other cost sharing for covered benefits as well as high deductible health policies.

(3) (A) For nongrandfathered policies, essential health benefits and basic health care services.

(B) For grandfathered policies, covered benefits, including mandates, if any.

(4) Standard and nonstandard benefit designs, including on-exchange and off-exchange nonstandard benefit designs.

(5) Enrollment by actuarial value tier, product, benefit design and premiums, including both of the following:

(A) Enrollment in products with zero deductibles, high deductibles as defined in this section, and deductibles between zero and high.

(B) (i) Enrollment by premium.

(ii) For small group products, enrollment by share of premium.

(6) Trend factors as reported in individual and small group rate filings for the health insurer, including both price and utilization, as required in Section 10181.3.

(d) By October 1, 2021, and annually thereafter, a health insurer shall submit the annual report, as described under subdivision (a), to the department in a form and manner determined by the department.

(e) Beginning in 2022, the department shall annually present the information reported under this section in the meeting specified in Section 10181.45 or at any other public meeting the department deems appropriate. The department also shall post the information reported under this section on its internet website no later than December 15 of each year.

(f) For purposes of this section, the following definitions apply:

(1) “Average premium weighted by enrollment” means both of the following:

(A) For the individual market, the average premium shall be weighted by the number of individual insureds in the insurer’s individual market during the 12-month period.

(B) For the small group market, the average premium shall be weighted by the number of insureds in each small group benefit design in the insurer’s small group market during the 12-month period.

(2) "Benefit design" means the cost sharing for covered benefits.

(3) "High deductible" has the same meaning as defined in Section 223(c)(2)(A) of Title 26 of the United States Code.

(4) "Nonstandard benefit design" means a benefit design other than the standard benefit design.

(5) "Share of premium" means the share of premium paid by the insured on behalf of the insured and any dependents, not the employer.

(6) "Standard benefit design" means the standardized products approved by the executive board of the California Health Benefit Exchange pursuant to subdivision (c) of Section 100504 of the Government Code.

(g) Until January 1, 2023, a health insurer shall not be required to report either of the following information:

(1) Share of premium paid by insured.

(2) Enrollment by benefit design, deductible, or share of premium.

(h) The commissioner may issue guidance to health insurers regarding compliance with this section. This guidance 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) until January 1, 2024.

SEC. 3. 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.

O