SENATE THIRD READING
SB 1037 (Weber Pierson)
As Amended July 02, 2026
Majority vote

SUMMARY

Requires the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI), in consultation with the Office of Health Care Affordability (OHCA), to evaluate whether health plan or insurance rates meet an affordability standard, as specified. Makes other changes to the rate review process and related health plan and insurer reporting.

Major Provisions

1) Defines ″affordability standard″ 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.

2) Requires a health plan or insurer, in submitting rates for review, to demonstrate the impact of OHCA cost targets on rate development. Requires a health plan or insurer to demonstrate whether its rate growth meets or will meet the cost target for the rating period. Requires, if rate growth is expected to exceed the cost target for the rating period, a health plan or insurer to provide plans or proactive steps being taken to meet cost targets and factors driving rate increases to exceed cost targets.

3) Requires the DMHC director or CDI commissioner, in determining whether a rate increase is unreasonable, to consider whether a health plan or insurer has sufficient or excessive financial capacity for the past three years using specified measures.

4) Requires DMHC and CDI, if a plan′s financial capacity is excessive, to take into consideration whether the health plan or insurer has financial capacity to charge enrollees a lower rate than the proposed rate in determining if the proposed rate is unreasonable.

COMMENTS

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.

Covered California. Covered California is the state′s Affordable Care Act (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 federal poverty level, policy termination rates are double what they were in 2025 (22% up from 11%).

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.

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:

1) *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:

    a) 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;

    b) Whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and,

    c) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable;

2) *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,

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

   a) Are not permissible under applicable state law; or,

   b) 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.

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.

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.

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.

Arguments in 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 tangible net equity 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.

Arguments in 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.

FISCAL COMMENTS

According to the Assembly Appropriations Committee:

1) 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).

2) 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).

3) Department of Health Care Access and Information anticipates minor and absorbable costs.

VOTES

SENATE FLOOR: 30-9-1
YES: Allen, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Cortese, Durazo, Gonzalez, Grayson, Hurtado, Laird, Limón, McGuire, McNerney, Menjivar, Padilla, Pérez, Reyes, Richardson, Rubio, Smallwood-Cuevas, Stern, Umberg, Wahab, Weber Pierson, Wiener
NO: Alvarado-Gil, Choi, Grove, Jones, Niello, Ochoa Bogh, Seyarto, Strickland, Valladares
ABS, ABST OR NV: Dahle

ASM HEALTH: 12-4-0
YES: Bonta, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Mark González, Patel, Celeste Rodriguez, Schiavo, Sharp-Collins, Stefani
NO: Sanchez, Jeff Gonzalez, Johnson, Patterson

ASM APPROPRIATIONS: 11-2-2
YES: Wicks, Arambula, Calderon, Caloza, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache
NO: Hoover, Tangipa
ABS, ABST OR NV: Dixon, Ta

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