Board of Administration

Agenda Item 9a

August 21, 2019

Item Name: Assembly Bill 731 (Kalra) – Health Plan Data and Rate Review

Program: Legislation

Item Type: Action

Recommendation

Adopt a support position on Assembly Bill (AB) 731 (Kalra), as amended July 11, 2019. The bill could generally improve health care transparency and may improve the California Public Employees' Retirement Systems' (CalPERS) capacity to obtain and verify health care market information.

Executive Summary

This bill expands on the individual and group market data reporting and rate review by the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI). The bill generally applies current department determinations regarding unreasonable or unjustified for small group plan rates to all group plan rates; provides separate timelines for specified small and large group filings; requires notice of rate and coverage changes; and, adds a process for large group contract holders that are experience rated to request a review of the rate. Additionally, the bill adds new geographic reporting regions; expands on the data reporting by all group plans; and, adds new reporting requirements for community-rated, experience-rated, and blended large group plans.

Strategic Plan

This item supports CalPERS 2017-22 Strategic Goal "Transforming Health Care Purchasing and Delivery to Achieve Affordability."

Background

1. Existing Law

Individual and Small Group Market

Under existing federal law, the Affordable Care Act (ACA) requires that health care service plans and insurers planning to significantly increase premiums to submit their rates to either the state or federal government for review. The rate review process is designed to improve health

insurer accountability and transparency. The process ensures that experts evaluate whether the proposed rate increases are based on solid evidence and reasonable cost assumptions. It also gives consumers the opportunity to make comments on proposed increases. The ACA also requires that a summary of rate review justifications and results be accessible to the public in an easily understandable format.

Existing state law requires all group health care service plan contracts and insurer policies to deliver in writing a notice indicating changes in premium rates or changes in coverage prior to the contract renewal effective date. Any individual or small group health care service plan contract for which the department determines that a rate is not justified or unreasonable, based on ACA guidelines, must notify the contract holder or individual of that determination following specified guidelines. Among other things, the notification informs contract or policy holders that the rate is deemed unreasonable, and they may obtain other coverage, including from Covered California, or they may keep this coverage. Additionally, all individual and small group health care service plan contracts must, according to timelines set forth by the department, file all required rate information prior to implementing any rate change.

Large Group Market

Existing state law requires all group health care service plan contracts and insurer policies to deliver in writing a notice indicating changes in premium rates or changes in coverage prior to the contract renewal effective date. For large group health care service plans and policies, the rate and coverage notice must include whether the proposed rate exceeds certain benchmarks and whether it includes any portion of the ACA's excise tax paid by the health plan. Current law requires large group plans to make readily available to the public on their websites information on overall annual medical trend factor assumptions, actual costs by aggregate benefit category, and projected trend information.

The United States Department of Health and Human Services has not 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 and policies.

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. Each 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. Contracting health plans and third-party administrators submit data based on benefit categories specified by CalPERS. In addition, CalPERS team members develop independent rate forecasts based on underlying factors and trends identified from the data and engage independent consultants to develop additional rate projections. CalPERS develops statewide health plan rates for State of California and California State University members, and three regional rates for public agency and school members. Each June, the Board approves health plan rates for the following calendar year. The Board is under a statutory obligation to ensure the premiums charged for health plan enrollment reasonably reflect the cost of the benefits provided by the plans.

Analysis

1. No Direct Rate Approval or Denial for CalPERS Plans

AB 731 makes amendments and additions to the Health & Safety Code and the Insurance Code. CalPERS self-funded preferred provider organization (PPO) and exclusive provider organization plans are not under the purview of either authority. However, CalPERS contracted Health Maintenance Organization (HMO) plans are subject to the Knox-Keene Act in the Health & Safety Code. DMHC is the state agency responsible for administering the Knox-Keene Act and regulating HMO plans. Therefore, CalPERS contracting HMO plans would be subject to this bill's provisions, and this analysis focuses on the impacts the bill will have on these plans.

The bill provides for individual, small group, and large group health plan data reporting and rate review including the ability for DMHC to determine that a rate increase is unreasonable or unjustified. While the bill requires a plan to notify a contract holder that a rate is deemed by DMHC to be unreasonable or unjustified, the bill does not include rate approval or denial. The bill does, however, prohibit a change in premium or changes in coverage to take effect unless the plan has provided written notice a specified number of days prior to the renewal date.

2. Proposed Changes

Among its provisions, AB 731:

- Extends reporting requirements and review of rates by the DMHC which currently apply only in the individual and small-group markets, to the large-group market.
- Requires the reporting of new items, including trends by geographic region, comparison to Medicare pricing, and outliers in terms of utilization.
- Establishes additional reporting requirements for plans that fail to file required information, including spending and utilization for a number of categories for the prior two years, current year, and a subsequent year.
- Authorizes large group contract holders to request a rate change review within prescribed timelines.
- Defines "community-rated" as a rating method in the large group market that bases rates on the expected costs to a health care service plan of providing covered benefits to all enrollees, including both low-risk and high-risk enrollees.
- Defines "experience-rated" as a rating method in the large group market under which a health care service plan calculates the premiums for a large group in whole or blended based on the group's prior experience.
- For community-rated large group health care service plan contracts DMHC shall determine whether a plan's rate change is unreasonable or not justified.
- For experience-rated groups or groups with a blended rating method, DMHC shall determine whether the methodology, factors, and assumptions used to determine rates are unreasonable or not justified.
- Establishes seven geographic regions for large group market products as follows:
    - An area composed of existing regions for the individual and small group markets 2, 4, 5, 6, 7, and 8, which consist of the counties of Alameda, Contra Costa, Marin, Napa, San Mateo, Santa Clara, Solano, Sonoma, and the City and County of San Francisco.
    - An area composed of existing regions for the individual and small group markets 1 and 3, which consist of the counties of Alpine, Amador, Butte, Calaveras, Colusa,

Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

- An area composed of existing regions for the individual and small group markets 9 and 12, which consist of the counties of Monterey, San Benito, San Luis Obispo, Santa Barbara Santa Cruz, and Ventura.
- An area composed of existing regions for the individual and small group markets 10, 11, and 14, which consist of the counties of Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, and Tulare.
- An area composed of existing regions for the individual and small group markets 13 and 17, which consist of the counties of Imperial, Inyo, Mono, Riverside, and San Bernardino.
- An area composed of existing regions for the individual and small group markets 15 and 16, which consist of the county of Los Angeles.
- An area composed of existing regions for the individual and small group markets 18 and 19, which consist of the counties of Orange and San Diego.

3. Author's Intent

According to the author, "the skyrocketing cost of health care is contributing to wage stagnation and fueling income inequality in our state. Many are struggling with ever rising copays and health insurance premiums that have risen 249% since 2002 – more than six times the increase in the state's overall inflation. This bill builds upon our state's proven rate review policy for health insurance that has already saved consumers $226 million. Consumers are in desperate need of relief and Californians deserve a clearer picture of what's driving health care costs."

4. Arguments in Support

The California Labor Federation, a cosponsor of this bill, indicates that "in the third year of large group health insurance reporting, premiums continue to rise at a rate well above inflation, prices continue to account for three fourths of the projected premium dollar. For the third year in a row, Kaiser and United Health Care, which together cover 66% of the large group market, have failed to fully break out medical trend increases attributable to the various benefit categories. Premium increases among the top seven insurance companies was 1.3 to three times California's 3.8 percent inflation rate last year. For the top seven companies, the disclosures reveal 83 percent of the projected 2019 fully-insured large group market medical trend is due to price inflation and 16 percent is due to increase in utilization. While existing laws helped protect consumers and save money for individual consumers and businesses, almost 10 million consumers who work for large employers or who have coverage through union trust funds do not have the same protection."

SEIU California states that "transparency has been an effective tool for better understanding the underlying health care cost drivers and holding the industry accountable."

UNITE HERE writes that "this is a common sense piece of legislation, and will help reign in the exorbitant cost of healthcare."

5. Arguments in Opposition

In opposition, the California Association of Health Plans writes that "this bill subjects health plans to a multi-layered and complicated regulatory review of policies. Regulators would have the authority to judge an agreement between two relatively large and sophisticated market actors (large employers and health plans) as 'unreasonable.' This bill will also significantly expand the type of information included in all rate filings, raising the cost and burden of compliance to even higher levels."

The California Chamber of Commerce argues that "this bill will increase the cost of health care coverage for employers by establishing an unnecessary and burdensome rate review process for large-group health care contracts. Large employers have been able to negotiate and keep premium increases to a lower level than the combined individual and small group markets, which are subject to rate review."

Budget and Fiscal Impacts

1. Benefit Costs

According to the Assembly Appropriations Committee and the Senate Committee on Health analysis, DMHC will incur costs of $1.2 million in 2019-20, $3.2 million in 2020-21, and $3.0 million ongoing to review contracts and rates (Managed Care Fund). Costs will likely be in the hundreds of thousands annually for CDI (Insurance Fund) for similar activities as DMHC.

While the dollar amount may be sizable for an impacted health plan, it is likely the plan would be able to spread it across many consumers, such that the effect on premiums would be minimal. To the extent HMO plans are successful in negotiating these increased costs into rates with all their large group customers, including CalPERS, AB 731 could translate into increased premiums or other costs for CalPERS members and contracting PEMHCA employers.

2. Administrative Costs

No additional cost to CalPERS.

Benefits and Risks

1. Benefits
   - Potential for increased transparency into large group health plan rate information including community and experience rated health plan rate methodologies.
   - Data reporting and rate review may help moderate rate increases in the large group market.

2. Risks
   - CalPERS may not experience any direct, quantifiable benefit from the bill, but could see increases in its premiums. While far from certain, CalPERS would expect any increase to be minimal.
   - DMHC review of experience rating methodologies, factors, and assumptions may impact the confidential and proprietary nature of the CalPERS rating process.

- Misalignment between service categories and regions in the bill and those used by CalPERS may cause stakeholder confusion.
- After review of rate methodologies, factors, or assumptions used to determine rates, DMHC could potentially determine that Board approved HMO rate or coverage changes are unreasonable or not justified. Such findings may call into question whether the Board is fulfilling its statutory duty to ensure premiums reasonably reflect the cost of benefits provided by CalPERS HMO plans.

Attachments

Attachment 1 – Legislative History

Attachment 2 – Support & Opposition

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