
SENATE COMMITTEE ON HEALTH

Senator Dr. Akilah Weber Pierson, Chair

BILL NO: SB 1037
AUTHOR: Weber Pierson
VERSION: April 7, 2026
HEARING DATE: April 15, 2026
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SUBJECT: Health care coverage: rate review

SUMMARY: Requires the Department of Managed Health Care and the Department of Insurance, in collaboration with the Office of Health Care Affordability (OHCA), to conduct an enhanced premium rate review to determine if health insurance premiums are affordable for individual and group purchasers. Makes other changes to rate review requirements, including retrospective reviews and reconciling proposed rate information with OHCA analyses.

Existing law:

- 1) Establishes OHCA, within the Department of Health Care Access and Information (HCAI), to, among other things, be responsible for: analyzing the health care market for cost trends and drivers of spending; developing data-informed policies for lowering health care costs for consumers and purchasers; creating a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers; and, enforcing cost targets, including those established by the OHCA board. The HCAI director also serves as the OHCA director. [HSC §127501]
- 2) Requires the OHCA board to establish a statewide health care cost target, and specific targets by health care sector, including fully integrated delivery systems, geographic regions, and individual health care entities, as appropriate. Permits the OHCA board to adjust cost targets, when warranted, to account for the baseline costs in comparison to other health care entities in the health care sector and geographic region. [HSC §127502]
- 3) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the Department of Insurance (CDI) to regulate health insurance. [HSC §1340, et seq. and INS §106, et seq.]
- 4) Requires health plans and health insurers, for the group and individual markets, to file with DMHC and CDI, at a specified minimum length of time prior to implementing any rate change (generally 120 days prior), specified rate information so that the departments can review the information for unreasonable and unjustified rate increases. [HSC §1385.03 and INS §10181.3]
- 5) States legislative intent to ensure enrollees and insureds benefit from reductions in the health care growth rates resulting from OHCA cost targets, and requires in submitting health plans and insurer rates for review, health plans and insurers to demonstrate the impact of any changes in the growth rate because of the targets, and requires the DMHC director and CDI commissioner to consider the impact of targets in premium rate reviews. [HSC §1385.035 and INS §10181.35]

This bill:

- 1) Codifies the meaning of “unreasonable rate increase” as defined in federal law and clarifies that the DMHC director or CDI commissioner determines if the rate increase is excessive, unjustified, or unfairly discriminatory (which are the terms used in the federal law). Adds “otherwise unreasonable” to the list of reasons a rate increase can be determined unreasonable.
- 2) Requires the DMHC director or CDI commissioner to consider any excessive tangible net equity of the plan or insurer when determining whether a rate is unreasonable or not justified.
- 3) Requires health plans and insurers to demonstrate the impact of OHCA cost targets on rate development, including medical trends, medical inflation, and medical administrative costs.
- 4) Requires a plan or insurer, if it asserts that aging, high-cost drugs, or other cost drivers explain a rate increase, to explain how it reconciles this information with analysis published by OHCA.
- 5) Requires DMHC and CDI, in collaboration with OHCA, to conduct an enhanced rate review to determine if health care premiums are affordable for individual and group purchasers. Requires the review to include the annual change in premiums and cost-sharing for the prior five years, including, but not limited to, deductibles, copayments, coinsurance, and any other cost-sharing that impact actuarial value.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

- 1) *Author’s statement.* According to the author, health care costs are growing at unsustainable rates. Federal policies are putting even more pressure on state budgets and more importantly the budgets of California families and small businesses. Federal tax subsidies to help offset health insurance premiums and other policies that contributed to coverage rates in California of 94% are being rolled back. At the same time new federal policies are creating more bureaucratic hurdles that will also result in coverage losses. More has to be done in all health care sectors to control health care costs and health insurance premiums. California’s OHCA was created to rein in health care spending growth and has adopted health cost growth targets to limit growth in line with median household incomes and families’ food and housing budgets. This bill will require health insurance regulators to focus their reviews of proposed rate increases with an eye toward affordability for Californians. This bill will require regulators to connect their health plan and insurer rate reviews with the work of OHCA and require retrospective reviews of medical trends and cost-sharing requirements reported by health plans and insurers and take into account plan and insurer financial indicators that are well in excess of minimum standards.
- 2) *Rate Review.* DMHC regulates health plans, including preferred provider organizations (PPOs) offered in the individual and group markets (covering approximately 13 million Californians) and another 16 million in public coverage (mostly Medi-Cal). CDI regulates health insurance (only PPOs) also in the individual and group markets for approximately 800,000 Californians (mostly in large group coverage). As part of their regulatory responsibilities, both departments have similar requirements to review prospective rate filings submitted by plans for products sold in the individual and group markets. Rate filings submitted by plans include total premiums, incurred claims, average rate increases, enrollee cost sharing and benefit changes, medical trend assumptions, fees, prices paid in comparison

to Medicare, and variation in trends by geography. The regulators do not have authority to deny a rate increase, but they can declare a rate “unjustified” or “unreasonable,” which triggers disclosure requirements to purchasers. CDI reports that since 2011, the total savings for major medical policies is almost \$400 million due to their premium rate reviews. DMHC reports that their premium rate reviews in the individual and small group markets have saved Californians almost \$300 million since 2011. Generally, the departments have actuaries perform an in-depth review of the proposed premium rate changes and require health plans and insurers to demonstrate the changes are supported by data, including underlying medical costs and trends. In their 2024 Annual Report, DMHC indicates that its rate review efforts hold health plans accountable through transparency. If DMHC finds a health plan rate change is not supported, it negotiates with the health plan to reduce the rate, called a modified rate. If the health plan refuses to modify its rate, DMHC can find the rate to be unreasonable. When DMHC finds a proposed rate change to be unreasonable, the health plan must notify impacted members of the unreasonable findings. Additionally, health plans that offer individual, small group and large group coverage must file annual aggregated rate information with the DMHC. The DMHC holds a public meeting every other year to increase transparency of health plan premium rate changes. CDI also participates in this meeting. Health plans and insurers in the commercial market must also file certain prescription drug cost information with their regulators. DMHC and CDI summarize the data and the impact of prescription drug costs on health care premiums into annual reports and share this information at the biennial public meeting. DMHC also has a premium rate review section on its public website that makes it easy for the public to view and submit public comments on health plan proposed rate changes.

- 3) *OHCA*. OHCA was established by the enactment of SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022) with a focus on slowing the growth of health care spending, promoting high value health care, and assessing the impact of market consolidations on health care costs and access. According to the OHCA 2025 Annual Report, per capita spending in California in 2020 was \$10,299 compared with \$7,998 in 2015, a 28.8% increase. While 75% of low-income households report they have skipped or delayed care, many Californians are having difficulty affording and accessing health care. Approximately 25% of White, 36% of Latino, and 40% of Black Californians report having difficulty paying medical bills. High health care costs contribute to increases in health care premiums. California’s per capita total health care expenditures increased by 8.4% for the baseline period from 2022 to 2023. Growth in spending varied across markets, payers, regions, and service categories between 2022 and 2023. Total health care expenditures per-member/per-year growth for Medi-Cal and Medicare averaged 2.9% and 5.4%, respectively, compared with an average of 6.4% for commercial payers. Retail pharmacy, professional services, and hospital outpatient services contributed to the largest increases in spending growth across service categories for both commercial and Medicare markets, similar to trends observed in other states. In April 2024, OHCA announced a statewide health care spending target of 3%. The spending target will be phased in over time, initially starting at 3.5% for 2025 and 2026, lowered to 3.2% for 2027 and 2028 before reaching 3% beginning in 2029. In April of 2025, the OHCA board voted to define high-cost hospitals and set high-cost hospital targets for seven hospitals at 1.8% in 2026, 1.7% in 2027 and 2028, and 1.6% in 2029. Enforcement on cost targets will begin with the 2026 target but enforcement actions will not take place until sometime in 2028 after data collection in 2027 and public reporting in 2028. Because OHCA’s spending target is a shared expectation to meet annual rates of growth for health care spending, slowed spending growth will require cost-reducing

strategies by health care entities, while maintaining or improving quality and equity.

- 4) *Tangible Net Equity (TNE)*. TNE is a health plan's financial solvency indicator. TNE is a plan's total assets minus total liabilities reduced by the value of intangible assets (goodwill, organizational or start-up costs, etc.) and unsecured obligations of officers, directors, owners, or affiliates outside of the normal course of business. Any debt that is properly subordinated may be added to the TNE calculation, which serves to increase the plan's TNE. The required TNE for a full-service plan is the greater of \$1 million, a percent of premium revenues, or a percent of health care expenses. Excess TNE is the difference between total TNE and required TNE. Liquid TNE excludes receivables, fixed assets (non-liquid) and affiliate payables (except subordinated liabilities) from the TNE calculation. All health plans must meet the TNE reserve requirement described in regulations. In 2020, total excess TNE for all full-service plans was over \$54 billion and in 2024 was over \$94 billion (an increase of 74%). Excess TNE amounts for the top ten full-service health plans range from \$826 million to \$70 billion.
- 5) *Medical Loss Ratio (MLR)*. MLR in the individual and small group market is 80% and in the large group market is 85%. This means a commercial health plan is required to spend at least 80% or 85% of premium revenues on medical care and quality improvement. "Premium revenue" is all monies paid by members or employer groups for coverage, adjusted for taxes and regulatory fees. "Medical care" is payments made by a health plan for medical services provided to members, including claims incurred during the reporting year regardless of when they are paid and reserves for unpaid claims. "Quality improvement" expenses are costs incurred by a health plan that are designed to improve health outcomes and enhance quality of care. Routine administrative costs, marketing expenses, and utilization management are excluded. If a health plan does not meet the MLR requirement they must issue rebates to the individual or employer. DMHC may conduct MLR audits of health plans. For 2024 no full-service plans in the individual or large group market paid rebates, but in the small group market, \$13.4 million in rebates were paid back to small business purchasers.
- 6) *Prior legislation*. AB 731 (Kalra, Chapter 807, Statutes of 2019) imposes rate filing requirements to large group health plan contracts and health insurance policies; requires a health plan or insurer to disclose specified information in a rate filing by geographic region for individual, grandfathered group, and nongrandfathered group contracts and policies, including the price paid compared to the price paid by the Medicare Program for the same services in each benefit category; and, requires DMHC and CDI to determine if large group community rate changes are unreasonable or unjustified, and if so, requires health plans and insurers to notify the purchaser of an unreasonable or unjustified rate determination.

SB 908 (Hernandez, Chapter 498, Statutes of 2016) requires plans and insurers to notify purchasers in the individual and large group market if premiums rates have been determined unreasonable.

SB 546 (Leno, Chapter 801, Statutes of 2015) establishes weighted average rate increase disclosure requirements for a health plan's or insurer's aggregated large group market products and required DMHC and CDI to conduct a public meeting.

SB 1182 (Leno, Chapter 577, Statutes of 2014) requires health plans and insurers to share specified data with purchasers that have 1,000 or more enrollees, insureds or that are multiemployer trusts.

SB 746 (Leno of 2013) would have established new data reporting requirements on all health plans and insurers applicable to products sold in the large group market and would have established new specific data reporting requirements related to annual medical trend factors by service category, as well as claims data or deidentified patient-level data, as specified, for a health plan that exclusively contracts with no more than two medical groups in the state to provide or arrange for professional medical services for the enrollees of the plan (referring to Kaiser Permanente). *SB 746 was vetoed by Governor Brown, who stated:*

“This bill would require all health plans and insurers to disclose every year broad data relating to services used by large employer groups, including aggregate rate increases by benefit category. The bill also requires that one health plan additionally provide anonymous claims data or patient level data upon request and without charge to large purchasers. I support efforts to make health care costs more transparent, and my administration is moving forward to establish transparency programs that will cover all health plans and systems. I urge all parties to work together in this effort. If these voluntary efforts fail, I will seriously consider stronger actions.”

SB 1163 (Leno, Chapter 661, Statutes of 2010) requires carriers to submit detailed data and actuarial justification for small group and individual market rate increases at least 60 days in advance of increasing their customers' rates.

- 7) *Support.* Health Access California writes that despite California's progress to expand health care coverage in the last two decades, rising health care costs have prevented many Californians from getting the care they need and forced many into crushing debt. According to Health Access California, health care costs have risen faster than wages, inflation and what Californians can afford for decades. Health Access California writes with the health care affordability crisis being exacerbated by HR 1 and the loss of the subsidies, it's even more critical the state scrutinizes health insurance and plan rate increases with consumer affordability in mind. Health Access writes this bill requires enhanced rate review to include the annual change in premiums and cost-sharing for the last five years to consider what rate increases mean for consumers, and this bill ensures that rate review aligns with OHCA's cost growth targets. The California Hospital Association writes that this bill would provide a necessary and logical framework to ensure OHCA and other state regulators can examine root causes of excessive premium growth and instability. The California Pan Ethnic Health Network writes, "adding a consumer affordability factor will increase rate transparency and accountability by requiring plans to consider the extent to which rate increases will lead to massive disenrollments. Instead of justifying rate increases based solely on medical costs or utilization, plans would now be required to estimate how those increases affect people's ability to stay enrolled including how many members might drop coverage, which groups are most at risk and how premiums compare to wages or household budget. This will discourage excessive or poorly justified rate hikes." The California Teachers Association (CTA) believes health care should be a bridge to well-being, not a barrier to financial security. CTA says hard-won wage increases are frequently eroded by double-digit hikes in medical costs. CTA writes even if a union secures a 4% or 5% annual raise for its members, a 10% or more hike in health care premiums effectively neutralizes that increase in take-home pay.
- 8) *Opposition.* The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) write that this bill introduces

subjective, duplicative, and administratively burdensome framework that threaten the stability of the market and undermine the actuarial integrity essential to sound rate-setting. CAHP and ACLHIC believe the bill creates implementation challenges and introduces numerous undefined terms that can lead to regulatory confusion and costs to the departments and plans and insurers. The opposition believes the bill conflates prospective rate review and retrospective OHCA targets. CAHP and ACLHIC writes that the use of excessive TNE in rate review reflects a misunderstanding of insurance solvency, and that this bill emphasizes administrative reporting requirements instead of tackling the root causes of rising hospital and pharmaceutical costs.

SUPPORT AND OPPOSITION:

- Support:** California Hospital Association
California Pan-Ethnic Health Network
California Teachers Association
Health Access California
- Oppose:** Association of California Life & Health Insurance Companies
California Association of Health Plans

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