Senate Bill No. 343

CHAPTER 247

An act to amend Sections 1385.03, 1385.045, 1385.07, 128735, 128740, and 128760 of the Health and Safety Code, and to amend Section 10181.45 of the Insurance Code, relating to health care.

[Approved by Governor September 5, 2019. Filed with Secretary of State September 5, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

SB 343, Pan. Health care data disclosure.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan or health insurer in the individual, small group, or large group markets to file rate information with the appropriate department, but specifies alternative information to be filed by a health care service plan or health insurer that exclusively contracts with no more than 2 medical groups.

Existing law establishes the Office of Statewide Health Planning and Development (OSHPD) in the California Health and Human Services Agency to regulate health planning and research development. Existing law generally requires a health care facility to report specified data to OSHPD, but requires OSHPD to establish specific reporting provisions for a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans. Existing law authorizes hospitals to report specified financial and utilization data to OSHPD, and file cost data reports with OSHPD, on a group basis, and exempts hospitals authorized to report as a group from reporting revenue separately for each revenue center.

This bill would eliminate alternative reporting requirements for a plan or insurer that exclusively contracts with no more than 2 medical groups or a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and would instead require those entities to report information consistent with any other health care service plan, health insurer, or health facility, as appropriate. The bill would also eliminate the authorization for hospitals to report specified financial and utilization data to OSHPD, and file cost data reports with OSHPD, on a group basis, but would authorize a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and that is operated as a unit of a coordinated group of health facilities under common management

to report specified information for the group and not for each separately licensed health facility. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1385.03 of the Health and Safety Code is amended to read:

1385.03. (a) A health care service plan shall file with the department all required rate information for grandfathered individual and grandfathered and nongrandfathered small group health care service plan contracts at least 120 days prior to implementing a rate change. A health care service plan shall file with the department all required rate information for nongrandfathered individual health care service plan contracts on the earlier of the following dates:

(1) One hundred days before October 15 of the preceding policy year.

(2) The date specified in the federal guidance issued pursuant to Section 154.220(b) of Title 45 of the Code of Federal Regulations.

(b) A plan shall disclose to the department all of the following for each individual and small group rate filing:

(1) Company name and contact information.

(2) Number of plan contract forms covered by the filing.

(3) Plan contract form numbers covered by the filing.

(4) Product type, such as a preferred provider organization or health maintenance organization.

(5) Segment type.

(6) Type of plan involved, such as for profit or not for profit.

(7) Whether the products are opened or closed.

(8) Enrollment in each plan contract and rating form.

(9) Enrollee months in each plan contract form.

(10) Annual rate.

(11) Total earned premiums in each plan contract form.

(12) Total incurred claims in each plan contract form.

(13) Average rate increase initially requested.

(14) Review category: initial filing for new product, filing for existing product, or resubmission.

(15) Average rate of increase.

(16) Effective date of rate increase.

(17) Number of subscribers or enrollees affected by each plan contract form.

(18) The plan's overall annual medical trend factor assumptions in each rate filing for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology. A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in the geographic regions listed in Sections 1357.512 and 1399.855.

(19) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(20) A comparison of claims cost and rate of changes over time.

(21) Any changes in enrollee cost sharing over the prior year associated with the submitted rate filing.

(22) Any changes in enrollee benefits over the prior year associated with the submitted rate filing.

(23) The certification described in subdivision (b) of Section 1385.06.

(24) Any changes in administrative costs.

(25) Any other information required for rate review under the federal Patient Protection and Affordable Care Act (PPACA).

(c) A health care service plan subject to subdivision (a) shall also disclose the following aggregate data for all rate filings submitted under this section in the individual and small group health care service plan markets:

(1) Number and percentage of rate filings reviewed by the following:

(A) Plan year.

(B) Segment type.

(C) Product type.

(D) Number of subscribers.

(E) Number of covered lives affected.

(2) The plan's average rate increase by the following categories:

(A) Plan year.

(B) Segment type.

(C) Product type.

(3) Any cost containment and quality improvement efforts since the plan's last rate filing for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(d) The department may require all health care service plans to submit all rate filings to the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Submission of the required rate filings to SERFF shall be deemed to be filing with the department for purposes of compliance with this section.

(e) A plan shall submit any other information required under PPACA. A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(f) (1) A plan shall respond to the department's request for any additional information necessary for the department to complete its review of the plan's rate filing for individual and small group health care service plan contracts under this article within five business days of the department's request or as otherwise required by the department.

(2) Except as provided in paragraph (3), the department shall determine whether a plan's rate increase for individual and small group health care service plan contracts is unreasonable or not justified no later than 60 days following receipt of all the information the department requires to make its determination.

(3) For all nongrandfathered individual health care service plan contracts, the department shall issue a determination that the plan's rate increase is unreasonable or not justified no later than 15 days before October 15 of the preceding policy year. If a health care service plan fails to provide all the information the department requires in order for the department to make its determination, the department may determine that a plan's rate increase is unreasonable or not justified.

(g) If the department determines that a plan's rate increase for individual or small group health care service plan contracts is unreasonable or not justified consistent with this article, the health care service plan shall provide notice of that determination to any individual or small group applicant. The notice provided to an individual applicant shall be consistent with the notice described in subdivision (c) of Section 1389.25. The notice provided to a small group applicant shall be consistent with the notice described in subdivision (c) of Section 1374.21.

(h) For purposes of this section, "policy year" has the same meaning as set forth in subdivision (g) of Section 1399.845.

SEC. 2. Section 1385.045 of the Health and Safety Code is amended to read:

1385.045. (a) For large group health care service plan contracts, a health care service plan shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of enrollees in each large group benefit design in the plan's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A plan shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within four months of posting the aggregate information

described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health care service plan subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of enrollees.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Enrollees' share of premiums.

(H) Enrollees' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual plan contract trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(C) A comparison of the aggregate per enrollee per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in enrollee cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in enrollee cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of enrollees.

(E) Any changes in enrollee benefits over the prior year, including a description of benefits added or eliminated, as well as any aggregate changes, as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts since the plan's prior year's information pursuant to this section for the same category of health benefit plan. To the extent possible, the plan shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health care service plan.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health care service plan spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The plan shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The plan shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The plan shall also include the name or names of the pharmacy benefit manager, or managers if the plan uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2018, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 1385.07.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 3. Section 1385.07 of the Health and Safety Code is amended to read:

1385.07. (a) Notwithstanding Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code, all information submitted under this article shall be made publicly available by the department except as provided in subdivision (b).

(b) (1) The contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The contracted rates between a health care service plan and a provider shall not be disclosed by a health care service plan to a large group purchaser that receives information pursuant to Section 1385.10.

(2) The contracted rates between a health care service plan and a large group shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Information provided to a large group purchaser pursuant to Section 1385.10 shall be deemed confidential information that shall not be made public by the department and shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) All information submitted to the department under this article shall be submitted electronically in order to facilitate review by the department and the public.

(d) In addition, the department and the health care service plan shall, at a minimum, make the following information readily available to the public on their internet websites in plain language and in a manner and format specified by the department, except as provided in subdivision (b). For individual and small group health care service plan contracts, the information shall be made public for 120 days prior to the implementation of the rate increase. For large group health care service plan contracts, the information shall be made public for 60 days prior to the implementation of the rate increase. The information shall include:

(1) Justifications for any unreasonable rate increases, including all information and supporting documentation as to why the rate increase is justified.

(2) A plan's overall annual medical trend factor assumptions in each rate filing for all benefits.

(3) A health care service plan's actual costs, by aggregate benefit category to include hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(4) The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by aggregate benefit category, such as hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

SEC. 4. Section 128735 of the Health and Safety Code is amended to read:

128735. An organization that operates, conducts, owns, or maintains a health facility, and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on forms specified by the office that are in accord, if applicable, with the systems of accounting and uniform reporting required by this part, except that the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center.

(d) A statement of cashflows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) (1) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting organization.

(2) Notwithstanding paragraph (1), a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and that is operated as a unit of a coordinated group of health facilities under common management may report the information required pursuant to subdivisions (a) and (d) for the group and not for each separately licensed health facility.

(f) Data reporting requirements established by the office shall be consistent with national standards, as applicable.

(g) A Hospital Discharge Abstract Data Record that includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) ZIP Code.

(5) Preferred language spoken.

(6) Patient social security number, if it is contained in the patient's medical record.

(7) Prehospital care and resuscitation, if any, including all of the following:

(A) "Do not resuscitate" (DNR) order on admission.

(B) "Do not resuscitate" (DNR) order after admission.

(8) Admission date.

(9) Source of admission.

(10) Type of admission.

(11) Discharge date.

(12) Principal diagnosis and whether the condition was present on admission.

(13) Other diagnoses and whether the conditions were present on admission.

(14) External causes of morbidity and whether present on admission.

(15) Principal procedure and date.

(16) Other procedures and dates.

(17) Total charges.

(18) Disposition of patient.

(19) Expected source of payment.

(20) Elements added pursuant to Section 128738.

(h) It is the intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) A person reporting data pursuant to this section shall not be liable for damages in an action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (g).

(j) A hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

(k) On or before July 1, 2021, the office shall promulgate regulations as necessary to implement subdivision (e). A health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and that is operated as a unit of a coordinated group of health facilities under common management shall comply with the reporting requirements of subdivisions (b), (c), and (e) once the office finalizes related regulations.

SEC. 5. Section 128740 of the Health and Safety Code is amended to read:

128740. (a) The following summary financial and utilization data shall be reported to the office by a hospital within 45 days of the end of a calendar quarter. Adjusted reports reflecting changes as a result of audited financial

statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.

(7) Total operating expenses.

(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(11) Total capital expenditures.

(12) Total net fixed assets.

(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(15) Other operating revenue.

(16) Nonoperating revenue net of nonoperating expenses.

(b) The office shall make available at cost, to any person, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(c) The office shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

SEC. 6. Section 128760 of the Health and Safety Code is amended to read:

128760. (a) On and after January 1, 1986, the systems of health facility accounting and auditing formerly approved by the California Health Facilities

Commission shall remain in full force and effect for use by health facilities, but shall be maintained by the office.

(b) The office shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this chapter if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) The office shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not permit the office to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) The office shall allow and provide, in accordance with appropriate regulations, for modifications to emergency care data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not permit the office to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) The office shall allow and provide, in accordance with appropriate regulations, for modifications to ambulatory surgery data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not permit the office to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

(f) The office shall adopt comparable modifications to the financial reporting requirements of this chapter for county hospital systems consistent with the purposes of this chapter.

SEC. 7. Section 10181.45 of the Insurance Code is amended to read:

10181.45. (a) For large group health insurance policies, a health insurer shall file with the department the weighted average rate increase for all large group benefit designs during the 12-month period ending January 1 of the following calendar year. The average shall be weighted by the number of insureds in each large group benefit design in the insurer's large group market and adjusted to the most commonly sold large group benefit design by enrollment during the 12-month period. For the purposes of this section, the large group benefit design includes, but is not limited to, benefits such as basic health care services and prescription drugs. The large group benefit

design shall not include cost sharing, including, but not limited to, deductibles, copays, and coinsurance.

(b) (1) A health insurer shall also submit any other information required pursuant to any regulation adopted by the department to comply with this article.

(2) The department shall conduct an annual public meeting regarding large group rates within four months of posting the aggregate information described in this section in order to permit a public discussion of the reasons for the changes in the rates, benefits, and cost sharing in the large group market. The meeting shall be held in either the Los Angeles area or the San Francisco Bay area.

(c) A health insurer subject to subdivision (a) shall also disclose the following for the aggregate rate information for the large group market submitted under this section:

(1) For rates effective during the 12-month period ending January 1 of the following year, number and percentage of rate changes reviewed by the following:

(A) Plan year.

(B) Segment type, including whether the rate is community rated, in whole or in part.

(C) Product type.

(D) Number of insureds.

(E) The number of products sold that have materially different benefits, cost sharing, or other elements of benefit design.

(2) For rates effective during the 12-month period ending January 1 of the following year, any factors affecting the base rate, and the actuarial basis for those factors, including all of the following:

(A) Geographic region.

(B) Age, including age rating factors.

(C) Occupation.

(D) Industry.

(E) Health status factors, including, but not limited to, experience and utilization.

(F) Employee, and employee and dependents, including a description of the family composition used.

(G) Insureds' share of premiums.

(H) Insureds' cost sharing, including cost sharing for prescription drugs.

(I) Covered benefits in addition to basic health care services, as defined in Section 1345 of the Health and Safety Code, and other benefits mandated under this article.

(J) Which market segment, if any, is fully experience rated and which market segment, if any, is in part experience rated and in part community rated.

(K) Any other factor that affects the rate that is not otherwise specified.

(3) (A) The insurer's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and

other ancillary services, laboratory, and radiology for the applicable 12-month period ending January 1 of the following year.

(B) The amount of the projected trend separately attributable to the use of services, price inflation, and fees and risk for annual policy trends by aggregate benefit category, including hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology.

(C) A comparison of the aggregate per insured per month costs and rate of changes over the last five years for each of the following:

(i) Premiums.

(ii) Claims costs, if any.

(iii) Administrative expenses.

(iv) Taxes and fees.

(D) Any changes in insured cost sharing over the prior year associated with the submitted rate information, including both of the following:

(i) Actual copays, coinsurance, deductibles, annual out of pocket maximums, and any other cost sharing by the benefit categories determined by the department.

(ii) Any aggregate changes in insured cost sharing over the prior years as measured by the weighted average actuarial value, weighted by the number of insureds.

(E) Any changes in insured benefits over the prior year, including a description of benefits added or eliminated as well as any aggregate changes as measured as a percentage of the aggregate claims costs, listed by the categories determined by the department.

(F) Any cost containment and quality improvement efforts made since the insurer's prior year's information pursuant to this section for the same category of health insurer. To the extent possible, the insurer shall describe any significant new health care cost containment and quality improvement efforts and provide an estimate of potential savings together with an estimated cost or savings for the projection period.

(G) The number of products covered by the information that incurred the excise tax paid by the health insurer.

(4) (A) For covered prescription generic drugs excluding specialty generic drugs, prescription brand name drugs excluding specialty drugs, and prescription brand name and generic specialty drugs dispensed at a pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be disclosed:

(i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs as defined in this subparagraph.

(ii) The year-over-year increase, as a percentage, in per-member, per-month total health insurer spending for each category of prescription drugs as defined in this subparagraph.

(iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium.

(iv) The specialty tier formulary list.

(B) The insurer shall include the percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.

(C) (i) The insurer shall include information on its use of a pharmacy benefit manager, if any, including which components of the prescription drug coverage described in subparagraphs (A) and (B) are managed by the pharmacy benefit manager.

(ii) The insurer shall also include the name or names of the pharmacy benefit manager, or managers if the insurer uses more than one.

(d) The information required pursuant to this section shall be submitted to the department on or before October 1, 2016, and on or before October 1 annually thereafter. Information submitted pursuant to this section is subject to Section 10181.7.

(e) For the purposes of this section, a "specialty drug" is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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