Agenda Item 5a

June 16, 2015

ITEM NAME: Senate Bill 546 (Leno) – Large Group Health Plan Data Disclosure and Rate Review

As Amended June 2, 2015

Sponsors: California Labor Federation and UNITE HERE

PROGRAM: Legislation

ITEM TYPE: Action

RECOMMENDATION
Adopt a **Support, If Amended** position on Senate Bill (SB) 546.

EXECUTIVE SUMMARY
SB 546 establishes a rate review process for health plans and health insurers that provide coverage in the large group market. The review process would require the plans and insurers to file specified rate information with either the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) prior to a rate increase and require these departments to make a determination of whether the increase is reasonable or unreasonable in accordance with the Affordable Care Act (ACA). The bill also modifies existing annual reporting requirements for plans and insurers to file specified aggregate data for all the plans and policies they sell in the large group market.

The California Public Employees' Retirement System (CalPERS) Legislative and Policy Engagement Guidelines suggest a support position on proposals that promote transparency and accountability for the System or entities that conduct business with the System, provided these proposals do not jeopardize the System's ability to conduct business or infringe on the CalPERS Board of Administration's (Board) fiduciary authority. The provisions in the bill that modify existing reporting requirements could be viewed as promoting additional transparency and accountability. The rate review provision would allow the DMHC to review proposed rate increases from health plans that provide health maintenance organization (HMO) plans to CalPERS, but it would be after the time the Board has negotiated and adopted rates. Thus, a determination as to whether the CalPERS health rates are reasonable or unreasonable would not be helpful to the CalPERS rate setting process nor would the timing allow for any adjustments without interrupting the open enrollment process. Therefore, staff believes this type of review of the rates CalPERS has negotiated with its contracted HMO plans is unnecessary and provides no extra

value. As a result of the conflicting policy issues this bill presents, staff is recommending a support, if amended positon on SB 546. Staff recommends to the author to amend the bill to exempt CalPERS from its rate review provisions.

STRATEGIC PLAN

This item supports CalPERS 2012-17 Strategic Plan Goal A to improve long-term pension and health benefit sustainability by ensuing high-quality, accessible, and affordable health benefits.

BACKGROUND

1. Existing Law

   Individual and small group market

   Under existing federal law, the 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 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. 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 policies, plans and insurers must 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 DMHC or CDI promulgated regulations describing how they would use this rate filing information from large group health plans and policies.

   Furthermore, state law requires health care plans and insurers to provide at no charge, 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. If claims data is not available, it requires health plans and insurers to provide de-identified aggregated data sufficient for the purchaser to compare costs of similar services from other health plans or insurers and de-identified aggregated patient level data that includes demographics and encounter data, including data used to experience rate the group, as specified, provided a qualified statistician formally determines that data does not provide a reasonable basis to identify an individual.

2. Excise Tax
   Beginning in 2018, the ACA will impose a 40 percent excise tax on the aggregate cost of health benefits that exceed $10,200 for individual coverage and $27,500 for family coverage, indexed to inflation. The tax applies to the total premium (both employer and employee share) for fully-insured and self-insured employer coverage exceeding the annual thresholds, as well as, other health benefits including some contributions to health Flexible Spending Accounts, Health Savings Accounts, and Archer Medical Savings Accounts. Employers are responsible for determining the excess benefit and for notifying each coverage provider and the Internal Revenue Service (IRS). For fully-insured plans, the health insurance issuer is the coverage provider and for self-insured plans, the employer or other responsible party is the coverage provider. The coverage provider is responsible for paying the tax to the IRS.

   On February 23, 2015, the IRS issued Notice 2015-16, which is intended to initiate and inform the process of developing guidance about the excise tax. This Notice describes potential approaches that could be incorporated in future guidance and invites comments on these potential approaches and other issues related to this tax.

3. 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. <u>Proposed Changes</u>
   Because CalPERS self-funded preferred provider organization (PPO) plan is not subject to CDI oversight, this analysis only addresses impacts on large group HMO plans regulated by the DMHC.

   <u>Annual Rate Filings</u>

   - Require large group health care service plans to annually file rate information for rate changes aggregated for the entire large group market by October 1, 2016 and annually thereafter.
   - Require DMHC to hold a public meeting for each health plan in the large group market regarding the large group rate changes between November 1, 2016 and March 1, 2017, and annually thereafter.
   - Delete some existing large group rate filing requirements and adds the following as part of the aggregated filing:
     - Any factors affecting the rate, and the actuarial basis for those factors, including:
       A. Geographic region;
       B. Age, including age rating factors;
       C. Occupation;
       D. Industry;
       E. Health status, including health status factors considered;
       F. Employee, employee and dependents, including a description of the family composition used;
       G. Enrollee share of premiums;
       H. Enrollee cost sharing;
       I. Covered benefits in addition to basic health care services, as specified; and,
       J. Any other factors that affect the rate that are not otherwise specified.
     - The plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category, as specified, or actual trend experience for the prior contract year by aggregate benefit category, as specified for other plans, for a plan with exclusive contracts with no more than two medical groups.
     - 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, as specified, or the amount of its actual trend experience for the prior contract year by aggregate benefit category, as specified for other plans, for a plan with exclusive contracts with no more than two medical groups.
     - 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 plan benefits over the prior year associated with the submitted rate filing.

  - The average rate increase for the large group market enrollees covered in the filing with the average rate weighted by the number of covered lives.

Large Group Purchaser Notice

- Expands the current requirement that health plans notify large group purchasers of rate changes to include information on whether rate increase exceeds the average rate increase for the California Health Benefit Exchange or CalPERS or whether the rate increase triggers the excise tax.

Rate Review

- Require large group health care service plans to file required rate information with DMHC at least 60 days prior to implementing any rate increases if either of the following apply:
  - The rate increase is greater than 150 percent of the average rate increase for its large group plans.
  - The rate increase would cause the health plan for the large group purchaser to incur the excise tax for any part of the period the rate increase is proposed to be in effect.
- Require all health care service plans with rate increases that meet any of the two triggers above to disclose data including but not limited to:
  - plan name, product type, business segment
  - factors affecting the rate including enrollment, geographic regions and demographics
  - plan design, medical trends and health factors considered
  - certain claims cost comparisons
  - new cost containment and qualify improvement strategies
- Require DMHC to determine within 60 days of filing whether the large group rate increase is reasonable or unreasonable.
- Require plan to submit all information required by the ACA and any other information required by DMHC.

2. Author's Intent
According to the author, "lack of transparency on the part of insurance providers makes it difficult for purchasers to make prudent choices that could control the costs that have become a burden for both workers and employers…Large group purchasers still do not know what factors are considered in establishing rates. SB 546 will give them this information so they can bargain more effectively and so that they can develop strategies to help contain health care costs."

3. Impinges on Board Authority
The Board has authority and fiduciary responsibility for the administration of CalPERS health plans and for contracting for health coverage with carriers providing health benefits. SB 546 could override this authority and responsibility by subjecting the rates negotiated and approved by the Board to DMHC review –

giving regulators the opportunity to usurp CalPERS determinations regarding benefit design, co-pay, co-insurance, etc. Regulators will have no more data or other information than CalPERS to make determinations regarding the reasonableness of proposed rates.

4. Several Government Administered Plans Already Exempted from Rate Filings and Review
Existing law exempts specialized health care service plan contracts (e.g.- dental, vision), as well as Medicare, Medi-Cal, Healthy Families Program, Access for Infants and Mothers Program, and the California Major Risk Medical Insurance Program 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 rates.

5. Similar Legislation
In 2010, the Board has adopted an oppose position on AB 52 (Feuer) which 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.

   SB 546, if enacted, 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 review large-group health care plan rates, including the rates of the CalPERS HMO plans negotiated and approved by the Board, in addition to determining whether these rates are reasonable or unreasonable.

BUDGET AND FISCAL IMPACTS

1. Benefit Costs
Our contracting health plans estimate this bill could result in requiring them to file thousands of individual filings with DMHC and CDI. They estimate their costs for doing these filings to be millions of dollars in administrative costs annually. To the extent CalPERS health plans are successful in negotiating these increased costs into the rates with all of their large group customers, including CalPERS, SB 546 could translate into increased premiums or other costs for CalPERS members and contracting PEMHCA employers.

2. Administrative Costs
   None.

BENEFITS/RISKS

1. Benefits of Bill Becoming Law
   - Increases oversight and transparency of how health plans derive rates for health insurance coverage, which may help control rates in the large group HMO market.

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, thus increasing costs and complexity to its rate setting process.
   - 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 – List of Support and Opposition

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