California Department of Insurance

Submission of
Large Group Methodology, Factors, and Assumptions
(Assembly Bill 731)

Final release date: July 10, 2020

Section I: Background

Assembly Bill 731(Kalra) (Stats. 2019, ch. 807), requires health plans offering a large group health care service plan contract to file information regarding the methodology, factors, and assumptions used to determine rates with the Department of Managed Health Care (DMHC) at least 120 days before implementing any change in the methodology, factors, or assumptions that would affect rates. The bill also requires health insurers offering large group health insurance policies to file information regarding the methodology, factors, and assumptions used to determine rates with the Department of Insurance (CDI) at least 120 days before implementing any change in the methodology, factors, or assumptions that would affect rates. Health plans and insurers must file specified information by geographic region, provide certain actuarial certifications and meet specified consumer notice requirements.

Section II: Basis and Scope

A. Basis. See Health and Safety Code sections 1374.21, 1385.01, 1385.02, 1385.03, 1385.045, 1385.046 and 1385.07, relating to large group health care service plan contracts, and Insurance Code sections 10199.1, 10181, 10181.2, 10181.3, 10181.45, 10181.46 and 10181.7 relating to large group health insurance policies.

Section III: Definitions

A. "Community Rated" means a rating method in the large group market that bases rates on the expected costs to a health care service plan or health insurer for providing covered benefits to all enrollees or insureds, including both low-risk and high-risk enrollees or insureds. (H&SC § 1385.01(a)(2) & CIC § 10181(a)(2).) This is also commonly known as manually rated.

B. "Experience Rated" means a rating method in the large group market under which a health care service plan or insurer calculates the premiums for a large group in whole or blended based on the group's prior experience. (H&SC § 1385.01(a)(3) & CIC § 10181(a)(3).)

C. "Blended" means a rating method that combines community rating and experience rating methods. (H&SC § 1385.01(a)(1) & CIC § 10181(a)(1).)

D. "Methodology Change" includes, but is not limited to, a change from one of the three rating methods (Experience Rated, Community Rated or Blended) to another, or any

change to the rating formula, credibility criteria, assumptions, or factors affecting the rates paid by a large group.

E. “Enrollee Cost-Sharing” or “Insured Cost-Sharing” means any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the enrollee or insured other than premium or share of premium.

F. “Geographic Region” has the same meaning as the seven geographic regions found in Health and Safety Code section 1385.01(b)(2) and Insurance Code section 10181(b)(2).

G. “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 Health and Safety Code sections 1357, 1357.500, or 1357.600.

H. “Large Group Health Insurance Policy” means a group health insurance policy other than a policy issued to a small employer, as defined in Insurance Code sections 10700, 10753, or 10755. (CIC § 10181(c).)

I. “Other benefits in addition to those described in subdivision (b) of Section 1345 of the Health and Safety Code”: “Basic Health Care Services” is defined at Health and Safety Code section 1345(b). Health care service plans in all markets (individual, small, and large group) must cover these benefits and there are also other benefits not enumerated in Health and Safety Code section 1345 that are mandated/required to be covered.

Section IV: Filing

These filing requirements apply to all large group filings submitted after July 1, 2020. Health plans and health insurers file a separate filing for each rating method (i.e., community or blended).

The annual filing required by Health and Safety Code section 1385.03(a)(3) or Insurance Code section 10181.3(a)(3) are submitted annually to the respective Department via SERFF on or before September 2. Additionally, health plans/insurers submit a large group rate filing120 days before any change in the methodology, factors, or assumptions. In the SERFF “Filing Description” line, indicate “Large Group Methodology Annual Filing.”

A. For ***new products*** and/or ***existing products***, complete the following spreadsheets, contained in the “Large Group Workbook”:

1. Cover-Input Page – Where most of the information will be filled out;

2. New_Product – Pricing information if a new product is being filed;

3. Existing_Product – Pricing information for products that already exist;

4. CA Rate Filing Spreadsheet;
5. CA Plain-Language Rate Filing;
6. CA Plain-Language Spreadsheet;
7. Geo_Region – Pricing information, such as trends, by seven defined geographic regions;
8. Price_Inflation – Allowed trends split into more granular detail, such as cost, utilization, etc.;
9. Amt_spent_util – Cost and utilization data for a 3-year period (this spreadsheet does not have to be completed by health insurers);
10. Avg Rate Changes – Rate changes in rating period by effective month, product type, and rating method;
11. Rating Factors – Miscellaneous factors and data used to develop rates at the rate cell level;
12. Methodology – Whether the rates were developed using experience rating, community rating, or a blend, credibility threshold, etc.;
13. Experience – 3-year data showing relevant incurred experience (including IBNP data) for the impacted plans;
14. Checklist – Assists the reviewer with locating the various requested information (e.g., file name, page number, etc.)

Submit the “Large Group Workbook” under the “Supporting Documentation” tab in SERFF as well as a separate spreadsheet containing rate information in response to questions within the workbook. This “Large Group Workbook” can be found on the DMHC or the CDI website.

B. Actuarial Certification

The certification required under Health and Safety Code section 1385.06(b)(2) and Insurance Code section 10181.6(b)(2) is a “Statement of Actuarial Opinion,” as defined in the *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*, promulgated by the American Academy of Actuaries. Such a certification is also a “Health Filing,” as defined in Actuarial Standard of Practice No. 8, promulgated by the Actuarial Standards Board, and it is also an “Actuarial Communication,” as defined in Actuarial Standard of Practice No. 41, promulgated by the Actuarial Standards Board.

Include the following information with the certification required under Health and Safety Code section 1385.06(b)(2) or Insurance Code section 10181.6(b)(2):

1. A statement of the qualifications of the actuary issuing the certification. The actuary's qualifications must meet the standards stated in *Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States*. The statement of qualifications must include a statement that the actuary meets the independence requirements stated in Health and Safety Code section 1385.06(b)(3) or Insurance Code section 10181.6(b)(3).

2. A statement of opinion that the proposed changes to affected rates in the filing are actuarially sound in aggregate for the particular market segment (i.e., large group). The proposed changes to affected rates are actuarially sound if, for business in California and for the period covered by the certification, projected premium income, expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital reserves required by the California Insurance Code or the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing at Health and Safety Code section 1340, et seq.

3. For each contract included in the filing, a complete description of the data, assumptions, rating factors and methods used , with sufficient clarity and detail that another qualified health actuary can make an objective appraisal of the reasonableness of the data, assumptions, factors, and methods. The descriptions must include examples of rate calculations for each contract form included in the filing.

4. A description of the testing performed by the actuary to arrive at the statements of opinion in paragraph (2) above, including any independent rating models and rating factors utilized.

Section V: Public Availability

Health and Safety Code section 1385.07 and Insurance Code section 10181.7 specifically require the DMHC and CDI to make all submitted information publicly available except for contracted rates between a plan or insurer and provider and contracted rates between a plan or insurer and large group.

Section VI: Notice

A. No change in premium rates or changes in coverage stated in a large group health care service plan contract shall become effective unless the plan has delivered in writing a notice indicating the change or changes at least 120 days prior to the contract renewal effective date. (H&SC § 1374.21.)

   No change in premium rates or changes in coverage stated in a group health insurance policy shall become effective unless the insurer has delivered in writing a

notice indicating the change or changes at least 60 days prior to the contract renewal effective date. (CIC § 10199.1.)

B. Renewal notices delivered by plans and insurers shall include a statement comparing the proposed rate change stated in a group health plan service contract or health insurance policy to the average rate increases negotiated by CalPERS and by Covered California. Include information on:

1. Whether the rate proposed to be in effect is greater than, less than or equal to 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.

2. Whether the rate proposed to be in effect is greater than, less than or equal to the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year in which the rates are final or greater than the average rate increase that the plan filed under Health and Safety Code section 1385.045 or Insurance Code section 10181.45.

3. Whether the rate change includes any portion of the excise tax paid by the health plan or insurer.

4. A health care service plan or 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.

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