

**California Department of Managed Health Care
California Department of Insurance**

**Submission of
Individual and Small Group Market Aggregate Rate Information
(Assembly Bill 2118)**

Guidance

Section I: Background.

Assembly Bill 2118 (Kalra-Stats. 2020, ch.277), requires a health care service plan and a health insurer, not including a specialized health care service plan or specialized health insurer, to annually report specified rate information on premiums, cost sharing, benefits, enrollment, and trend factors for products in the individual and small group markets for all grandfathered and non-grandfathered products.

Section II: Basis and Scope.

- A. Basis. This document implements Health and Safety Code section 1385.043, relating to individual and small group health care service plan contracts, and Insurance Code section 10181.46 relating to individual and small group health insurance policies.

- B. Scope. This document establishes the requirements for individual and small group health care service plan filing requirements to ensure consistent and appropriate implementation of the Health and Safety Code section 1385.043, and the requirements for individual and small group health insurance filings under Insurance Code section 10181.46.

Additional guidance may be forthcoming.

Section III: Definitions.

The following definitions apply unless otherwise specified.

- A. "Average premium weighted by enrollment" means the following: (1) 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. (2) 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. (Health & Saf. Code § 1385.043(f)(1) & Ins. Code § 10181.46(f)(1).)

- B. "Benefit design" means the cost sharing for covered benefits. (Health & Saf. Code § 1385.043(f)(2) & Ins. Code § 10181.46(f)(2).)

- C. “High Deductible” has the same meaning as defined in Section 223(c)(2)(A) of Title 26 of the United States Code. (Health & Saf. Code § 1385.043(f)(3) & Ins. Code § 10181.46(f)(3).)
- D. “Member months” means the equivalent of one covered life for which the health plan company has premium revenue in one month. The total annual number of member months is calculated by summing the twelve end-of-month totals of covered lives for the reported year, for each product category. Report the member months as this sum of twelve end-of-month totals for entire calendar year for the reporting year.
- E. “Nonstandard benefit design” means a benefit design other than the standard benefit design. (Health & Saf. Code § 1385.043(f)(4) & Ins. Code § 10181.46(f)(4).)
- F. “Number of enrollees/Covered lives” means the number of employees, and dependents enrolled (i.e., members or covered lives) during the 12-month reporting period; reasonable approximations are allowed when actual information is not available.
- G. “Reporting year” is the calendar year that a health plan or health insurer files the AB 2118 worksheet with the Department of Managed Health Care or the Department of Insurance. Data for the final quarter of the calendar year should reflect projected estimates as of the filing date.
- H. “Share of premium” means, for the small group market, the share of premium paid by the enrollee/insured on behalf of the enrollee/insured and any dependent, not the subscriber/employer. (Health & Saf. Code § 1385.043(f)(5) & Ins. Code § 10181.46(f)(5).)
- I. “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. (Health & Saf. Code § 1385.043(f)(6) & Ins. Code § 10181.46(f)(6).)
- J. “Weighted average rate change” means the weighted average of the annual rate increases or decreases that were implemented (actual or a reasonable approximation when actual information is not available) weighted by the number of enrollees/covered lives.

Section IV: Filing Requirements

These filing requirements apply to all individual and small group filings submitted on October 1, 2021 and annually thereafter. Health plans and health insurers are required to file a separate filing for each market (i.e., individual and small group).

The annual filing required by Health and Safety Code section 1385.043(d) or Insurance Code section 10181.46(d) shall be submitted annually to the respective Department via SERFF on or before October 1. In the SERFF “Filing Description” line, indicate either “Individual Annual Aggregate Rate Filing” or “Small Group Annual Aggregate Rate Filing.”

A. For Individual Annual Aggregate Rate Filing and Small Group Annual Aggregate Rate Filing, the following spreadsheets, contained in the “Individual Annual Aggregate Rate Workbook” and “Small Group Annual Aggregate Rate Workbook,” must be completed:

1. Index – Listing of required spreadsheets in the workbook;
2. General_Info – Where most of the information will be filled out; such as Health Plan/Health Insurer’s name, submission date, reporting year and etc.
3. Premium – Premium Information;

Effective January 1, 2023, the share of premium paid by enrollees is required pursuant to Section 1385.043 of the California Health and Safety Code and Section 10181.46 of the California Insurance Code.

4. Cost Sharing – Cost sharing by ranges and by metal tiers;

Individual cost sharing refers to plan benefits, not the actual dollars paid or out of pocket expenses by the enrollees.

These individual cost sharing includes the following:

- Deductibles (medical + Rx combined),
- Coinsurance percentage (hospital inpatient),
- Coinsurance percentage (specialty drugs): If a health plan or a health insurer has only copays for specialty drugs, a health plan or a health insurer may divide the copay amount by the average retail price of the specialty drugs to convert to an effective coinsurance percentage to populate this form,
- Copayment for primary doctor visits and specialist visits (composite),
- Average cost sharing for brand name drugs,
- Individual out of pocket maximum (medical + Rx combined in-network only) and
- Family out of pocket maximum (medical + Rx combined in-network only).

5. Benefit;
6. Benefit Design – Covered Benefits;
7. Enrollment; Effective January 1, 2023, the enrollment by benefit design, deductible, or share of premium information is required pursuant to Section 1385.043 of the California Health and Safety Code and Section 10181.46 of the California Insurance Code.

8. Trend – Before or After Normalization for Demographic, Plan Mix and other Changes. Specify if the trend has been normalized for demographic changes by selecting “Before” or “After” in the drop-down boxes and filling in the appropriate information.
 - a. Health insurers should leave the cells marked “capitation” blank.
9. CA Aggregate Form – Health Plans and Health Insurers must include information on cost containment and quality improvement efforts and product type by number of filings, percentage of total filings, number of subscribers, number of covered lives affected and average percent rate increase.
10. Explanation – Additional explanations and supporting information
Additional explanations must be disclosed in the “Explanation” tab of the workbook. Attachments to support the Health Plans or Health Insurers’ explanations must be submitted under the “Supporting Documentation” tab in SERFF.
11. Glossary – Terminology.

The “Individual Annual Aggregate Rate Workbook” and “Small Group Annual Aggregate Rate Workbook,” as well as any additional documents in response to questions within the workbook, must be submitted under the “Supporting Documentation” tab in SERFF. This “Individual Annual Aggregate Rate Workbook” and “Small Group Annual Aggregate Rate Workbook” can be found on the Department of Managed Health Care or the Department of Insurance website.