Legislative History

2014 Chapter 577 (SB 1182, Leno) - Requires health care service plans and insurers to provide at no charge, upon request, specified de-identified claims data or equivalent cost information to any large group purchaser that is able to demonstrate its ability to comply with state and federal privacy laws, and is either an employer with at least 1,000 covered lives (at least 500 of which are covered under the disclosing health plan or insurer), or a multi-employer trust with at least 500 covered lives (at least 250 of which are covered under the disclosing plan or insurer). If claims data is not available, it requires health plans and insurers to provide de-identified aggregated data sufficient for the purchaser to compare costs of similar services from other health plans or insurers and de-identified aggregated patient level data that includes demographics and encounter data, including data used to experience rate the group, as specified. *CalPERS Position: Support.*

2013 SB 746 (Leno) – Would have required specified aggregate data related to unreasonable rate filings be disclosed annually and would have added two additional required data elements. The bill also would have required all health care service plans annually disclose to the DMHC, specified aggregate data for all products sold in the large group health plan market, or, in the event that a plan is unable to furnish that data, to provide aggregate data on its year-to-year cost increases for specified major service categories. In addition, it would have required health care service plans that contract with no more than two medical groups in the state to provide, upon request, specified de-identified claims data or equivalent cost information to any large group purchaser that is an employer-sponsored plan with more than 1,000 covered lives or a multi-employer trust, and that demonstrates its ability to comply with applicable privacy laws. The bill was vetoed by the Governor. *CalPERS Position: Support.*

2011 AB 52 (Feuer) – Would have required health plans and insurers to file a complete rate application for any rate change for an existing product effective January 1, 2011 and a proposed rate for a new product that would become effective on and after January 1, 2012 with the DMHC or CDI. The bill also would have granted authority to DMHC and CDI to approve, deny, or modify any proposed rate or rate change found to be excessive, inadequate, or unfairly discriminatory, and order refunds. The Department of Health Care Services and the Managed Risk Medical Insurance Board would have been exempt from the provisions of the bill. AB 52 was placed on the inactive file and subsequently died. *CalPERS Position: Oppose unless Amended.*

2010 Chapter 661 (SB 1163, Leno) – Requires carriers to file, with regulators, specified rate information for individual and small group coverage at least 60 days prior to implementing any rate change, as specified. Requires the filings for large group contracts only in the case of unreasonable rate increases, as defined by the Affordable Care Act, prior to implementing any such rate change. Increases, from 30 days to 60 days, the amount of time that a health plan or insurer provides written notice to an enrollee or insured before a change in premium rates or coverage becomes effective. Requires carriers that decline to offer coverage to or deny enrollment for a large group applying for coverage, or that offer small group coverage at a rate that is higher than the standard employee risk rate to, at the time of the denial or offer of coverage, to provide the applicant with reason for the decision, as specified.
CalPERS Position: None.

AB 2578 (Jones and Feuer) – Would have required carriers to file a complete rate application with regulators for a rate increase that becomes effective on or after January 1, 2012. It also would have prohibited a health plan or insurer's premium rate (defined to include premiums, co-payments, coinsurance obligations, deductibles, and other charges) from being approved or remaining in effect that is determined to be excessive, inadequate, unfairly discriminatory, as specified. AB 2578 failed passage off the Senate Floor. *CalPERS Position: None.*

2009 AB 1218 (Jones) – Would have required health plans and health insurers to obtain approval from the DMHC or the CDI for any rate increases in the amount of the premium, copayment, coinsurance obligation, deductible and other charges under a health plan or insurance policy. This bill would have required departments to notify the public of rate applications and would have authorized the departments to assess a charge related to the rate application and to deposit that charge in the Health Rate Approval Fund. In addition, it would have established the California Health Rate Advisory Board. This bill died in the Assembly Health Committee.
CalPERS Position: None.

2006 SB 425 (Ortiz) – Would have required health care service plans and insurers to obtain approval from the DMHC or the CDI before implementing any increase in rates, premiums, copayments, deductibles, charges, and covered costs imposed by a plan or health insurer between April 1, 2000 and January 1, 2006. The bill’s first hearing in the Senate Health Committee was cancelled at the author’s request.
CalPERS Position: None.