California Department of Managed Health Care
California Department of Insurance

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

Final release date: May 1, 2023

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 day 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. This document implements 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.

B. Scope. This document establishes the requirements for large group health care service plan filing requirements to ensure consistent and appropriate implementation of the Health and Safety Code sections 1374.21, 1385.01, 1385.02, 1385.03, 1385.045, 1385.046 and 1385.07, and the requirements for large group health insurance filings under Insurance Code sections 10199.1, 10181, 10181.2, 10181.3, 10181.45, 10181.46 and 10181.7.

Additional guidance may be forthcoming.

Section III: Definitions.

The following definitions apply unless otherwise specified.

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 Requirements

These filing requirements apply to all large group filings submitted after July 1, 2020. Health plans and health insurers are required to 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) shall be submitted annually to the respective Department via SERFF on or before September 2. Additionally, health plans/insurers must 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.”

Other filings required by Health and Safety Code section 1385.03(a)(3) or Insurance Code section 10181.3(a)(3) in response to a change in methodology, factors, or assumptions shall be submitted through SERFF, no later than 120 days before implementing that change. In the "Filing Description" line, indicate "Large Group Methodology Change Filing."

For community rated, please provide the proposed rate increase for all 12 months. For experience rated, please provide the proposed rate increase for January and the coming renewal months that are known at the time of filing.

A. For ***new products*** and/or ***existing products,*** the following spreadsheets, contained in the "Large Group Workbook", must be completed:

    1. Cover-Input Page – Fill out the general filing information;

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

    3. Existing_Product – Pricing information for products that already exist, such as average rate increase, projected allowed trends, and changes in administrative costs;

    4. CA Rate Filing Spreadsheet – Information at the product level, enrollees at the last month of the experience period, enrollee months, earned premium, incurred claims, and average rate change;

    5. CA Plain-Language Spreadsheet – Information at the product level, comparing before and after for enrollee months, premium PMPM, medical costs as % of premium, administrative costs %, taxes and fees %, and after-tax profit/margin %;

    6. CA Plain-Language Rate Filing – Allowed cost PMPM at the service category and cost as % of Medicare, projected annual Medical Services + Rx allowed trend, and projected allowed trends at the service category;

    7. Geo_Region – Pricing information at the service category, such as projected allowed trends, utilization per thousand members per year (PTMPY), allowed unit cost, allowed claim PMPM, paid claim PMPM, by seven defined geographic regions;

    8. Price_Inflation – Allowed trends split into more granular detail, such as use of services, pricing inflation, and fees and risk;

    9. Amt_spent_util – If a health plan is unable to file the information of Geo_Region, Price_Inflation, Rating Factors and Methodology tabs, it will need to file this tab instead. Please provide justification in the Comment Section on why the health plan cannot provide that. Allowed PMPM and utilization PTMPY at the service category and geographic regions;

10. Avg Rate Changes – Weighted average premium PMPM, rate changes in rating period by effective months, product types, and rating methods, and the key drivers of annual rate change;

11. Experience – 3-years of experience data showing earned premium, incurred claims (including IBNP), and Medical Loss Ratios;

12. Rating Factors – Miscellaneous factors and data used to develop rates at the rate cell level;

13. Methodology- Whether the rates were developed using experience rating, community rating, or blended, credibility threshold, etc.;

14. Checklist – Assists the reviewer to locate the various requested information (for example, file name, page number, Efiling number, etc.)

15. Appendix – Define the geographic regions with the corresponding counties.

The “Large Group Workbook” must be submitted 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.

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

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 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. The statement must 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. 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.