Guidelines for Health Insurers Requesting Rate Increase Issued by California Insurance Commissioner (SB 1163)

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On February 4, 2011, California Insurance Commissioner Dave Jones released draft guidelines for implementing SB 1163 ("Guidance 1163:2").

SB 1163, signed by former Governor Schwarzenegger on September 30, 2010, responds to the federal Patient Protection and Affordable Care Act ("PPACA"), which requires the United States Secretary of Health and Human Services to establish a process for the annual review of "unreasonable" increases in premiums for health insurance coverage.

Under the federal act, health insurers must submit to the secretary, and the relevant state, a justification for an "unreasonable" premium increase prior to implementation of the increase.

SB 1163, effective January 1, 2011, requires health insurers to file with the California Department of Managed Health Care or the California Department of Insurance detailed rate information regarding proposed premium increases and requires that the rate information be certified by an independent actuary.

The bill authorizes the departments to review these filings and issue guidance regarding compliance. It also requires the departments to consult with each other regarding specified actions as well as post certain findings on their Internet Web sites.

In his draft guidelines ("Guidance 1163:2"), Commissioner Jones lists several factors that will be used by the Department to determine if a rate is "unreasonable."

Under Section A: Unreasonable Rate Increases, the first factor the Department will look at is:

[t]he relationship of the projected aggregate medical loss ratio to the federal medical loss ratio standard in the market segment to which the rate applies, after accounting for any adjustments allowable under federal law." (Guidance 1163:2, § A, p. 1.)

The draft guidelines expressly incorporate, by reference, the interim federal regulation effective January 1, 2011, titled "Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act," 45 C.F.R. §§ 158.101-158.232.

The interim federal regulation requires health insurers to spend a certain percentage of consumers' premiums on direct care for patients and efforts to improve health care quality.

For individual and small group market insurers, this is 80% of the consumers' premium, and for large group market insurers, it is 85% of the consumers' premium.

If insurers fail to meet the ratio requirements, beginning in 2012, they will be required to provide a rebate to their customers by August 1 of each year.

The federal rule allows for a State to require a higher medical loss ratio than that required under the interim regulation. The interim federal regulation (pdf), published December 1, 2010, is subject to a 60-day public comment period.

Other factors identified in Commissioner Jones' draft guidelines to determine whether a premium increase is "unreasonable" include:

- Whether the assumptions for the rate increase are supported by substantial evidence;
- Whether the choice of assumptions or combination of assumptions for the rate increase is reasonable;
- Whether the data or documentation provided is incomplete or inadequate;
- Whether the filed rates result in premium differences between insureds within similar risk categories that either are not permissible under California law or do not reasonably correspond to differences in expected costs;
- Whether itemized changes are substantially justified by credible experience data;
- Rate of return for prior three years and anticipated for the following year;
- Insurer's employee and executive compensation;
- Degree to which the increase exceeds rate of medical cost inflation;
- For individual policies, compliance with 10 C.C.R. 2222.12. (Guidance 1163:2, § A, pp. 1-2.)

In addition to Filing and Notice requirements as well as specific filing forms (Sections B and D Guidance 1163:2), the draft guidelines contain several requirements for actuarial certification. Each of the following must be included in the actuarial certification:

- The actuary's qualifications and independence;
- Opinion that the proposed premium rates are "actuarially sound in the aggregate;"
- Complete description of data, assumptions, rating factors and methods with rate calculations for each contract or policy form;
- Statement of opinion whether the rate increase is reasonable or unreasonable, and if, the latter, the justification for the increase; a discussion of the factors listed in § A, and 10 C.C.R. § 2222.10 for individual health insurance;
- A description of the testing performed by the actuary. (Guidance 1163:2, § C, pp. 3-4.)

Notwithstanding the above requirements, the Insurance Commissioner currently does not have the authority under SB 1163 to reject health insurance rate increases.

In the last legislative term, Commissioner Jones (formerly an assemblyman) sponsored AB 2578, a strong insurance rate reform bill that would have given the Commissioner such authority (it failed to pass in the Senate).

The Commissioner is currently supporting another effort at such legislation.

Commissioner Jones' draft guidelines are subject to a 7 day public comment period before they are finalized.