



Agenda Item 7

June 17, 2014

ITEM NAME: Senate Bill 1182 (Leno) - Large Group Health Market: Data Disclosure

As Amended April 10, 2014

*Sponsors: California Labor Federation
UNITE HERE*

PROGRAM: Legislation

ITEM TYPE: Action

RECOMMENDATION

Adopt a **NEUTRAL** position on Senate Bill (SB) 1182 because the bill presents conflicting policy implications. On one hand, it would require the California Public Employees' Retirement System (CalPERS) contracting health maintenance organization (HMO) partners to submit information for CalPERS HMO plan rates to the Department of Managed Health Care (DMHC) if these rate increases exceed a certain threshold. CalPERS contracting health plans currently do not have to submit any information to any state agency with regard to the rates adopted by the CalPERS Board of Administration (Board). On the other hand, the bill would ensure that more health care purchasers have access to the types of data that CalPERS already receives, thus allowing them to negotiate benefit structures that may help to lower costs.

EXECUTIVE SUMMARY

Among other things, SB 1182 requires a large group health care service plan or health insurer to file specified rate information in filings to the DMHC or Department of Insurance (DOI), respectively, at least 60 days prior to implementing a rate change when a rate increase exceeds 5 percent of the prior year's rate. In addition, it requires a plan or insurer to annually file specified aggregate data for all products sold in the large group market. The bill also requires, in general, a plan or insurer to annually provide de-identified claims or patient-level data at no charge to a large group purchaser, if requested by the purchaser.

STRATEGIC PLAN

This item relates to Goal A of the CalPERS Strategic Plan, to improve long-term pension and health benefit sustainability, as it deals with a legislative proposal that would potentially have an impact on the costs associated with health care delivery.

BACKGROUND

1. Existing Law

Individual and small group market

Under existing federal law, the Affordable Care Act (ACA) requires the Secretary of the U.S. 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 premium increases 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 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 care service plans and insurers must provide to the DMHC or DOI, respectively, specified rate information for their individual and small group plans and policies at least 60 days prior to implementing any rate change. The regulating departments, however, do not have authority to approve or reject any proposed rate increases.

Large group market

Existing State law requires, for large group health care service plan contracts or insurance policies, plans and insurers must file with the DMHC or DOI at least 60 days prior to implementing any rate change all required information for unreasonable rate increases. State law also requires plans and insurers 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 the DMHC or DOI promulgated regulations describing how they would use this rate filing information from large group health plans.

2. CalPERS Health Plan Rate Development and Review Process

The Public Employees' Medical and Hospital Care Act (PEMHCA) grants the 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 develop 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 compare these rate projections to the preliminary rates submitted by the health plans; this information becomes the basis of subsequent negotiations used by the Board to evaluate and approve the rates for CalPERS health plans.

ANALYSIS

1. Proposed Changes

Because CalPERS does not offer health plans in the individual and small group markets and its self-funded preferred provider organization (PPO) plan is not subject to DOI oversight, this analysis only addresses impacts on large group HMO plans regulated by the DMHC.

Specifically, SB 1182 would:

- Remove from statute the unimplemented requirement that specified large group health care service plans file rate information with the DMHC at least 60 days prior to implementing an unreasonable rate increase.

- Require specified large group health care service plans to file the following information with the DMHC at least 60 days prior to implementing a rate increase that exceeds 5 percent of the prior year's rate for that group:
 - Company name and contact information
 - Plan contract form numbers covered by the filing
 - Product type, such as preferred provider organization or health maintenance organization
 - Segment type
 - Type of plan involved, such as for profit or not for profit
 - Whether the products are opened or closed
 - Enrollment in each plan contract and rating form
 - Enrollee months in each plan contract form
 - Annual rate
 - Total earned premiums in each plan contract form
 - Total incurred claims in each plan contract form
 - Number of plan contract forms covered by the filing
 - Average rate increase initially requested
 - Review category: initial filing for new product, filing for existing product, or resubmission
 - Average rate of increase
 - Effective date of rate increase
 - Number of subscribers or enrollees affected by each plan contract form
 - 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. For a health plan that exclusively contracts with no more than two medical groups, the amount of its actual trend experience for the prior contract year by aggregate benefit category, as specified. Authorizes a plan to provide aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories in major geographic regions of the state. Limits geographic regions to nine, and requires them to be defined by the DMHC.
- The amount of the projected trend attributable to the use of services, price inflation, or fees and risk for annual plan contract by aggregate benefit category, as specified. For a plan that exclusively contracts with no more than two medical groups, the amount of its actual trend experience for the prior contract year by aggregate services category, as specified
 - A comparison of claims cost and rate of changes over time;
 - Any changes in enrollee cost-sharing over the prior year associated with the submitted rate filing
 - Any changes in enrollee benefits over the prior year associated with the submitted rate filing
 - A certification of actuarially sound filing, as described;
 - Any changes in administrative cost
 - Any other information required for rate review under the ACA
- Require a health care service plan to provide to the DMHC annually, 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 plan's average rate increase by:
 - a. Plan year
 - b. Segment type
 - c. Product type
 - d. Benefit category, including, but not limited to, hospital, medical, ancillary, and other benefit categories reported publicly for individual and small employer rate filings
 - e. Trend attributable to cost and trend attributable to utilization by benefit category
- Require a health care service plan that is unable to furnish aggregate data to the DMHC on rate increases by benefit categories, as specified, 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, distinguished between the increase ascribed to the volume of services provided and the increase ascribed to the cost of services provided for those assumptions, for the following categories:
 - a. Hospital inpatient
 - b. Outpatient visits
 - c. Outpatient surgical or other procedures
 - d. Professional medical
 - e. Mental health
 - f. Substance abuse
 - g. Skilled nursing facility, if covered
 - h. Prescription drugs
 - i. Other ancillary services
 - j. Laboratory
 - k. Radiology or imaging
 - The amount of projected trend attributable to the following categories:
 - a. Use of service and disease category
 - b. Capital investment
 - c. 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.
 - A health care service plan may provide aggregated additional data that demonstrate or reasonably estimate year-to-year cost increases in each of the specific service categories listed for each of the major geographic regions of the state identified by the DMHC.
- Require a health care service plan to provide de-identified claims data, as determined by a qualified statistician, to a large group purchaser, upon request, annually and at no charge to the purchaser.
 - Require that if claims data is not available, the plan provide at no charge to the large group purchaser, 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 any rules, regulations, or guidance issued under the ACA
- 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 do not identify or provide a reasonable basis to identify an individual. It also requires the statistician to certify his or her formal determination in writing and, upon request, to provide the protocol used for de-identification to DMHC.
- Specify that data may only be provided to a large group purchaser that is able to demonstrate its ability to comply with state and federal privacy laws, and is either an employer with an enrollment of greater than 1,000 covered lives or a multiemployer trust.
- Specify that the DMHC may require all health care service plans to submit rate filings to the National Association of Insurance Commissioners System for Electronic Rate and Form Filing. These submissions shall be deemed to be the filing with the DMHC for purposes of complying with the aforementioned requirements.

2. Arguments in Support

According to the Author's statement in the Senate Health Committee analysis of SB 1182:

"The rising cost of health care is a major concern for employers in California, and the lack of transparency in pricing for the large group market has contributed to uncontrolled cost increases for large employers and union trusts. According to the 2014 California Employer Health Benefits Survey, health premiums in California rose by 185 percent since 2002, more than five times the state's overall inflation rate. In addition, one in four California employers reported that they reduced benefits or increased employee cost sharing in the last year because of the rising cost of health care."

According to the California Labor Federation, SB 1182 would extend existing transparency measures in the individual and small group market to products sold in the large purchaser market by requiring health plans and insurers to disclose information that will help the public understand premium increases.

According to the California School Employees Association (CSEA), rate review is an important factor in overall health care cost containment and should be available in both the individual and large group market. CSEA also believes it

is important to provide claims data to large employers and multi-employer trusts. This transparency and data will help large group purchasers understand what is driving increases and allow them to develop strategies to address it.

3. Arguments in Opposition

According to the California Department of Finance (DOF), the bill would require health plans to annually disclose aggregate, product, and cost data but does not provide clear direction as to what to do with the accumulated data. DOF indicates the bill increases costs and creates additional workload at a time when the DMHC is undergoing major and complex changes due to ACA implementation. DOF also states that it is unclear whether SB 1182 fully addresses privacy concerns and discrimination that may arise from the release of de-identified claims data reporting.

According to Kaiser Permanente, SB 1182 inserts the Legislature into private and voluntary contractual discussions between two entities by mandating what information one party must provide to the other. Kaiser Permanente states that it provides robust information to its large group purchasers during renewal and during the contract year and is working hard to expand the amount of information provided. It is also concerned about revealing patient level medical information to employers, especially without employee consent. Kaiser Permanente also indicates that this bill requires large group rate information to be filed at DMHC without specifying the purpose of such a filing and how that information will be used.

According to Anthem Blue Cross, this bill creates an added substantial compliance burden for plans and state regulators. Anthem Blue Cross already provides a significant amount of information to its large group purchasers and the utilization of health care services.

4. Rate Submission Impacts All HMOs in the Large Group Market

At this time, CalPERS offers HMO plans through contracts with Anthem Blue Cross, Blue Shield of California, HealthNet, Kaiser Permanente, Sharp, and United Health Care. Under existing law, CalPERS contracting health plans are subject to mandatory rate filings with the DMHC for unreasonable rate increases. In addition, under existing law, health care service plans and policies are subject to certain disclosure requirements in connection with such rate filings.

SB 1182 expands the scope of existing law by requiring all health care service plans in the large group market, including all of CalPERS contracting health plans, to annually disclose specified plan data for individual large group products with a rate increase that exceeds 5 percent of the prior year's rate. This provision goes beyond the ACA which, currently, does not require large group health plans to have their rates submitted to, or reviewed by, state

regulators, and generally authorizes rate review for the individual and small group market if an annual rate increase is 10 percent or more.

Depending on the rate of increase in health care cost drivers in a particular plan year, this bill could potentially require thousands of new filings with DMHC because health plans structure and price their products based on the population characteristics and level of benefits desired by each of their individual large group purchasers, whereas they typically structure and price one, or only a handful of products for the individual and small group markets.

SB 1182 also expands the scope of existing law by requiring all health care service plans in the large group market to provide to the DMHC annually, specified aggregate data for all products sold in the large group market, including data from CalPERS HMO plan products.

5. Several Government Administered Plans Already Exempted from Rate Filings and Review

Existing law exempts specialized health care service plan contracts (e.g., dental and vision), as well as, Medicare, Medi-Cal, Healthy Families Program, Access for Infants and Mothers Program; California Major Risk Medical Insurance Program, and the Federal Temporary Risk Pool from rate filings and review. These governmental programs, like CalPERS, provide health benefits to individuals, which are subsidized by taxpayer dollars and have existing cost control strategies and authorizations under State statute to establish or negotiate health plan rates. Given the exemptions already provided to these other State-administered plans, staff has been unable to identify the value added to CalPERS plan design and rate negotiation processes by providing another government agency the authority to review health rates.

6. CalPERS Data Collection Practices

CalPERS contracting health plans provide the data elements required under SB 1182, including claims data, either as part of the rate development process, or through monthly submissions to CalPERS Health Care Decision Support System (data warehouse), which helps CalPERS staff and the Board determine whether the submitted rate is reasonable. For example, our contracting plans provide:

- 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 that is attributable to use of services, price inflation, or fees, and risk for annual plan contract trends. The report reflects this information by each major service category using actual data, not projections

- A report showing the amount of projected trend that is attributable to specified categories
- A 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.
- Rate development process 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 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 contracting health plans. 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 CalPERS contracting health plans to provide CalPERS with this data is built into premium rates. The de-identified patient-level data CalPERS receives is not shared with participating employers; and this bill would not require CalPERS to share data with our participating employers.

7. Similarities to Prior Legislation

Last year, the Board adopted a support position on SB 746 (Leno) that would have established new data reporting requirements on all health plans applicable to products sold in the large group market and specific data related to annual medical trend factors by service category, as well as claims data or de-identified patient-level data. In his veto message for SB 746, the Governor stated:

“...I support efforts to make health care costs more transparent, and my administration is moving forward to establish transparency programs that will cover all health plans and systems. I urge all parties to work together in this effort. If these voluntary efforts fail, I will seriously consider stronger actions.”

The reporting of individual plan data to DMHC by health care service plans in the large group market is similar to the provisions of Assembly Bill (AB) 52 (Feuer) from 2011, as well as what is currently required to be disclosed to the DMHC by plans in the small and individual group markets. In addition AB 52 would have required DMHC to review and approve, deny, or modify proposed

rates in the large group market. The Board adopted an oppose, unless amended position on AB 52 and requested the Author remove CalPERS health plans from the rate review process because it would have circumvented the Board's rate-setting authority and added greater cost and complexity to the rate setting process.

If enacted, SB 1182 would set up the necessary infrastructure for rate regulation and could be the first step in the legislative process towards providing DMHC the authority to approve, deny or modify health care plan rates, including the rates of the CalPERS HMO plans negotiated and approved by the Board.

BUDGET AND FISCAL IMPACTS

1. Benefit Costs

Because only those large group health care plan contracts whose rate increases exceed 5 percent of the prior year's rate will be required to make individual contract rate filings with the DMHC, and only those plan contracts that cover more than 1,000 lives and whose claims information is required to be provided to a purchaser upon request, only a portion of the approximately 14,000 total large group products estimated by the California Association of Health Plans to be offered in this state will be impacted in any given year. Our contracting health plans estimate various amounts for the administrative and compliance burden associated with SB 1182. Assuming the one-time filing, disclosure and certification costs estimated by our health plans for a large group product reaches \$75,000, the total costs of SB 1182 could run from the tens of millions, to hundreds of millions of dollars annually.

While the cost of the data CalPERS receives from its health plan partners is included in its health care plan rates, to the extent that CalPERS contracting plans are unable to pass on the costs associated with their implementation of SB 1182 to their other large group customers, implementation of SB 1182 could translate into increased premiums or other costs for CalPERS members and contracting PEMHCA employers.

2. Administrative Costs

Minor and absorbable administrative costs for CalPERS.

BENEFITS/RISKS

1. Benefits of Bill Becoming Law

- Increased transparency of health plan product data may help control rates in the large group market.
- Disclosing this information may help purchasers understand health care cost drivers and institute cost savings programs.

2. Risks of Bill Becoming Law

- Increases the likelihood that Board-approved CalPERS health plan rates could become subject to approval, denial, or modification by the DMHC in the future, thus increasing costs and complexity to its rate setting process.
- Disclosing sensitive patient records to large group employers could lead to negative or costly consequences for employees if not adequately protected.
- To the extent health plans cannot absorb the administrative and compliance burden of this bill, if CalPERS contracts with these plans, then CalPERS members and employers could experience increased premiums or other costs.

ATTACHMENTS

Attachment 1 – Legislative History

Attachment 2 – Support and Opposition

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