Pension & Health Benefits Committee

California Public Employees' Retirement System

Agenda Item 5f

August 20, 2013

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

As Amended August 6, 2013

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

PROGRAM: Legislation

ITEM TYPE: Action

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

EXECUTIVE SUMMARY
Existing law requires a health care service plan (ie. Health Maintenance Organization) to disclose specified aggregate data when the plan makes a mandatory filing with the Department of Managed Health Care (DMHC) for an unreasonable rate increase for a large group plan contract. This bill would require that this aggregate data related to unreasonable rate filings be disclosed annually and would add two additional required data elements. The bill would also establish a new requirement that all health care service plans annually disclose to the DMHC, specified aggregate data for all products sold in the large group health plan market, or, in the event that a plan is unable to furnish that data, to provide aggregate data on its year to year cost increases for specified major service categories. It would also require health care service plans that contract with no more than two medical groups in the State to provide, upon request, specified de-identified claims data or equivalent cost information to any large group purchaser that is an employer-sponsored plan with more than 1,000 covered lives or a multiemployer trust, and that demonstrates its ability to comply with applicable 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

Individual and small group market

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 provide that health insurance issuers in individual and small group markets must report specified rate increase information, and that 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.

Under existing State law designed to provide conformity with the ACA, Health Maintenance Organization (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. DMHC, however, has no authority to approve or reject any proposed rate increases.

Some of the information that HMOs in the individual and small group markets are required to provide to the DMHC in 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.

Large group market

Existing State law requires that for large group health care service plan contracts, all HMOs must file with the DMHC at least 60 days prior to implementing any rate change all required information for unreasonable rate increases. State law also requires HMOs to submit all information required by the ACA and to disclose specified aggregate data related to such rate filings. HHS has not, however, issued regulations specifying what constitutes an “unreasonable rate increase” in the large group market nor has DMHC promulgated regulations describing how this rate filing information from large group health plans would be used

2. CalPERS Health Plan Rate Development and Review Process
   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 is used by the Board to evaluate and approve the rates for the CalPERS health plans.

ANALYSIS

1. Proposed Changes
   SB 746 would:
   - Require annual disclosure to the DMHC of certain data elements already required from large group health plans subject to review for unreasonable rate increases and adds the following two additional disclosure requirements: (1) the plan's average rate increase by benefit category and (2) the number of covered lives affected.

   - Require a health care service plan to disclose annually to the DMHC the following aggregate data for all products sold in the large group market:
     - Plan year.
     - Segment type.
     - Product type.
     - Number of subscribers.
     - Number of covered lives affected.
     - The plans average rate increase by the following:
       - Plan year.
       - Segment type.
       - Product type.
       - Benefit category –including but not limited to hospital, medical, ancillary, and other benefit categories reported publicly for individual and small employer rate filings.
       - Trend attributable to cost and trend attributable to utilization by benefit category.

   - Require a health care service plan that is unable to furnish information on rate increases by benefit category to the DMHC, to disclose annually all of the following aggregate data for its large group health care service plan contracts:

- The plan's overall aggregate data demonstrating or reasonably estimating year-to-year cost increases for large group rates by major service category. The plan shall distinguish between the increase ascribed to the volume of services provided and the increase ascribed to the cost of services provided, for those assumptions that shall include the following categories:
  - Hospital inpatient.
  - Outpatient visits.
  - Outpatient surgical or other procedures
  - Professional medical.
  - Mental health.
  - Substance abuse.
  - Skilled nursing facility, if covered.
  - Prescription drugs.
  - Other ancillary services.
  - Laboratory.
  - Radiology or imaging.
- Aggregated additional data that demonstrate or reasonably estimate 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 projected trend attributable to the following categories:
  - Use of service and disease category;
  - Capital investment;
  - Community benefit expenditures – excluding bad debt and valued at cost.
- The amount and proportion of costs attributed to contracting medical groups that would not have been attributable as medical losses if incurred by the health plan rather than the medical group.

- Require that a health care service 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 shall provide claims data at no charge to a large group purchaser annually if the large group purchaser requests information, can demonstrate its ability to comply with State and federal privacy laws, and is a an employer-sponsored plan with an enrollment greater than 1,000 covered lives or a multiemployer trust.

- The health care service plan shall provide claims data that a qualified statistician has determined are de-identified so that the claims data do not identify or provide a reasonable basis for which to identify an individual. Stipulates this information shall not be subject to the public disclosure requirements, as specified.

- Require that if claims data are not available, the plan shall provide at no charge all of the following:

- De-identified 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.

- Require a health care service plan to obtain a formal determination from a qualified statistician that the data was de-identified, so that the data doesn't identify or provide a reasonable basis to identify an individual. The statistician shall certify the formal determination in writing and upon request shall provide the protocol used for de-identification to DMHC.

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. Under existing law, these contracts are subject to mandatory rate filings with the DMHC for unreasonable rate increases. In addition, under existing law, health care service plans are subject to certain disclosure requirements in connection with such rate filings. SB 746 expands the scope of existing law by requiring all health service plans in the large group market to annually disclose specified aggregate data for all their large group plans. Although health care service plans are already required to provide this information to the DMHC for their filings in the individual and small group markets,

this would require additional reporting on the nearly 14,000 large group plans in the State.

4. DMHC Data Disclosure for HMOs Unable to Report Rate Increases by Benefit Category
Under SB 746, a health plan that is unable to provide information on rate increases by benefit categories, or information on trend attributable to cost and trend attributable to utilization by benefit category, would be required to annually disclose certain information regarding its large group plan 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.

Kaiser Permanente already provides CalPERS with a large majority of the data for which SB 746 would mandate disclosure to the DMHC. For example, Kaiser Permanente provides a Periodic Utilization Report 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.

5. Employer Data Disclosure for HMOs That Contract With No More Than Two Medical Groups
SB 746 would also mandate that Kaiser Permanente provide claims data for enrollees at no charge to specified large group purchasers requesting the information. The bill was recently amended to include additional language, that the data must be provided to a qualified statistician, who will determine that the data does not identify nor provide a reasonable basis to identify an individual. In addition, the statistician is required to certify his or her formal determination in writing and upon request provide the protocol used for de-identification to DMHC.

If claims data is not available, Kaiser Permanente must provide alternative 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.

SB 746 stipulates that the data be provided only to a large group purchaser that meets the following two conditions: 1) it can demonstrate its ability to comply with state and federal privacy laws; and 2) it is a large-group purchaser that is either an employer-sponsored plan with an enrolment of greater than 1,000 covered lives or it is a multiemployer trust. The author's office stated this amended language strengthens privacy for de-identified claims language in the bill.

The data CalPERS currently 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 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 ratio, 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 Preferred Provider Organization (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 CalPERS with this data to CalPERS is built into its premium rates. The de-identified patient-level data CalPERS receives is not shared with participating employers.

6. <u>Arguments in Support and Opposition</u>

<u>Supporters of SB 746</u>
According to the Assembly Health Committee analysis, the sponsors of this bill, UNITE HERE and United Food and Commercial Workers Union, Western States Council, indicate that this bill would give their trust funds the information they need to bargain with Kaiser and to better manage the care of their members. When their health care strategists tried to design programs that manage the care of their of highest cost patients, taking into account the realities of working in the

hospitality industry, they were unable to do so. UNITE HERE recognizes that Kaiser doesn't have claims data but believes Kaiser has other comparable data. UNITE HERE believes the programs offered by Kaiser are mostly designed for white collar employees who spend all day sitting at a desk. AARP supports this bill because it will improve price transparency in the large group market. The Campaign for a Healthy California believes this bill will clarify what information is required of integrated health plans which do not report cost drivers the same way as other health plans. Health Access California indicates they have been disappointed that, contrary to the intent of SB 1163, DMHC has failed to implement rate review for large employer coverage, and that integrated health plans have not provided the same level of detail about how rate increases were determined as other health plans.

Opponents of SB 746

Opponents, generally health insurance companies and associations and business organizations, argue that this bill sets a disturbing precedent as it would interfere and essentially control private contracts between customers and business. These reports will have little value other than to the sponsors of this bill who would like to use them as a comparison. The Service Employees International Union – United Healthcare Workers West (SEIU-UHW) is concerned that this bill unwittingly will place Kaiser at a market disadvantage when compared to its competitors. SEIU-UHW also raises questions about why the disclosures in this bill are superior to those already required by DMHC for the small group market. Kaiser writes in opposition that this bill is over reaching and is an attack on the integrated model of care delivery. Kaiser asserts that this bill attempts to insert legislative process into a private, voluntary contract discussion between Kaiser and one of their large group purchasers. Kaiser indicates that this bill would reveal patient level data and even de-identified data can be misused. Kaiser believes this bill is divisive and will erect unnecessary administrative barriers.

BUDGET AND FISCAL IMPACTS

1. Benefit Costs

Kaiser Permanente estimates the cost of complying with the new reporting requirement of this bill at approximately $10 million. Actual costs will depend on the extent of the involvement of actuaries, new administrative workload, significant changes to health IT systems and record keeping, as well as staff time for creating reporting that is not done in the ordinary business operations of Kaiser Permanente.

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.

2. 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

DANNY BROWN, Chief
Office of Governmental Affairs

ANN BOYNTON
Deputy Executive Officer
Benefit Programs Policy and Planning