California AB 52: Rate Increase Regulation on the Horizon

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On June 2 the California Assembly passed legislation that would subject health care coverage to the same oversight and rate approval process that currently applies to home, auto and property/casualty insurance in the state. AB 52, which Rep. Mike Feuer (D. Los Angeles) introduced in December 2010, now moves to the Senate for approval. It needs 20 votes to win in the Senate which means that all but 5 of the 25 Democratic senators must approve the bill, presuming (as is expected) that all of the 15 Republican state senators will not support the measure.

AB 52, if passed as currently drafted, would add California to the list of more than 30 states that directly regulate health care rate increases. ("Rate" for these purposes would include premiums, base rates, underwriting relativities, discounts, copayments, coinsurance, deductibles, and any other out-of-pocket costs.) Current law allows the California Department of Insurance or the Department of Managed Health Care (governing HMOs) to review proposed rate increases and publicly to contest what they view as excessive increases, but do not empower those agencies to prevent a rate increase from happening. An example of this process happened early last year when Anthem Blue Cross proposed rate increases of up to 39%; the resulting tsunami of negative attention (which included a letter of protest from Kathleen Sibelius, the Secretary of Health and Human Services (HHS)) eventually caused Anthem to withdraw the proposed increases.

Under AB 52, insurers and HMOs would be required to submit proposed rate increases for review and approval to the Department of Insurance or DMHC (collectively, the "agencies") at least 60 days before the increases are to go into effect. The disclosures required in the application are very extensive, and run to over 40 discrete categories of information (including the salaries of the 10 highest paid company executives) in the case of a proposed increase in rates for a large group market product. Disclosures for rate increases in the individual and small group market are slightly less burdensome, running to "only" 18 categories of information.

These applications will be made public by the agencies through posting on their websites, with the exception of certain financial items needed to be protected from competitors, such as contracted rates between a carrier and a provider. The agencies will also notify major statewide media of the filing of an application, as well as any individuals who sign on to a mailing list the agencies will maintain.

An agency must grant, deny or modify a proposed rate increase within 60 days from the date the application information publicly is posted, unless the applicant agrees to waive the response deadline, or in the event that the agency schedules a public hearing on the application. In the latter event, the agency will have 100 days from the hearing to issue a decision. Public hearings automatically are required for proposed rate increases that would exceed 10% of the amount of the current rate, or would exceed 15% for any individual subject to the rate increase. Additionally, an individual enrollee or his or her representative may request a public hearing on an application; the agency has the discretion to grant or deny the request but must issue written findings in the event the request is denied. AB 52 would allow consumers who successfully challenge rate increases to recoup, from carriers, legal and other fees incurred in the challenge process.

If, upon review of an application, the agency determines a proposed fee increase is "excessive, inadequate or unfairly discriminatory," it can deny or modify the proposed increase. AB 52 does not define the key terms "excessive, inadequate or unfairly discriminatory," leaving this language to be defined in regulations that are to be issued by January 1, 2013.

Funding for implementation of AB 52 will come in part from the federal government, by virtue of PPACA. For each of the next three years, California will collect $3 million in federal funds set aside for state rate review programs. Other funding would come from civil penalties imposed against carriers

who violate the rate review and approval requirements, and from application fees the agencies may impose on carriers.

If enacted, AB 52 would apply to policies and HMO contracts going into effect on or after January 1, 2012. However, it also would allow agencies retroactively to disallow or modify rate increases that went into effect between January 1, 2011 and January 1, 2012, and to order refunds to policy holders if those rate increases are determined to be excessive. Certain plans or policies are exempt from AB 52, including dental- or vision-only policies, Medicare supplement contracts, and contracts offered in the California MRMIP and federal temporary high risk pools.

Needless to say, insurers and HMOs are dead set against AB 52 becoming law and are lobbying heavily against it. Other AB 52 opponents include the pro-business and medical industry interest groups including the California Chamber of Commerce, California Hospital Association, Association of California Life & Health Insurance Companies, California Medical Association, California Association of Health Plans, and the California Association of Physician Groups. (Source: www.calhealthplans.org).

I will continue to track AB 52 through the Senate and provide updates on its progress.

In related news on the federal level, final regulations on review of "unreasonable" premium increases were published in the Federal Register on May 23, 2011. Beginning September 1, 2011 the regulations require review by the Centers for Medicare and Medicaid Service ("CMS") of any rate increase under which the average increase for all enrollees, weighted by premium, is 10% or more. Beginning in September 2012, the 10 percent threshold will be replaced by state-specific thresholds. The regulations only apply to individual and small group health insurance, and do not apply to grandfathered group health plans, self-funded plans, or to dental or vision-only coverage.

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