California Department of Managed Health Care/Department of Insurance
Individual and Small Group Guidance

Final release date: May 1, 2023

Section I: Background.

Beginning January 1, 2011, health plans are required to submit rate filings to the DMHC pursuant to Senate Bill 1163 (Leno, Stats. 2010, ch. 661).

Assembly Bill 731 (Kalra, Stats. 2019, ch.807) amends existing law that required health plans to file rate information for individual and small group health care service plan contracts by, among other changes, requiring that plans include in the filings geographic rating trends.

Section II: Basis and Scope.

A. Basis. This document implements Health and Safety Code sections 1374.21, 1385.01, 1385.02, 1385.03, and 1385.07, relating to individual and small group health care service plan contracts.

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 sections 1374.21, 1385.01, 1385.02, 1385.03, and 1385.07.

Additional guidance may be forthcoming.

Section III: Definitions.

The following definitions apply unless otherwise specified.

A. "Rate Change" includes, but is not limited to, any change of the rates for a specific product or plan within a product offered in the individual and small group.

B. "Geographic Region" has the same meaning as the geographic regions found in Health and Safety Code sections 1385.01(b)(1), 1357.512 and 1399.855.

C. "Small Group Health Care Service Plan Contract" means a group health care service plan contract issued to a small employer, as defined in Health and Safety Code sections 1357, 1357.500, or 1357.600.

D. "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 individual and small group filings due on or after September 2, 2020.

For individual and small group health contracts, rate submissions for new products and rate changes for existing products must be filed on dates consistent with Health and Safety Code (HSC) section 1385.03 (a).

The Department of Managed Health Care and Department of Insurance have consolidated the individual and small group templates into a workbook format. This workbook is called "Ind SG Workbook" which also includes the geographic rating trends as required by AB 731.

A. For ***new products*** and/or ***existing products,*** the following spreadsheets, contained in the "Individual and Small 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 nineteen 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. Checklist – Assists the reviewer with locating the various requested information (e.g., file name, page number, etc.)

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

The "Individual and Small 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 "Individual and Small 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) 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) 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).

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., individual and small 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 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.

   A statement of opinion, with respect to each individual or small group rate increase included in the filing, whether the rate increase filed is reasonable or unreasonable and, if unreasonable, that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies, including benefit relativities that reflect the expected variations in cost, taking into consideration historical experience and the credibility of the historical data. Statements of opinion regarding whether a rate increase is reasonable or unreasonable shall address, at a minimum, the first five factors listed in "Unreasonable Rate Increases" in this Guidance. In addition, statements of opinion shall discuss the criteria promulgated by the U.S. Department of Health and Human Services in 45 C.F.R. sections 154.200 and 154.205

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

C. Unreasonable Rate Increases

For all health plan rate filings, for the purpose of the actuarial certification required under Health and Safety Code section 1385.06(b)(2) and review under Health and Safety Code section 1385.11, the factors the DMHC will consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the factors expressly referenced in 45 C.F.R. 154.205:

1. The relationship of the projected aggregate medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law.

2. Whether the assumptions on which the rate increase is based are supported by substantial evidence.

3. Whether the choice of assumptions or combination of assumptions on which the rate increase is based is reasonable.

4. Whether the data, assumptions, rating factors, and methods used to determine the premium rates, or documentation provided to the DMHC in connection with the filed rate increase, are incomplete, inadequate, fail to provide sufficient clarity and detail such that a qualified health actuary could

not make an objective appraisal of the reasonableness of the rate, or which otherwise do not provide a basis upon which the reasonableness of the rate may be determined.

5. Whether the filed rates result in premium differences between enrollees within similar risk categories that are otherwise not permitted under California law or that do not reasonably correspond to differences in expected costs.

6. Whether the specific, itemized changes that led to the requested rate increase are substantially justified by credible historical emerging experience data, including comparisons of experience data to projections submitted as support for prior rate filings.

7. The annual compensation of each of the ten most highly paid officers, executives, and employees of both the health plan submitting the filing, and the parent corporation/ultimate controlling party of the health plan.

8. The rate of return of the health plan and the parent corporation/ultimate controlling party of the health plan, evaluated on a return-on-equity basis, for the prior three years, and anticipated rate of return for the following year, taking into account investment income.

9. The degree to which the increase exceeds the rate of medical cost inflation as reported by the U.S. Bureau of Labor Statistics Consumer Price Index for All Urban Consumers Medical Care Cost Inflation Index.

10. Whether the cumulative impact of the filed rate increase, combined with previous increases over the 12 months immediately preceding the effective date of the proposed filed rate increase, would cause the rate increase to be unreasonable.

11. The health plan's surplus condition, which may include dividend history.

12. Whether the rating factors applied and any change in rating factors are reasonable and result in a distribution of the proposed rate increase across risk categories that is reasonable and not overly burdensome on any particular individual or group, including consideration of the minimum and maximum rate increases an enrollee could receive, and how many enrollees will be subject to increases lower or higher than the average.

13. The nature and amount of transactions between the health plan and any affiliates.

14. To the extent not otherwise covered by the factors listed above, additional factors that the DMHC may consider in determining whether a rate increase is "unreasonable" include, but are not limited to, the factors set forth in the most current version of federal regulations, including 45 C.F.R, section 154.301.

Section V: Public Availability

Health and Safety Code section 1385.07 specifically require the DMHC to make all submitted information publicly available except for contracted rates between a plan and provider and contracted rates between a plan and individual and small group.

Section VI: Notice

A. No change in premium rates or changes in coverage stated in a small 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 60 days prior to the contract renewal effective date. (H&SC § 1374.21.)

B. No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has provided a written notice of the change at least 10 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year. (H&SC § 1389.25.)

C. The notice to enrollees or subscribers required by Health and Safety Code section 1374.21 and 1389.25 must include the date on which the proposed rate increase will be applied to the individual(s) to whom the notice is addressed.