



Agenda Item 8

August 19, 2014

ITEM NAME: Proposition 45 – Healthcare Insurance Rate Changes

PROGRAM: Legislation – State Initiative Statute

ITEM TYPE: Information

EXECUTIVE SUMMARY

Proposition 45 would give the Insurance Commissioner (Commissioner) the power to review proposed rate changes for health care insurance in the individual and small-group markets and to deny rate increases not found to be justified.

STRATEGIC PLAN

This item relates to Goal A of the California Public Employees' Retirement System (CalPERS) Strategic Plan, to improve long-term pension and health benefit sustainability, as the intent of the initiative is to ensure access to affordable health benefits for all Californians.

BACKGROUND

1. Existing Health Insurance and Health Plan Regulation

The Department of Managed Health Care (DMHC) provides regulation and oversight of health plans, including Health Maintenance Organizations (HMOs) and some Preferred Provider Organization (PPO) plans. Among other things, the California Department of Insurance (CDI) regulates the remaining forms of health insurance, including disability insurers offering health insurance, and more generally, PPO plans and traditional indemnity coverage.

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 annual review of unreasonable increases in premiums for health insurance coverage. The process requires health insurers to submit to the Secretary and the applicable state, justifications for unreasonable premium increases prior to the implementation of the increases.

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 subject to approval by the Secretary.

Under existing state law designed to provide conformity with the ACA, health care service plans and insurers must provide to the DMHC or CDI, respectively, specified rate information for their individual and small-group plans and policies at least 60 days prior to implementing any rate change. This requirement applies to all increases, even those that fall below the 10 percent threshold. The rate filings must be actuarially sound and accompanied by a certification by an independent actuary or actuarial firm that the rate increase is reasonable and that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies. With the exception of contracted rates between a health plan or insurer and a health care provider, all rate filing information must be readily available to the public via DMHC, CDI, health plan and insurer websites be in plain language and in a manner and format specified by DMHC and CDI. The regulating departments, however, do not have authority to approve or reject any proposed rate increases.

Large-group market

For large-group health care service plan contracts or insurance policies that cover more than 50 employees, existing state law requires plans and insurers to file with the DMHC or CDI 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 CDI promulgated regulations describing how they would use this rate filing information from large-group health plans.

2. Proposition 103 Regulation of Automobile Insurance Rates

In 1988, the passage of Proposition 103 made the Office of Insurance Commissioner an elected office and imposed a rate rollback on automobile insurance rates. It also provided the Commissioner authority to approve all proposed insurance rate hikes in a number of insurance lines, including automobile, fire, and liability insurance, and also mandated a public hearing for substantial increases defined as 7 percent for personal lines of insurance and 15 percent for commercial lines.

The regulatory process created by Proposition 103, which its proponents now wish to expand to health care insurance, is a prior approval system vesting the Commissioner with the power to review and approve insurance rates before they go into effect. It specifies that no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory, or otherwise in violation of statute. Applications are deemed approved after 60 days unless; a) a consumer requests a hearing within 45 days of the public notice and the Commissioner grants the requests, b) the Commissioner decides on his own motion to hold a hearing, or c)

the proposed rate increase exceeds 7 percent for personal lines or fifteen percent for commercial lines, in which case a hearing is mandatory.

Rate change applications that undergo the hearing process are deemed approved after 180 days from their submission, unless the Commissioner disapproves the application, or specified extraordinary circumstances exist. Any person may intervene in any rate approval proceeding or challenge any action of the Commissioner pursuant to Proposition 103, and may be awarded reasonable advocacy and witness fees and expenses, subject to certain tests.

ANALYSIS

1. Proposed changes

Specifically, Proposition 45 would:

- Apply the provisions of the Insurance Code created by Proposition 103 to individual and small-group health plan rates and health insurance, notwithstanding any other provision of law.
- Make the specified health plan and insurance rates proposed after November 6, 2012 reviewable by the Commissioner prior to their use, and rates in effect as of November 6, 2012, would be subject to refund.
- Require applications for health insurance rates to be accompanied by a sworn statement under penalty of perjury by the chief executive officer of the company, declaring that the contents are accurate and comply in all aspects with California law.
- Allow, during a transitional period, the Commissioner to permit, on a conditional basis and subject to refund, the use of rates not formally approved under the provisions of Proposition 45 but have an implementation date is prior to January 1, 2014, provided the new health insurance has not previously been marketed in California and contains provisions mandated by federal or state law in effect as of January 1, 2012.
- Provide that if a hearing requested by an intervenor results in a determination that a company charged health insurance rates that are excessive or otherwise in violation of the law, the company shall be required to pay refunds with interest, notwithstanding any other provision of law and in addition to any other penalty permitted by law.
- Prohibit insurers from using absence of prior insurance coverage or a person's credit history as criterion for determining eligibility for a policy or contract, or generally for rates, premiums, or insurability for health, automobile or homeowners insurance.
- Grant the Commissioner the powers necessary to carry out the provisions of the proposed law, including any and all authority for health care service plan rate review granted to the DMHC.
- Require health plans and insurance companies to pay filing fees which are continuously appropriated to cover operational or administrative costs; the

Commissioner shall make an annual report of such expenditures and the impact of the proposed law.

- Define “health insurance” as a policy or contract issued under Insurance Code section 106(b) or a health care service plan as defined by Health and Safety Code section 1345(f).
- Define “rates” as charges assessed for health insurance or anything that affects charges associated with health insurance, including, but not limited to, benefits, premiums, base rates, underwriting relativities, discounts, co-payments, co-insurance, deductibles, premium financing, installment fees, and any other out-of-pocket costs of the policyholder.
- Exempt large-group health insurance policies or contracts (such as those provided by CalPERS), or a policy or contract excluded under specified sections of the Health and Safety Code and the Insurance Code, as those provisions were in effect on January 1, 2011.

2. Rate Approval Applies Only to Small-Group and Individual Markets

Proposition 45 seeks to include individual and small-group health plan and health insurance rates under the same regulatory process as was established by Proposition 103 for automobile and casualty insurance, in order to provide the Commissioner authority to approve or deny proposed rates for health plans and insurance policies before they take effect. This additional layer of regulation could add greater cost and complexity to the rate setting processes for plans and insurers providing coverage in the individual and small-group markets, and potentially result in health care premium reductions for some consumers in these markets. These additional costs for health plans and insurers may increase the potential for cost shifting to consumers in the large-group market.

According to a background paper prepared by the joint Senate and Assembly Health Committees, DMHC regulated plans subject to Proposition 45 cover 1.6 million enrollees in the small-group market and 450,000 in the individual market, while CDI regulated policies subject to the Initiative cover 800,000 insureds in the small-group market and 1 million in the individual market. The background paper also estimates another 2 million insureds and enrollees are expected to gain small-group and individual coverage by 2015. The HMO and PPO plans and policies of the approximately 10.6 million Californians (which includes more than 1.3 million CalPERS health plan participants) in the large-group market would not be subject to rate approval by the Commissioner under Proposition 45.

According to an analysis by the Legislative Analysts’ Office (LAO): “The measure also broadly defines “rates” in a way that includes other factors beyond premiums, such as benefits, copayments, and deductibles. While there is some uncertainty regarding how this provision would be interpreted, it likely would not give the Commissioner any new authority to approve characteristics of health insurance products beyond premiums, such as the types of benefits covered.” The LAO goes on to note that there will be “Increased state administrative costs to regulate health

insurance, likely not exceeding the low millions of dollars annually in most years, funded from fees paid by health insurance companies.”

BUDGET AND FISCAL IMPACTS

1. Benefit Costs

The measure does not directly impose new requirements or costs on CalPERS health program. Proposition 45 could eventually have an effect on the cost of health care purchased by CalPERS depending on its impacts to the health care industry as a whole. CalPERS staff has identified the potential for higher administrative costs for health plans and insurers due to the additional regulatory requirements. These requirements may adversely affect their ability to meet the requirements under the ACA regarding Medical Loss Ratio limits, or lead to increased premiums to the plan's entire book of business including CalPERS plans.

2. Administrative Costs

There are no anticipated administrative costs for CalPERS.

ATTACHMENTS

Attachment 1 – CalPERS Board of Administration's State Ballot Initiative Policy
Standards

Attachment 2 – Support and Opposition

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