Making Sense of Health Insurance Oversight in California

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Approval of Health Insurance Rate Changes: Initiative Statute
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Mr. Chairmen and members of the Senate and Assembly Health Committees, Deborah Kelch with the Kelch Policy Group and Director of the Health Insurance Alignment Project. Thank you for inviting me to testify.

I am here today based on research and analysis I have done for more than a decade on California's system of health insurance regulation; particularly California's framework of two autonomous state entities, Department of Insurance and Department of Managed Health Care, administered by two elected constitutional officers, the Insurance Commissioner and the Governor respectively, each with independent authority to regulate specific health insurance products, a structure unique among states.

In previous studies commissioned by the California HealthCare Foundation, and in the work of the Alignment Project, we highlight the complex legal, historical and political context for this dual framework. This research identified the relative strengths and weaknesses of each regulatory regime and the challenges associated with having two separate regulators.

For purposes of this discussion, I will consider the November initiative as posing two questions to voters – first, should California move from our current health insurance rate ***review*** program under the ACA, which does not allow regulators to disapprove rates they find to be unreasonable, and instead impose rate ***regulation*** – which requires regulatory prior approval or disapproval before rates can take effect. The second question addressed by the initiative is how to implement rate regulation given California's dual regulatory structure. I am not offering any judgment on rate regulation per se but I am focusing today on the second question.

We all know this is a time of major change affecting nearly every aspect of the individual and small group markets under the ACA and recently enacted implementing California legislation, including the methods and factors for health insurance rate setting. In addition to the rate review program, major changes include guaranteed availability of coverage without regard to a person's age, gender or health condition; benefit and coverage changes; elimination of rating factors based on enrollee or group health status; medical loss ratio requirements, whereby issuers in these markets must spend 80% of premiums on health care or provide rebates to consumers; products categorized in coverage tiers, or metal levels, based on the percentage of costs covered by the plan, known as actuarial value; ACA programs to stabilize premiums and reduce uncertainty starting for the 2014 plan year, including temporary reinsurance, risk adjustment and risk corridors; and the establishment of a state exchange, Covered California, which is authorized and encouraged to be an active purchaser choosing carriers that optimize "choice, value, quality and service."

The ACA also created a new program for review of unreasonable rate increases. California has a federally approved rate review program, although California's program went farther than the federal law by requiring all proposed rate changes to be reviewed, not just those above a minimum threshold, and by establishing in state law additional review criteria beyond what is required in federal rules, including, among other things, the annual compensation of a health insurer's ten most highly paid officers and the degree to which the proposed increase exceeds medical cost inflation. The ACA does not require states to implement prior approval in order to be approved as an effective rate review program and California's approved program does not include a prior approval requirement.

One way to enact prior approval for health insurance in California would be to grant both CDI and DMHC authority to approve or disapprove rates for the products each regulates through the existing rate review process. The November initiative instead proposes that the insurance commissioner exercise authority over all rates, including authority for plans and products subject to DMHC regulation, and imposes on health insurance the rate regulation standards which currently apply to property and casualty insurance under Proposition 103. This for the first time means that distinct health insurance products, those offered under DMHC licensure, would be subject to regulation by both California regulators. Currently, despite having two regulators in the state, any one health plan product is subject to either DMHC or CDI oversight, but not both.

However, the initiative is silent as to how, if at all, CDI, DMHC and Covered California are expected to collaborate in order to carry out their respective statutory obligations. It is also unclear from the initiative whether CDI's prior approval process would supplement or replace the existing rate review process of the DMHC. At the same time, the DMHC would continue to have responsibility for the financial solvency of health plans under its jurisdiction, while CDI would have authority over the revenues those health plans would receive, potentially complicating DMHC's ability to ensure health plan solvency.

The initiative language also does not limit the Commissioner's newly granted authority to regulation of health insurance premiums. The initiative prohibits any health insurance "rate" from becoming effective without the Commissioner's prior approval and defines a "rate," for that purpose, as "anything that affects the charges associated with health insurance, including but not limited to benefits, ... copayments, coinsurance, deductibles" and other specified elements. The Commissioner's potentially extensive authority under the initiative is also granted "notwithstanding any other law." Based on the language, it would be possible for an insurance commissioner to conclude that he or she has prior approval authority over the benefits of every health insurance policy and health plan contract in the state, including products under DMHC, and the standard benefit designs for products in Covered California, all but a handful of which are DMHC-regulated products. The breadth of the initiative also could encompasses provider payments and reimbursement, as one of the primary factors "affecting

charges," but review and approval of provider rates is not contemplated or included in the Proposition 103 rate regulation scheme which would apply under the initiative.

Were a commissioner to assert broad regulatory authority beyond health insurance premium rates the differences between the two regulatory regimes could complicate enforcement. CDI and DMHC administer two different legal frameworks despite common elements. One core difference is that DMHC enforces the Knox-Keene Act, which embodies the duty and promise of health plans to directly provide or arrange for care under a contract, as in an HMO plan, while the CDI enforces the Insurance Code and the insurer's promise to pay claims under a policy. The legislature affirmed these historic differences in the late 1990s by moving Knox-Keene enforcement from the Department of Corporations to the new DMHC and reinforcing its specific mandate to oversee managed care plans.

This core difference plays out in lots of ways in the two regulatory approaches but, most notably, DMHC health plans are subject to different and additional standards related to the care and services provided which are not found in the Insurance Code – such as periodic onsite medical surveys, quality assurance standards and review of provider solvency. If an insurance commissioner, who may lack historical context or practical experience implementing Knox-Keene standards, such as overseeing HMOs and provider risk-sharing arrangements, asserted duplicate authority over DMHC health plans in these areas, and chose to ignore or reinterpret

Knox-Keene it would, at a minimum, create legal confusion and ambiguity for health plans, providers and consumers.

The November initiative raises substantive policy and legal questions beyond whether California should adopt a program of prior approval for health insurance rates. It is unclear whether and to what extent the legislature could subsequently address or resolve these questions given the breadth of the initiative language and the 2/3 vote requirement to make changes to it. If enacted, the initiative will likely require reconciliation -- of the relative roles and responsibilities of DMHC, CDI and Covered California, and between the Proposition 103 rate standards and existing California health insurance rate review standards.

The actual impacts of the initiative, if passed, cannot be known until CDI implements and interprets its provisions. Based on the plain reading of the initiative, and the sweeping authority delegated to the insurance commissioner, it most certainly will make health insurance regulation in California, and the respective roles and responsibilities of CDI, DMHC and Covered California, more complex and uncertain at this critical juncture of historic and unprecedented change for health insurance and health care in the state.

I appreciate the opportunity to testify today and would be happy to answer any questions.

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