Date of Hearing: August 5, 2026

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 1037 (Weber Pierson) – As Amended July 2, 2026

Policy Committee: Health Vote: 12 - 4

Urgency: No State Mandated Local Program: Yes Reimbursable: No

SUMMARY:

This bill requires a health care service plan or health insurer's (collectively, health plan) rate growth meet the cost target established by the Office of Health Care Affordability (OHCA) for the rating period and requires the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI), in collaboration with OHCA, to conduct an enhanced rate review to determine whether health care premiums are affordable.

More specifically, this bill:

1) Defines an "unreasonable rate increase" to mean a rate increase that the director of DMHC or the Insurance Commissioner (Commissioner), as applicable, determines is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable, as defined in federal law.

2) Requires DMHC and CDI, in collaboration with OHCA, to evaluate as part of the existing rate review process whether health care premium rates meet affordability standards for individual and group purchasers, and requires the evaluation to include the annual change in premiums and cost-sharing for the prior five years, including deductibles, copayments, coinsurance, and any other cost-sharing that impacts actuarial value.

3) Requires the DMHC director or Insurance 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 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.

    e) Other measures determined by DMHC or CDI.

4) Requires, if a plan's financial capacity is excessive, DMHC and CDI 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.

5) Requires a health plan, in submitting rates for review, demonstrate the impact of OHCA cost targets and whether its rate growth meets or will meet the cost target, and if not, requires the health plan include in its filing (a) a list of steps it will take to meet cost targets, (b) a delineation of factors driving rate increases to exceed cost targets, and (c) a reconciliation of its findings relevant to any specific cost drivers it cites and about which OHCA has published an analysis.

6) Defines "the affordability standard" to mean the plan contract or insurance policy requires no greater individual contribution to premium, share of premium, and deductible than the amount described under the state's individual mandate law and requires the determination of affordability to be included in specified reports.

7) Requires DMHC and CDI, in consultation with OHCA, evaluate as part of the rate review process whether the health plan's rates meet the affordability standard for an individual and a family of four with household incomes at 200%, 400%, and 800% of the federal poverty level (FPL), as specified.

FISCAL EFFECT:

DMHC estimates the total cost of this bill to be approximately $461,000 for two staff positions in fiscal year (FY) 2026-27 and $1.2 million for four positions in FY 2027-28, and annually thereafter. The costs would be for additional workload to conduct legal review, promulgate complex regulations and draft legal memoranda to clarify the requirements in this bill, revise rate filing templates and review premium rate filings for compliance (Managed Care Fund).

CDI estimates costs of $2.4 million in FY 2027-28 and $459,000 in FY 2028-29 and annually thereafter. These costs would be for actuarial work, to coordinate rate-review work with OHCA, develop regulations in coordination with DMHC, analyze filings, assess affordability, request clarifications from insurers, and develop written findings (Insurance Fund).

HCAI anticipates minor and absorbable costs.

COMMENTS:

1) **Purpose.** According to the author:

> California's Office of Health Care Affordability 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. 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. 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.** ***Rate Review***. The federal Patient Protection and Affordable Care Act (ACA) brought a new level of scrutiny and transparency to health plan rate increases. Under the ACA, any health plan planning to significantly increase premiums for plans on the individual and small group markets must submit rates for review. The federal Centers for Medicare & Medicaid Services (CMS) determines that a rate increase is an unreasonable increase if it is an excessive, unjustified, or unfairly discriminatory rate increase, as defined.

   CMS encourages states to conduct their own rate review through Effective Rate Review Programs. In California, DMHC and CDI manage the rate review process. AB 731 (Kalra), Chapter 807, Statutes of 2019, expanded rate review requirements to also apply to large group health insurance products. In 2023, AB 1048 (Wicks), Chapter 557, Statutes of 2023, further expanded rate review requirements to cover health plans covering dental services. 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.

   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 plans are subject to the spending targets. Enforcement on cost targets will begin with the 2026 target but enforcement actions will not take place until 2028 after data collection in 2027 and public reporting in 2028.

3) **Opposition.** The California Association of Health Plans (CAHP) and Association of California Life and Health Insurance Companies (ACLHIC) contend 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, and that mixing these measures in the reasonableness review of premiums is not actuarially sound. CAHP and ACLHIC argue 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 health plan. CAHP and ACLHIC point out 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. CAHP and ACLHIC conclude 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.

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