California Public Employees' Retirement System
Office of Governmental Affairs
P.O. Box 942720
Sacramento, CA 94229-2720
TTY: (916) 795-3240
(916) 795-3689 phone • (916) 795-3270 fax
www.calpers.ca.gov

Agenda Item 3a

August 16, 2011

TO: MEMBERS OF THE HEALTH BENEFITS COMMITTEE

I. SUBJECT: Assembly Bill 52 (Feuer) – As Amended June 1, 2011

Health Care Coverage: Rate Approval

II. PROGRAM: Legislation

III. RECOMMENDATION: Oppose, unless amended

This bill impinges on the Board's statutory authority to set HMO plan rates and creates unnecessary cost and complexity in the rate setting process.

IV. ANALYSIS:

Summary

This bill would require health plans and insurers to file a complete rate application for any rate change for an existing product effective January 1, 2011 and a proposed rate for a new product that would become effective on and after January 1, 2012 with the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). This bill would grant authority to DMHC and CDI to approve, deny, or modify any proposed rate or rate change found to be excessive, inadequate, or unfairly discriminatory and order refunds. The Department of Health Care Services (DHCS) and the Managed Risk Medical Insurance Board (MRMIB) would be exempt from the provisions of this bill.

Background

CalPERS Health Rate Setting Process

The Public Employees' Medical and Hospital Care Act (PEMHCA) grants the CalPERS Board of Administration (Board) authority to administer the health benefits program for eligible active and retired members and their families. This statutory authority allows the Board to design health benefit plans, and set co-payments, co-insurance, deductibles, premiums, rates, employer contributions, and enter into health plan contracts.

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 engages an independent consultant to develop additional rate projections. CalPERS then compares its own rate projections to the preliminary rates submitted by the health plans; this information becomes the basis of subsequent negotiations. Throughout the negotiation period between January and June rates are refined and typically decreased based on these comparisons and the availability of more recent experiential claims data as negotiations progress.

From February to June, CalPERS staff conducts several educational sessions with the Board and interested stakeholders. Stakeholder meetings are open to members of the general public. During the June meeting of the Board and its Health Benefits Committee, the Board evaluates and approves health plans and premium rates.

The Board must approve these rates no later than mid-June, so that contracting agencies can determine their applicable employer contribution for employee and retiree health coverage, budget for the following year, and decide whether to continue contracting with CalPERS for employee and retiree health coverage. Rates must also be set in June to enable CalPERS to begin the open enrollment process for approximately 1.3 million participants. Finally, the State requires this rate to appropriate the necessary funding in its annual budget, which must be approved by the Legislature on or before June 15th.

Department of Insurance (DOI) Regulatory Authority

The Department of Insurance licenses and regulates the rates and practices of insurance companies, agents, and brokers in California. Because the CalPERS PPO plans are self-funded, they are not subject to the authority of the Department of Insurance. Consequently, although AB 52 expands the authority of the Department of Insurance, we do not address these issues in this analysis.

Department of Managed Health Care (DMHC) Regulatory Authority

Under the Knox-Keene Health Care Service Plan Act, DMHC has the authority to regulate HMOs. To be licensed by the DMHC, a health plan must submit information regarding evidence of coverage and its network of providers. The DMHC evaluates the benefit-package compliance with current law, as well as the adequacy of the plan's provider network to ensure that sufficient access to hospitals and providers is available to enrollees in each zip code where plan

coverage is provided. Existing law also provides for a thorough review by the DMHC whenever a health plan makes substantive modification to its evidence of coverage or provider network, whereby the Department conducts an independent analysis and invites public comment.

Rand Study of Premium Regulation

In 2004, the California HealthCare Foundation commissioned a RAND study to analyze the likely effect of premium regulation on the California health insurance market. RAND researchers found no compelling need to regulate health-insurance premiums in California and noted that such regulation could have unintended, adverse consequences on consumers, such as reduction in the quality or quantity of care, stricter utilization management, and discouraging expensive technologies from coming to market while motivating the introduction of cost-saving technologies.

Existing State and Federal Rate Review

Federal and State laws already impose limits on health insurance premiums and require rate review. Starting September 1, 2011, in response to federal health reform, both federal and State officials will begin to scrutinize proposed rate increases of more than 10 percent to determine if they are justified. The federal Affordable Care Act (ACA) requires that 80 to 85 cents out of every $1 in premiums be spent on medical care. If not, insurers are required to pay a rebate to policyholders.

SB 1163 (Leno), a rate-review bill chaptered in 2010, requires health plans and health insurers to file with the DMHC and CDI, specified rate information for at least 60 days prior to implementing any rate change. It requires rate filings to be actuarially sound, and increases from 30 days to 60 days, the amount of time that a health plan or insurer must provide written notice before a change in premium rates or coverage becomes effective. Health plans that offer large group coverage, including plans offered by CalPERS, are required to report to DMHC or CDI only if the rate increase is “unreasonable” as defined by the ACA. Under ACA, an “unreasonable rate increase” is defined as a rate that is excessive – i.e., it is unduly high in relation to covered benefits using an issuer’s medical loss ratio as a benchmark, or it is not evidence-based.

Proposed Changes

Among other things, AB 52 would do the following:

Application Submission Requirements

- Requires individual, small group, and large group health care service plans and health insurers ("carriers") to file a complete rate application for any proposed rate change or rate for a new product that would become effective on or after January 1, 2012, 60 days prior to the proposed effective date of the proposed rate. The bill exempts a number of programs and contracts from the application submission and rate review requirements including Medicare supplement plans, Medi-Cal, Healthy Families Program, etc.
- Requires large group carriers, to disclose 44 enumerated data elements beyond those currently required under rate review, in addition to other information that might be required by any regulation adopted by DMHC, or CDI, and any information required under the ACA.
- Requires that all information submitted in a rate application, and all information submitted in support of the application, be subject to the California Public Records Act, except for financial data related to contracted rates between carriers and providers or large group subscribers.
- Requires the regulators to review for compliance with the requirements in this bill, all rate increases which became effective January 1, 2011. Requires regulators to order the refund of payments made pursuant to any such rate, to the extent the regulator finds the rate to be excessive, inadequate, or unfairly discriminatory.

Rate Review Procedures

- Defines "rate" to include the charges assessed for a health care service plan contract or anything that affects the charges associated with such a contract, including, but not limited to, premiums, base rates, underwriting relativities, discounts, copayments, coinsurance, deductibles, and any other out-of-pocket costs.
- Provides that no rate, including premiums, that is found to be excessive, inadequate, unfairly discriminatory, or otherwise in violation of the standards established by this bill shall be approved or remain in effect.
- Authorizes DMHC or CDI ("regulators") to approve, modify or deny any proposed rate or rate change submitted for review.
- Requires regulators to issue a decision within 60 days after the date of the public notice, unless the regulator and the applicant agree to waive the 60-day period.
- Permits regulators, to review the rate filing to ensure compliance with the law under certain circumstances.

- Requires that regulators notify the public of any rate application by a carrier.
- Requires regulators to hold a hearing on any of the following grounds:
    - An enrollee, or his or her representative, requests a hearing within 45 days of the date of the public notice, and the regulator grants the request for a hearing.
    - The regulator determines for any reason to hold a hearing on the application; or,
    - The proposed change would exceed 10 percent of the amount of the current rate, or would exceed 15 percent for any individual subject to the rate increase.
- If a hearing is held on the application, the regulator must issue a decision and findings within 100 days after the hearing.
- Requires that regulatory enforcement programs be entirely paid for by carrier fees and assessments, and authorizes regulators to charge fees associated with regulatory filings. Establishes the Consumer Participation Program within DMHC, which allows for the awarding of reasonable advocacy and witness fees to any person who meets specified criteria and who has made a substantial contribution on behalf of consumers to the adoption of a regulation, order, or decision made by the Director.
- Prohibits a carrier, from implementing a rate change within one year of the date of implementation of the most recently approved rate change for each product.

Legislative History

2010 Chapter 661 (SB 1163, Leno) – Requires carriers to file, with regulators, specified rate information for individual and small group coverage at least 60 days prior to implementing any rate change, as specified. Requires the filings for large group contracts only in the case of unreasonable rate increases, as defined by ACA, prior to implementing any such rate change. Increases, from 30 days to 60 days, the amount of time that a health plan or insurer provides written notice to an enrollee or insured before a change in premium rates or coverage becomes effective. Requires carriers that decline to offer coverage to or deny enrollment for a large group applying for coverage, or that offer small group coverage at a rate that is higher than the standard employee risk rate to, at the time of the denial or offer of coverage, to provide the applicant with reason for the decision, as specified.
CalPERS Position: None

AB 2578 (Jones and Feuer) – Would have required carriers to file a complete rate application with regulators for a rate increase that will become effective on or after January 1, 2012. Would have prohibited a health plan or insurer's premium rate (defined to include premiums, co-payments, coinsurance obligations, deductibles, and other charges) from being approved or remaining in effect that is excessive, inadequate, unfairly discriminatory, as specified. Failed passage off the Senate Floor. *CaPERS Position: None*

2009 AB 1218 (Jones) – Would have required health plans and health insurers to obtain approval from the DMHC or the CDI for any rate increases in the amount of the premium, copayment, coinsurance obligation, deductible and other charges under a health plan or insurance policy. This bill would have required departments to notify the public of rate applications and would have authorized the departments to assess a charge related to the rate application and to deposit that charge in the Health Rate Approval Fund. This bill would have created the California Health Rate Advisory Board. This bill died in the Assembly Health Committee. *CalPERS Position: None*

2006 SB 425 (Ortiz) – Would have required HMOs to obtain approval from the DMHC and the CDI, before any increases in rates, premiums, copayments, deductibles, charges, and covered costs imposed by a plan or health insurer between April 1, 2000 and January 1, 2006. Senate Health Committee hearing was cancelled at the author's request. *CalPERS Position: None*

Issues

1. Arguments by Those in Support

Supporters of the bill argue that HMOs and insurers not only are not accustomed to public rate scrutiny, but also fail to substantially justify their ever increasing proposed rates or even provide reasons for the increases, and that regulators must have the power to control rates to contain costs. According to supporters, 35 states already require prior health insurance rate approval by regulators and AB 52 would prevent unreasonable and unnecessary rate increases and enhance oversight of the health insurance industry.

The California School Employees Association stated that "it is not uncommon for classified school employees to have more than half of their paycheck taken to pay for their health insurance premiums" and that the bill will address escalating costs. The group Consumer Watchdog states that "Blue Shield of

California alone held $2.9 billion in excess surplus" and asserts that California regulators "should be able to consider this financial bloat when determining reasonable rates." The California Labor Federation contends that rate review legislation will bring more transparency to the rate filing process, but what is needed are the tools to check rate increases.

Organizations in Support: 131 organizations registered in support, including a number of consumer, labor, and business groups such as: AARP; California School Employees Association; SEIU California; California Teachers' Association; California Labor Federation; California Nurses Association; California Retired Teachers' Association; Peace Officers Research Association of California; California Professional Firefighters; Consumer Federation of California; and San Diego Chamber of Commerce.

2. Arguments by Those in Opposition

Anthem Blue Cross stated that since "insurance rates are a function of insurance costs, adding an additional layer of regulation will only increase the cost" of health care for Californians. It also stated that numerous studies show that the "primary drivers of premium cost increases are due to increasing consumer utilization of services and increasing provider prices." Premiums are not identified as cost drivers in these studies. Health Net stated that under rate regulation, the plan would have to request approval of a rate already agreeable to the purchaser. The California Hospital Association stated that the bill "creates an expensive bureaucracy that would siphon millions of dollars of critically needed funding away from direct patient care. It also stated that premiums are increasing, because the underlying costs of delivering care continue to increase, and that AB 52 does not address the root causes of those underlying cost increases . . ."

The California Medical Association stated that should the bill pass, "HMOs will merely force their providers to bear the burden, leading to lower provider reimbursement; fewer, contracted physicians; reduced access; and less time with patients." The California Chamber of Commerce stated that "simply capping rates will not make costs disappear, but will instead limit choices and quality for employers and their employees." The California Association of Joint Powers Authority stated that the bill "overrides mid-year bargaining agreements or modifications to existing bargaining agreements between labor and management to adjust premiums, cost-sharing, or any other level of service."

Organizations in Opposition: 55 organizations registered in opposition, including a number of health insurance and business groups that include:

Anthem Blue Cross; Blue Shield of California; Kaiser Permanente; California Chamber of Commerce; California Hospital Association; California Medical Association; California Manufacturers and Technology Association.

3. Impacts on CalPERS

It is unclear how AB 52's rate application requirements fit into the CalPERS rate-negotiation and rate-setting process, because the bill does not contemplate rate negotiations between the health care service plans or insurers and purchasers. At a minimum, AB 52's rate application requirements pose significant challenges for the CalPERS timelines required by our rate process. It is possible that not only will the proposed rate application process not be effective in lowering rates, but may actually have the effect of increasing health premium and other rates at issue. Consequences CalPERS anticipates from the rate application, should AB 52 be signed into law, include the following:

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. AB 52 would override this authority and responsibility by requiring that CalPERS health plans submit all proposed rates to DMHC for approval – 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. In addition, nothing in AB 52 prevents health plans from submitting proposed rates for DMHC approval prior to negotiations with CalPERS, which would inhibit the negotiation process.

Adds Unnecessary Oversight and Uncertainty to Rate Setting Process

CalPERS has a proactive and robust rate negotiation process that takes place from January through June and includes Board oversight and stakeholder input. Initial rates are currently submitted in April. Assuming health plans will submit final CalPERS-approved rates to the rate application process, CalPERS will have to begin and complete the rate negotiation process at least three months earlier than is our current practice and initial rates would be submitted in December. Conducting the rate negotiation process early means CalPERS and our health plans will rely upon less, actual claims and health-outcome data, and more projected data, leading to higher, more conservative preliminary rates and likely higher final rates.

AB 52 contemplates a rate application process that will take a minimum of 60 days. However, this does not account for the public hearing and intervener process that could add up to least 145 additional days to the process, assuming regulators are able meet deadlines set by the statute. [The additional days added to the process could increase significantly, since AB 52 does not specify when DMHC issues the public notice or when the public hearing takes place]. The statutory and regulatory scheme provided by the PEMHCA requires a certain level of predictability that is not contemplated by AB 52. Failure by the DMHC to approve rates within 60 days, as well as initiation of the hearing and intervener processes, interferes with State and contracting agency budgeting requirements.

Finally, uncertainty regarding final rates could delay CalPERS Open Enrollment period, typically held from September through October, including the development of publications necessary to assist members and their families in making health care decisions. The ripple effect caused by such delays could have serious implications for CalPERS ability to effectively process changes made by members during open enrollment including not only a timely transition to a new health plan but ensuring member's payroll deductions are adjusted to reflect the new premiums prior to the January 1 effective date.

4. Comparison of CalPERS HMO Rate Increases

The chart below shows the average HMO rate increases for active/pre-65 retirees for the West Region of the United States, the national average for HMO increases, and the CalPERS HMO rate increases for the period from 2008 to 2011.

HMO Rate Increases for Active/Pre-65 Retirees

Year	West Region HMO Increase*	National Average HMO Increase*	CalPERS HMO Rate Increase**
2008	10.2%	9.4%	7.4%
2009	9.4%	9.0%	6.6%
2010	9.2%	9.4%	3.4%
2011	9.0%	9.8%	10.6%
2012	Not Available Yet	Not Available Yet	5.3%

***Source: AON Hewitt*
***Source: CalPERS*

The data shows that CalPERS HMO rates are typically lower compared to the West Region and national average. This illustrates the effectiveness of the CalPERS Board in negotiating lower rates for its HMO plans, and calls into question any value that DMHC may bring to the CalPERS rate review process.

5. Several Government Administered Plans Already Exempted from AB 52

AB 52 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; California Major Risk Medical Insurance Program, and the Federal Temporary Risk Pool. 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 and set its health rates.

This July, the California Health Benefit Exchange Board voted to seek an exemption from AB 52. Like CalPERS under PEMHCA, the Exchange was established as an active purchaser, with the ability to negotiate and selectively contract with insurers offering a high-value product in exchange for a large volume of enrollees. Some of their concerns for seeking an exemption align with those identified by CalPERS staff, including the possible delay in final rate negotiations and implementation of plan renewals, coupled with the need to finalize HMO and PPO rates at the same time.

6. Legislative Policy Standards

The Board's Legislative Policy Standards suggest an oppose position on proposals which reduce or limit the Board's administrative authority, and proposals which create unreasonable cost or complexity for the administration of the System. AB 52 would circumvent the Board's authority to set rates and make it far more costly and complicated to determine them. Therefore, staff recommends an **Oppose, unless amended** position to remove CalPERS PEMHCA plans from the rate review provisions of AB 52.

V. STRATEGIC PLAN:

This item is not a specific product of the Annual or Strategic Plans, but is a part of the regular and ongoing workload of the Office of Governmental Affairs.

VI. RESULTS/COSTS:

Program Cost

CalPERS would be required to begin its rate-review process months earlier to accommodate the DMHC rate submission deadlines. Since CalPERS would have to rely on more estimated versus actual data, this increases the likelihood that the estimated rate could vary by a greater amount. For example, two percent weighted-average increase based on increased reliance on projected data would have increased CalPERS 2012 HMO rates for by $98.7 million. The State employer share of this increase would have been $41.3 million, with $32.5 million of this coming from the State General Fund.

Additionally, this bill could require CalPERS to begin the rate negotiate process early to allow time for the DMHC rate approval process. Starting the rate negotiation process earlier means staff would have less actual claims experience and health-outcome data to rely on, which could result in more conservative cost trends being used by our health plans and our own staff. This will lead to higher premium rates, which are borne by employers and members.

Administrative Costs

To accommodate the proposed rate application process, CalPERS estimates rate negotiations with health plans would necessarily begin at least three months ahead of the current schedule. Additional administrative costs incurred by the longer negotiation period, including a possibly truncated open enrollment and processing period, are estimated to increase by at least $254,000 per year to cover additional PY's and consultant costs.

_____
DANNY BROWN, Chief
Office of Governmental Affairs

_____
ROBERT UDALL GLAZIER
Deputy Executive Officer
External Affairs Branch

_____
ANN BOYNTON
Deputy Executive Officer
Benefit Programs Policy and Planning