

Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON HEALTH  
Mia Bonta, Chair  
SB 1037 (Weber Pierson) – As Amended June 22, 2026

**SENATE VOTE:** 30-9

**SUBJECT:** Health care coverage: rate review.

**SUMMARY:** Requires the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI), in collaboration with the Office of Health Care Affordability (OHCA), to conduct an enhanced rate review to determine if health care premiums are affordable, as defined. Makes other changes to the rate review process and related health plan and insurer reporting. Specifically, **this bill**:

- 1) Requires DMHC and CDI, in collaboration with OHCA, to conduct enhanced rate review as part of the existing rate review process to consider if health care premium rates 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.
- 2) Requires the DMHC director or CDI commissioner, in determining whether a rate increase is unreasonable, to consider whether a plan or insurer has sufficient or excessive financial capacity for the past three years using all of the following measures:
  - a) Tangible net equity (TNE);
  - b) Working capital;
  - c) Payouts to shareholders and investors, if a for-profit entity;
  - d) Reserves and investments; and,
  - e) Other measures determined by the department.
- 3) Requires DMHC and CDI, if a plan's financial capacity is excessive, to take into consideration whether the plan has financial capacity to charge enrollees a lower rate than the proposed rate in determining if the proposed rate is unreasonable.
- 4) Requires 2) and 3) above to be implemented in a manner that does not conflict with any financial solvency provisions under existing law.
- 5) Requires a plan or insurer, in submitting rates for review, to demonstrate the impact of OHCA cost targets on rate development, including medical trends, medical inflation, and medical administrative costs. Requires, if a plan or insurer asserts that aging, high-cost drugs, or other cost drivers explain a rate increase in part or in whole, the plan or insurer to explain how it reconciles this information with analysis published by OHCA.

- 6) Defines “affordable” to mean that the plan contract or insurance policy requires no greater individual contribution to premium, share of premium, and deductible as the amount described under the state’s individual mandate law.
- 7) Requires the review to look at affordability of rates, including cost-sharing, for an individual and family of four at 200%, 400%, and 800% of the federal poverty level (FPL).
- 8) Requires the determination of affordability to be reported.
- 9) Specifies that an “unreasonable rate increase” exists if the DMHC director or CDI commissioner makes a determination that a rate increase is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable.

**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. [Health and Safety Code (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 DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the CDI to regulate health insurance. [HSC § 1340, *et seq.* and Insurance Code (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]
- 6) Permits a large group contract holder, upon receiving notice of a rate change, to apply within 60 days to have the DMHC or CDI review the rate change to determine whether the rate change is unreasonable or not justified. [HSC § 1385.046 and INS § 10181.31]

- 7) Defines “unreasonable rate increase” to have the same meaning as in the Patient Protection and Affordable Care Act (ACA). [HSC § 1385.01 and INS § 10181]
- 8) Exempts individuals from the individual mandate penalty if the responsible individual’s required contribution, determined on an annual basis, for coverage for the month exceeds 8.3% of that responsible individual’s applicable household income for the taxable year. [Revenue and Taxation Code § 61020]

**FISCAL EFFECT:** According to the Senate Appropriations Committee, unknown ongoing costs, likely high hundreds of thousands, for DMHC for state administration (Managed Care Fund). Unknown ongoing costs for CDI for state administration (Insurance Fund). Unknown ongoing General Fund costs for HCAI to work in collaboration with DMHC and CDI in the rate review process.

**COMMENTS:**

**1) PURPOSE OF THIS BILL.** 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 that help offset health insurance premiums and other policies that saw rates of health care coverage in California exceed 94% are being rolled back at the same time new federal policies are creating more bureaucratic hurdles that will result in additional coverage losses. OHCA was created in 2022 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. The author argues that this bill will result in health insurance regulators focusing their reviews of premium rates proposed by health plans and insurers with an eye toward affordability for Californians. The author continues that 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) BACKGROUND.**

**a) Growing consumer premiums and affordability concerns.** Over the last two decades, significant federal policy changes have reshaped the health insurance landscape in California, expanding coverage, increasing affordability, and strengthening consumer protections for millions of residents. These policies drove historic reductions in the uninsured rate and provided greater stability for families, providers, and health systems across the state. These gains, however, are under threat as the expiration and rollback of key federal supports, combined with broader economic uncertainty and rising health care costs, risk reversing hard-won progress and increasing the number of Californians who are struggling to access affordable health care. According to the California Health Care Foundation 2026 Health Policy Survey (CHCF Survey), half of Californians (51%) reported that their health care expenses have increased faster than their incomes, and a vast majority (71%) are experiencing financial strain due to health care costs. About 6 in 10 Californians overall (59%), and 70% of Californians with low incomes, say they skipped or postponed care due to cost in the past year. Nearly half of Californians (47%) say it is “very” or “somewhat” difficult to afford health care.

- i) Covered California.** Covered California is the state’s ACA marketplace where small-businesses and individuals can directly purchase coverage. Over 90% of Covered California enrollees receive some combination of state and federal subsidies to afford their premiums. However, the expiration of federal enhanced premium tax credits at the end of 2025 is creating stark affordability concerns. Covered California estimates that about 1.7 million Californians will see significant increases to their costs in 2026; on average, enrollees will notice 97% increases to their monthly health insurance premiums. As of February, Covered California estimated a 3% decrease in enrollment overall, with a 32% decrease in new enrollments compared to 2025. One-third of enrollees are opting for lower-cost Bronze plans, compared to 25% in 2025, and 75% of renewals who switched plans downgraded to Bronze-level coverage. About 14% of previous enrollees cancelled their plans, and for those making over 400% of the FPL, policy termination rates are double what they were in 2025 (22% up from 11%).
  - ii) Employer coverage.** For those on employer-based individual and family plans, the California Health Benefits Survey found that the average total premium for family coverage in California has increased by 24% since 2022 – rapidly outpacing the national rates of inflation (12%) and wages (14%). This continues a 20-year trend: according to the UC Labor Center, family health care premiums for private-sector workers have grown by 129% since 2005, faster than the state’s median household income (94%) and the inflation rate (69%). Because health insurance is part of an employee’s total compensation plan, higher premiums cut into employee wage increases and other benefits.
- b) Rate Review.** The ACA brought a new level of scrutiny and transparency to health insurance rate increases. Under the ACA, any insurer planning to significantly increase premiums for plans on the individual and small group markets must submit their rates to the government for review. The Centers for Medicare and Medicaid Services (CMS) determines that a rate increase is an unreasonable increase if it is:
- i) An excessive rate increase,** meaning the increase causes the premium charged for coverage is unreasonably high in relation to the benefits provided under the coverage. In determining whether the rate increase causes the premium charged to be unreasonably high in relationship to the benefits provided, CMS considers:

    - (1)** Whether the rate increase results in a projected medical loss ratio below the federal standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under federal law;
    - (2)** Whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and,
    - (3)** Whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable;
  - ii) An unjustified rate increase,** meaning the health insurance issuer provides data or documentation to CMS in connection with the increase that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of an increase may be determined; or,

iii) **An unfairly discriminatory rate increase**, meaning the increase results in premium differences between insureds within similar risk categories that:

- (1) Are not permissible under applicable state law; or,
- (2) In the absence of an applicable state law, do not reasonably correspond to differences in expected costs.

CMS encourages states to conduct their own rate review through Effective Rate Review Programs. If a state lacks the resources or authority to conduct the required reviews, CMS reviews the rates for compliance. In California, DMHC and CDI manage the rate review process. In 2019, the Legislature expanded rate review requirements to also apply to large group health insurance products with AB 731 (Kalra), Chapter 807, Statutes of 2019. In 2023, the Legislature further expanded rate review requirements to cover health plan contracts and insurance policies covering dental services with AB 1048 (Wicks), Chapter 557, Statutes of 2023. DMHC and CDI review proposed health plan rate changes and ask health plans questions about their changes to be sure health plans are providing detailed information to the public to support any rate increases. While DMHC and CDI do not have the authority to deny rate increases, their rate review efforts hold health plans accountable, ensure consumers get value for their premium dollar, and save Californians money. According to the DMHC, their premium rate review program has saved Californians hundreds of millions of dollars by negotiating lower premium increases or no premium increases when increased rates are not supported.

- c) **OHCA cost targets.** OHCA was established in 2022 in response to widespread cost-related access challenges across California. OHCA collects, analyzes, and publicly reports data on total health care expenditures and enforces spending targets. OHCA's spending targets are intended to reduce excess spending and slow health care spending growth. In April of 2024, OHCA approved a statewide cost growth target of 3.5% starting in 2025 and phasing down to 3% by 2029. Health care entities, including health plans and insurers, are subject to the statewide spending target and are subject to progressive enforcement if the entity's costs exceed the target. 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. Recent reporting from CMS shows that health care costs will outpace economic growth over the next decade.
- d) **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.

- e) **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.
- 3) **SUPPORT.** Health Access California (HAC) supports this bill, stating that the goal with existing rate review is to determine if rates are adequate, excessive or discriminatory by looking at whether the health plan’s revenue will cover the costs of covered services, profits or reserves, are reasonable and whether different premiums charged to different insurance members are justified. With the enhanced rate review required in this bill, HAC notes that the regulator, in collaboration with OHCA, would evaluate the impact of the rate increase on consumer affordability. HAC argues that the affordability measures in this bill will allow the state to understand how unaffordable rates are now, and also see the improvements in affordability over time for consumers as the OHCA cost growth targets are implemented. HAC continues that by requiring enhanced rate review to include the annual change in premiums and cost-sharing for the last five years, this bill would ensure what consumers pay when they access covered services, and whether it is affordable, is considered through the rate review process, in addition to whether the rates are unreasonable under existing law. HAC states that the provisions of this bill requiring regulators to consider excessive TNE and other measures of financial capacity would ensure that regulators weigh if there is room for health plans and insurers to charge lower rates to consumers. If health plans have excessive financial capacity, it is important that the regulators consider that. HAC concludes that the escalating cost of care creates barriers to consumers using their coverage, and this bill will ensure that state rate review utilizes existing data being collected to make their determination of unreasonable and unjustified rates and whether proposed rates are unaffordable for consumers. This would take an important step to ensure that the benefits of the OHCA cost growth targets are realized in consumer rates, benefiting consumer affordability and state spending on health care coverage.
- 4) **OPPOSITION.** The California Association of Health Plans and Association of California Life and Health Insurance Companies oppose this bill, stating that rate review is a prospective process that ensures premiums can cover future claims, while OHCA spending targets are retrospective, analyzing performance over several years. The opposition argues that mixing these measures in the reasonableness review of premiums is not actuarially sound. The opposition continues that requiring plans or insurers to reconcile internal data

with OHCA's generalized benchmarks overlooks the unique clinical and demographic realities faced by the member population of each plan and insurer. The opposition notes that while drug spending by plans and insurers has increased exponentially over the last several years, drug companies are not subject to OHCA's spending targets. The opposition states that requiring the consideration of "excessive" financial capacity in rate review reflects a misunderstanding of insurance solvency and its role in protecting consumers. The opposition continues that existing consumer protections ensure health plans hold sufficient reserves to pay claims during emergencies or catastrophic events. The opposition argues that instead of tackling the root causes of rising hospital and pharmaceutical costs, this bill emphasizes administrative reporting requirements. The opposition continues that this bill exacerbates the compliance cost paradox, stating that the "medical administrative costs" this bill aims to monitor are likely to increase as plans and insurers dedicate resources to comply with the bill. The opposition concludes that California already operates some of the most transparent rate review processes in the country, and by introducing subjective definitions and conflating solvency reserves with premium pricing, this bill risks destabilizing the California insurance market.

## **5) PREVIOUS LEGISLATION.**

- a)** 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.
- b)** SB 908 (Hernández), 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.
- c)** 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.
- d)** 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.
- e)** 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.”

- f) 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.

## 6) PROPOSED AMENDMENTS.

- a) **Bolster OHCA cost target consideration.** The current version of this bill requires health plans to demonstrate the impact of OHCA cost targets on rate development. The committee may wish to amend the bill to additionally require a health plan to demonstrate whether its rate growth will meet the OHCA cost target for the rating period. If the cost target isn’t met, the amendments would further require a plan to report steps being taken to meet cost targets and detail factors driving rate increases.
- b) **Establish an affordability standard.** This bill’s requirements for DMHC and CDI to, through enhanced rate review, determine if premiums are affordable raises questions. What if a rate is determined to be unaffordable but also not unreasonable? What is the recourse? It is this committee’s understanding from the regulators that an unreasonable determination is based in actuarial soundness, whereas affordability would be a completely new and unrelated determination. Additionally, it could be argued that premiums are already unaffordable for many Californians. Instead, the committee may wish to amend the bill to establish an affordability standard based off existing measures for affordability that regulators will evaluate. This would allow the state to have full transparency into how many premiums offered in the market are truly affordable for consumers.
- c) **Technical amendments.** Lastly, the committee may wish to amend the bill to include technical amendments from CDI related to specialized health plans and the financial capacity provisions in the INS code sections.

## REGISTERED SUPPORT / OPPOSITION:

### Support

California Alliance for Retired Americans  
California Teachers Association  
Health Access California

### Opposition

Association of California Life & Health Insurance Companies  
California Association of Health Plans

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