Pension & Health Benefits Committee

California Public Employees' Retirement System

Agenda Item 5

June 18, 2013

ITEM NAME: Senate Bill 746 (Leno) – Large Group Health Plan Market: Data Disclosure

As Amended April 30, 2013

Sponsors: California Teamsters Public Affairs Council
United Food and Commercial Workers
UNITE HERE

PROGRAM: Legislation

ITEM TYPE: Action

RECOMMENDATION
Adopt a **Neutral** position on Senate Bill (SB) 746 because it does not significantly affect the benefit interests of our stakeholders and does not significantly impact CalPERS benefits or the administration of the System.

EXECUTIVE SUMMARY
This bill would require Health Maintenance Organizations (HMOs) in the large group market to annually provide specified aggregate information on plan participants and detailed information regarding rate increases to the Department of Managed Health Care (DMHC). It would also require HMOs that contract with no more than two medical groups in the state to provide additional aggregate data on cost increases to the DMHC and specified claims data or equivalent cost information to any large group purchaser that requests the information and demonstrates its ability to comply with relevant privacy laws.

STRATEGIC PLAN
The item is not a specific product of the Annual or Strategic Plan, but is a part of the regular and ongoing workload of the Office of Governmental Affairs.

BACKGROUND
1. Existing Law
   Under existing federal law, the Patient Protection and Affordable Care Act (ACA) requires the Secretary of the federal Department of Health and Human Services (HHS) in conjunction with states, to establish a process for the identification, disclosure, justification, and annual review of unreasonable increases in premiums for health insurance coverage in the individual and small group markets, beginning with the 2010 plan year. HHS final regulations issued in February 2013 provide for rate review of health plans in the large group market

starting in 2017, when health insurance issuers will be allowed to offer coverage in the large group market through the Exchanges.

HHS final regulations specify that health insurance issuers in individual and small group markets must report all rate increase information, and rate increases of 10 percent or more are subject to review by state regulators, or by the HHS for states that do not have the resources or authority to review rates. HHS final regulations also allow this 10 percent threshold to be replaced by state-specific thresholds that reflect the insurance and health care cost trends in each state. HHS has not issued regulations specifying what constitutes an “unreasonable rate increase” in the large group market.

Under existing state law designed to provide conformity with the ACA, HMOs must provide the DMHC specified rate information for all their individual and small group plans at least 60 days prior to implementing any rate change. In addition, state law requires HMOs, for their large group contracts, at least 60 days prior to implementing any such rate change, to file with the DMHC all specified rate information for unreasonable rate increases and to disclose specified aggregate data. DMHC, however, has no authority to approve or reject any proposed rate increases, and it has not promulgated regulations necessary to implement rate review for large group health plans.

Some of the information that HMOs in the individual and small group markets are required to provide to the DMHC in all their filings include, overall annual medical trend factor assumptions, amount of the projected trend attributable to certain factors, and a comparison of claims costs and rate of changes over time. In lieu of reporting the projected trend attributable to certain factors, existing state law also requires a health plan or insurer in the individual and small group markets that exclusively contracts with no more than two medical groups to instead disclose the amount of their actual trend experience for the prior contract year by aggregate benefit category, using benefit categories that are to the maximum extent possible the same or similar to those used by other plans.

2. <u>CalPERS Health Plan Rate Development and Review Process</u>
The Public Employees’ Medical and Hospital Care Act (PEMHCA) grants the CalPERS Board of Administration (Board) authority to design and administer a health benefits program for eligible active and retired members and their families. Beginning every January, CalPERS requests its participating health plans to prepare utilization assumptions and develop premium rate proposals for the following calendar year. Proposals are based on two years of actual data and one year of projected data. Meanwhile, CalPERS staff develops independent rate forecasts based on underlying factors and trends identified from the data, and engage an independent consultant to develop additional rate projections. CalPERS staff then compares these rate projections to the preliminary rates submitted by the health plans; this information becomes the basis of subsequent

negotiations that run until the Board evaluates and approves health plans, co-payments, co-insurance, deductibles, premiums, rates, and employer contributions in June.

ANALYSIS

1. Proposed Changes

   Specifically, SB 746 would:

   - In addition to all the information required by the ACA, require an HMO to disclose annually to the DMHC, aggregate data for products in the large group health plan market, to include the number and percentage of rate filings reviewed by the following:
     - Plan year;
     - Segment type;
     - Product type;
     - Number of subscribers; and
     - Number of covered lives affected.

   - Require an HMO to disclose annually to the DMHC, aggregate data for products in the large group health plan market, to include the plan's average rate increase by the following categories:
     - Plan year;
     - Segment type;
     - Product type;
     - Benefit category; and
     - Number of covered lives affected.

   - Require a health plan that exclusively contracts with no more than two medical groups in the state to disclose annually to the DMHC all of the following for its large group health care service plan contracts:
     - The plan's overall annual medical trend factor assumptions in the aggregate for large group rates by major service category, as specified;
     - A plan may provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in each of the specific service categories for each of the major geographic regions of the state;
     - The amount of the projected aggregate trend in the large group market attributable to the use of services, price inflation, or fees and risk for annual plan contract trends by each major service category, as specified;
     - The amount of projected trend attributable to specified categories; and
     - The amount and proportion of costs attributed to the medical groups that would not have been attributable as medical losses if incurred by the health plan rather than the medical group.

- Require a health care plan that exclusively contracts with no more than two medical groups in the state to provide claims data at no charge to a large group purchaser if the large group purchaser requests the information and demonstrates that it is able to comply with relevant state and federal privacy laws. If claims data is not available, the plan must instead provide, at no charge, all of the following:
    - Data sufficient for the large group purchaser to calculate the cost of obtaining similar services from other health plans and evaluate cost-effectiveness by service and disease category;
    - De-identified patient-level data on demographics, prescribing, encounters, inpatient services, outpatient services, and any other data as may be required of the health plan to comply with risk adjustment, reinsurance, or risk corridors, as required by the ACA; and
    - De-identified patient-level data used to experience rate the large group, including diagnostic and procedure coding and costs assigned to each service.

2. Author's Intent
According to the Author's Statement in the Senate Health Committee analysis of SB 746:

> "The cost of health insurance continues to climb even as California moves forward in implementing the ACA. I authored SB 1163 (Leno) of 2010 to provide oversight of health insurance rates because oversight and transparency should help to control rates. . . SB 1163 was intended to apply to individual, small employer and large employer insurance markets. The provisions with respect to large employers (over 50 employees) have not been implemented. Also, the information provided by Kaiser Permanente to justify its rate increases in the individual and small group markets does not provide information comparable to that provided by other health plans so that the DMHC and purchasers can scrutinize the reasons for the proposed rate increases and determine whether those rate increases are reasonable or not. The fact that Kaiser is an integrated system should not exempt it from rate review."

3. Impacts on All HMOs in the Large Group Market
At this time, CalPERS offers HMO plans through contracts with Blue Shield of California and Kaiser Permanente. These contracts are currently subject to rate review by DMHC. SB 746 expands the scope of existing law by requiring all HMOs in the large group market to annually provide to the DMHC, specified aggregate information on plan participants and detailed information regarding rate increases on all contracts, which are currently only required on a contract-by-contract basis for health plans whose rate filings meet the definition of an unreasonable rate increase. This does not appear to be a significant change in statute, as HMOs must already provide this information to the DMHC for their filings in the individual and small group markets.

4. DMHC Data Disclosure for HMOs That Contract With No More Than Two Medical Groups

Under SB 746, a health plan that exclusively contracts with no more than two medical groups in the state must annually disclose certain information regarding its large group plans contracts to the DMHC. The only health plan in California that appears to meet this requirement is Kaiser Permanente.

SB 746 would require Kaiser Permanente to disclose annual medical trend factor assumptions in the aggregate for large group rates by major service category for the following: hospital inpatient; hospital outpatient; physician services; prescription drugs; ancillary services; laboratory; and radiology or imaging. Under existing law, Kaiser Permanente and other HMOs are already mandated to file this aggregate data with DMHC for their individual and small group health service plan contracts. It is unclear to CalPERS staff, however, the benefit of requiring only one HMO in the large group market to disclose this information, and not the others.

Kaiser Permanente already provides CalPERS with a large majority of the data for which SB 746 would mandate disclosure to the DMHC, and which existing law requires to be provided in its filings for the individual and small group markets. For example, Kaiser Permanente provides a Periodic Utilization Report (PUR) that contains:

- Overall medical trend factor assumptions in the aggregate by major service categories;
- A report showing the amount of the aggregate which is attributable to the use of services, price inflation, or fees and risk for annual plan contract trends. This is also by each major service category and the data is **actual**, not projected data.
- A report showing the amount of projected trend which is attributable to specified categories.

The author seems to imply from his prior statements, that because Kaiser Permanente is an integrated health care delivery system, it is exempt from rate review. But, this is clearly not the case in the individual and small group markets, where Kaiser Permanente was allowed under SB 1163 to provide specified alternative data to the DMHC, because, as an integrated system, it does not produce the same type of claims data that other health plans typically make available. The DMHC indicates in the Senate Health Committee Analysis of SB 763 that while the data it receives from Kaiser Permanente through individual and small group rate review filings is different, it is sufficient data for the Department to complete an adequate review of their filings.

The issue of whether this bill provides health care purchasers in the large group markets sufficient data to compare the costs of one HMO versus another is subject to debate, given that it does not require any HMO besides Kaiser

Permanente to furnish data to the DMHC or purchasers. Furthermore, the proposed requirements may provide an unfair business advantage for other large group plans that are not required to provide such aggregate data.

5. Employer Data Disclosure for HMOs That Contract With No More Than Two Medical Groups
SB 746 would also mandate Kaiser Permanente to provide claims data for enrollees and for this to be provided at no charge to a large group purchaser requesting the information. In the alternative, if claims data is not available, it must instead provide data sufficient to calculate the cost of obtaining similar services from other health plans and evaluate cost-effectiveness by service and disease category. This alternative data would be required to include de-identified patient-level data as may be required for it to comply with risk adjustment, reinsurance, or risk corridors as required by the ACA, or used to experience rate the large group.

The data CalPERS receives from Kaiser Permanente as part of the rate negotiation and review process is analogous to the employer data disclosure requirements contained in SB 746. It includes:

- Rate Information Breakdown (RIB) report that contains aggregated additional data demonstrating or else reasonably estimating year-to-year cost increases in each of the specific service categories for each of the major geographic regions of the state. The report shows costs by Kaiser Permanente North and Kaiser Permanente South regions.
- Rate Renewal Request (3R) information that includes a total administrative cost ration, CalPERS-only administrative cost ratio, and CalPERS medical loss ratio. This data is used to infer the amount and proportion of costs attributed to the medical groups that would not have been attributable as medical losses if they were incurred by the health plan rather than the medical group.
- Monthly Encounter Data, which is loaded into the CalPERS Health Care Decision Support System (HCDSS), a data warehouse of our members' de-identified health care claims data provided by CalPERS HMO and PPO health plan partners. HCDSS is used to produce a variety of plan, provider, performance monitoring, and comparison reports. It also allows CalPERS to examine each plan's utilization experience and projected trends.

The cost for Kaiser Permanente to provide all this data is built into its premium rate. Furthermore, the de-identified patient-level data CalPERS receives is not shared with participating employers.

6. Arguments in Support and Opposition

Supporters of SB 746
According to a Senate Health Committee analysis: "UNITE HERE, the sponsor of this bill, writes that their union cannot sustain double digit rate increases in health insurance without any opportunity to manage care to reduce costs and that strike

after strike, labor dispute after labor dispute, is about how much they pay for health benefits. UNITE HERE states that Kaiser refuses to give them data that they know they must have, that they or comparable organizations produce for other reasons or in other states, and that would allow them to better manage care in order to improve outcomes and reduce costs."

According to the same analysis, another sponsor of the bill, the California Teamsters Public Affairs Council asserts: "One of their biggest problems as they negotiate healthcare costs is getting the information necessary to make an accurate assessment of what those costs should be and this problem is at its worst with Kaiser Permanente. According to the Teamsters, when they negotiate with other carriers or when they manage their own funds, they get claims data and the opportunity to tailor care to the needs of their members, but not so with Kaiser."

Opponents of SB 746
Again, according to the Senate Health Committee analysis, the California Association of Health Plans writes in opposition that: "If the federal government chooses to require states to extend rate review to the large group employer market, California is well positioned since it has a statutory process for large group rate review that would become immediately operative and therefore believe that this bill is unnecessary."

Kaiser Permanente states in its most recent letter of opposition that: "SB 746 inserts the Legislature into private and voluntary contractual discussions between two entities by mandating what information one party must provide to the other party." It also asserts that the proposed requirements attack its integrated model of care delivery, and would force it to disclose patient-level data to employers without any limitations on its use. It goes on to state that: "Even de-identified data can be misused…Forcing a health care provider to reveal such detailed information to the employer could lead to serious unintended consequences for the employees, including embarrassment, discrimination, and possibly job loss."

7. Costs

Benefit Costs
Given several ambiguous terms contained in SB 746, Kaiser Permanente estimates the bill could increase its costs associated with the extensive data it would be required to disclose annually from $20 million to $50 million, resulting in increased cost pressures to its 7,500 large group purchasers. The HMO indicates that its costs will depend on the extent of the involvement of actuaries, new administrative workload, significant changes to health IT systems and record

keeping, and staff time for creating reporting that is not done in the ordinary business operations.

While the cost of the data CalPERS receives from Kaiser Permanente is included in its plan rates, to the extent Kaiser Permanente is unable to pass on its costs to its other large group customers, implementation of SB 746 could translate into increased premiums, co-payments and or co-insurance for CalPERS Kaiser Permanente members and their employers.

Administrative Costs
Minor and absorbable administrative costs for CalPERS.

BENEFITS/RISKS

1. Benefits of Bill Becoming Law
   - Increased oversight and transparency of health plans may help control rates in the large group HMO market.

2. Risks of Bill Becoming Law
   - Disclosing sensitive patient records to employers could lead to negative or costly consequences for employees.
   - This bill may be premature as the DMHC has not yet implemented rate review for the large group market in California.
   - To the extent any health plans subject to this bill cannot absorb the costs for implementation, if CalPERS contracts with these plans, then CalPERS members and employers may experience increased premiums, copayments or co insurance.

ATTACHMENTS
Attachment 1 – Legislative History
Attachment 2 – Proponents and Opponents

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