



STATE OF CALIFORNIA  
DEPARTMENT OF MANAGED HEALTH CARE

May 18, 2010

Mr. Steve Ostlund  
Chair, Accident & Health Working Group  
c/o National Association of Insurance Commissioners  
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Kansas City, Missouri 64108-2662

Mr. Lou Felice  
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c/o National Association of Insurance Commissioners  
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**RE: PREMIUM REVIEW PROCESS; REQUEST FOR COMMENTS REGARDING  
SECTION 2794 OF THE PUBLIC HEALTH SERVICE ACT**

Dear Messrs. Ostlund and Felice:

The California Department of Managed Health Care (DMHC or Department) appreciates the opportunity to respond to the National Association of Insurance Commissioners (NAIC) regarding the request for information promulgated by the Department of Health and Human Services (HHS) with respect to premium review processes. For ease of reference, the DMHC's draft responses to HHS's questions are attached hereto as **Appendix 1**. Please note that the attached Appendix 1 represents the DMHC's preliminary thoughts regarding HHS's questions; we will provide further and more detailed information and analyses as needed.

We have a number of questions that remain unanswered including federal expectations for state participation in the process of collecting premium information, reviewing premium filings and

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enforcement activities as well as how such activities will be reimbursed by the federal government. It is imperative that any state administrative costs for this activity be borne by the federal government and not passed on to California policyholders through higher assessments on insurance premiums.

## **Background**

In California, the health insurance market is regulated by two separate agencies—the DMHC and the California Department of Insurance (CDI). The DMHC oversees health care services for more than 21 million insured Californians, regulating 108 health care service plans (health plans or plans) and certain preferred provider organization products operating in California. CDI regulates all other indemnity health products and touches approximately 2.5 million lives covered by CDI-regulated health insurance products. Another approximately 6.8 million lives are covered by Administrative Service Organization products regulated by CDI.

Of the DMHC’s regulated entities, 54 are full-service plans covering hospital, medical, and surgical services. The remaining plans are “specialized” plans, which cover dental, vision, behavioral or mental health, and chiropractic services. The plans regulated by the DMHC are governed by the California Knox-Keene Health Care Service Plan Act of 1975<sup>1</sup> (Knox-Keene Act or Act) and the regulations thereunder.

As discussed in detail in Appendix 1, although the Knox-Keene Act empowers the DMHC to enforce many standards to protect consumers, the Act provides the DMHC with limited scope and authority regarding premium rates. In fact, section 1367 of the Act expressly states, “Nothing in this section shall be construed to permit the director to establish rates charged subscribers and enrollees for contractual health care services.”

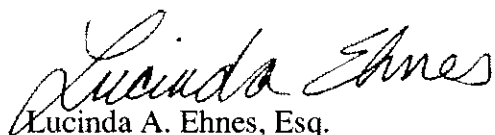
Despite this broad, general proscription against establishing rates, as discussed in detail in Appendix I, the Act provides certain mandates regarding how premium rates for some types of limited products must be calculated. For example, current California law requires health plans to use certain rating methods when calculating premium rates for small employer (2 to 50 employees) group coverage. Health plans must also comply with specific statutory limits on premium rates for individual conversion coverage products. However, in each of these limited circumstances, the Knox-Keene Act provides the specific rating methods and rate limitations applicable; the DMHC’s authority in those instances is limited to determining whether the rates comply with the methodology or rate limits specified in the Act.

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<sup>1</sup> California Health and Safety Code section 1340 et. seq.

Thank you for this opportunity to provide input regarding the NAIC's response to HHS's request for information. Should you have any questions, please do not hesitate to contact Sarah Ream or Gary Baldwin, both Senior Counsels in the DMHC's Office of Legal Services, at (916) 322-6727 or [sream@dmhc.ca.gov](mailto:sream@dmhc.ca.gov) and [gbaldwin@dmhc.ca.gov](mailto:gbaldwin@dmhc.ca.gov), respectively.

Sincerely,



Lucinda A. Ehnes, Esq.

Director

California Department of Managed Health Care

SR:sr

Enclosure: Appendix 1

## **Appendix 1—DMHC’s Draft Response to HHS’s Request for Rate Review Information**

For ease of reference, HHS’s questions are set forth below in bold, with the DMHC’s respective responses thereto.

### **A. Information Regarding Regulatory Guidance**

#### **1. Rate Filings and Review of Rate Increases**

##### **a. To what extent do States currently have processes in place to review premium rates and rate increases?**

The Knox-Keene Act generally prohibits the DMHC from establishing the rates charged to subscribers and enrollees for contractual health care services. However, with respect to a few limited types of products, the Act dictates the methodology by which allowable rates must be calculated.

First, the allowable premiums for the Health Insurance Portability and Accountability Act (HIPAA) Guaranteed Issue (GI) products are limited based on the premiums charged to similarly situated enrollees in California’s Major Risk Medical Insurance Program (MRMIP), which is California’s high risk pool. Specifically, for enrollees in a preferred provider organization (PPO), the maximum HIPAA GI premium may not exceed the average premium paid by a MRMIP enrollee who is of the same age and resides in the same geographic region as the HIPAA enrollee.<sup>2</sup> For HMO enrollees, the maximum HIPAA premium cannot exceed 170% of the standard premium charged for a MRMIP enrollee who is of the same age and resides in the same geographic region as the HIPAA enrollee.<sup>3</sup>

Second, a plan may not vary the premium rates for any particular small employer (2-50 employees) group by more than 20% based on specific risk factors of the employees.<sup>4</sup> The risk factors a plan can consider are employees’ age (but limited to age bands<sup>5</sup>), family size<sup>6</sup>, and geographic region within the state.<sup>7</sup>

The DMHC’s review of small group rates is limited to verifying compliance with the above-defined standards. Generally, an actuarial certification of compliance is provided with the small group rate filings. Also, the Knox-Keene Act’s allowable review does not include a comparison of rates from the prior year to assess rate increase for small employer groups.<sup>8</sup>

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<sup>2</sup> California Health and Safety Code section 1399.811, subdivision (a)(1).

<sup>3</sup> California Health and Safety Code section 1399.811, subdivision (a)(2).

<sup>4</sup> California Health and Safety Code section 1357.12, subdivision (a)(1).

<sup>5</sup> The allowable age bands are: under 30, 30-39, 40-49, 50-54, 55-59, 60-64, and 65 and over.

<sup>6</sup> The allowable family size categories are: single, married couple, one adult and child or children, and married couple and child or children.

<sup>7</sup> A plan that operates state-wide may have no more than nine geographic regions in the state. Plans also must not divide a county into more than two regions.

<sup>8</sup> In addition to the rate limits discussed above, health plans must also comply with certain statutory limits on premium rates for individual conversion coverage (Health & Safety Code § 1373.621) and Cal-COBRA products.

**1. What kinds of methodologies are used by States to determine whether or not to approve or modify a rate or a rate increase? What are the pros and cons of these differing methodologies?**

As stated above, the DMHC currently does not have authority to approve most rates or rate increases. However, with respect to small employer group rates, over which the DMHC has authority to confirm that the rates comply with statute, plans file their rates as amendments to their license applications and are not required to obtain DMHC approval prior to use.

Rate filings for HIPAA GI products are also submitted to the DMHC as amendments to the plans' license applications. If the DMHC finds that a HIPAA GI rate filing does not comply with applicable law, the DMHC will ask the plan to modify its rates to be in compliance.

**2. Are special considerations needed for certain kinds of plans (for example, HMOs, high deductible health plans, new policies, and closed blocks of business)? If so, what special considerations are typically employed and under what circumstances?**

As discussed above, under current state law the DMHC does not have, except in very limited circumstances, the authority to approve or disapprove rates, and, where the DMHC does have limited authority, that authority extends only to ensuring the plans followed the rate calculation methodology set out in statute.

**b. Where applicable, do health insurance issuers currently provide actuarial memorandums and supporting documentation relating to premium rate calculations, such as trend assumptions, for all premium rates and rate increases that are submitted, and/or for all premium rates and rate increases that are reviewed?**

The Knox-Keene Act's implementing regulations require new plan applicants to provide the methods, facts, and assumptions to support their premium rates. Likewise, small employer group rate filings and rate filings for HIPAA GI products generally are accompanied by an actuarial memorandum; however, such memoranda are typically limited to demonstrating compliance with the applicable statutory sections.

**1. How is medical trend typically calculated?**

The Knox-Keene Act does not include requirements relating to medical trend calculations.

- 2. Are specific exhibits, worksheets or other documents typically required? If so, are these documents generally submitted to the State Insurance Department directly, and if so, in what format?**

The Knox-Keene Act does not require any specific format for plans to file their HIPAA GI and small employer group rates. However, plans generally file these rates with the DMHC by submitting an explanatory cover letter along with the rate charts broken out by age, family size, and geographic areas.

- 3. To what extent do issuers use the following categories to develop justifications for rate increases: cost-sharing, enrollee population including health risk status, utilization increases, provider prices, administrative costs, medical loss ratios, reserves, and surplus levels? Are there other factors that are considered?**

Plans are not required to file justifications for rate increases unless their HIPAA GI or small employer group rates are found to be out of compliance with the standards discussed in section A.1.a., above.

- c. What level(s) of aggregation (for example, by policy form level, by plan type, by line of business, or by company) are generally used for rate filings, rate approvals, and any corrective actions? What are the pros and cons associated with each level of aggregation in these various contexts?**

As discussed above, with the exception of HIPAA GI and small employer group rates, health plans are not required to file their rates with the DMHC for approval. HIPAA GI and small employer group rates are broken out by region, product type, enrollee age, and family status (single, married, etc.).

- d. What requirements do States currently have relating to medical trend and rating calculations? What are the pros and cons of these different requirements, and what additional requirements could potentially be set?**

No comment at this time, as the Knox-Keene Act does not currently have requirements relating to medical trend or rating calculations.

**1. Do States generally allow enrollees under the same policy form to be further subdivided for purposes of calculating medical trends and rates?**

No comment at this time, as the Knox-Keene Act does not currently have requirements relating to medical trend or rating calculations.

**2. Do States generally allow enrollees under different policy forms to be grouped together for these calculations, and if so, how?**

No comment at this time, as the Knox-Keene Act does not currently have requirements relating to medical trend or rating calculations.

**2. Defining Unreasonable Premium Rate Increases**

**a. In States that currently have rate review processes, are all rates or rate increases generally reviewed? If so, for what markets and/or products? If not, what criteria do these States typically use when determining which rates or rate increases will be reviewed? To what extent do States require that these reviews take place before the proposed rate increases can be implemented?**

Under current law, the DMHC does not have authority to review rate increases. Rather, as discussed above, the DMHC's rate review authority is limited to verifying compliance with the statutory requirements for small employer group and HIPAA GI products.

**b. To what extent have States developed definitions of what constitutes a premium rate increase warranting review?**

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rate increases.

**3. Public Disclosure**

**a. To what extent is information on premium rates and premium rate increases, and related justifications, currently made available to the public?**

As required by California law, the DMHC posts on its public website the HIPAA GI rates charged by the various plans offering such coverage.

- 1. To what extent are annual summaries of premium rate increases currently made available to the public on State or consumer websites, and/or made available by request? Where available, to what extent is this information generally provided by policy form, type of product, line of business, or some other grouping?**

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rate increases.

- 2. To what extent are rate filings with actuarial justification and supporting documentation generally made available to the public? In what format(s) are rate filings currently made available to the public? What format(s) would be most useful to the public?**

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rates or rate increases, apart from the limited review of HIPAA GI and small employer group products, as discussed above.

- 3. What kinds of supporting documentation are necessary for consumers to interpret these kinds of information?**

The Knox-Keene Act does not currently authorize the DMHC to review rates or rate increases, apart from the limited review of HIPAA GI and small employer group products, as discussed above. However, consideration should be given to whether annual summaries of premium rate increases might be helpful to the public and, if so, what information might be included in such a summary (e.g., types of products offered, lines of business engaged in by a plan).

- b. What kinds of information relating to justification for an unreasonable premium increase could potentially be made available?**

Please see response to 3.a.3., above.

#### **4. Exclusion from Exchange**

- a. To what extent have States developed definitions of what constitutes an excessive or unjustified premium rate increase and/or a pattern or practice of such increases? How could a pattern or practice of excessive unjustified premium increases be defined in this context, and what are some of the pros and cons of the various approaches that are available?**

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rates or rate increases, apart from the limited review of HIPAA GI and small employer group products, as discussed above.

- b. What criteria could be established to determine whether insurers have engaged in a pattern or practice of excessive or unjustified premium increases?**

No comment at this time, as the Knox-Keene Act does not currently authorize the DMHC to review rates or rate increases, apart from the limited review of HIPAA GI and small employer group products, as discussed above.

## **5. Grant Allocation**

- a. What factors could be considered in grant allocation?**

Possible factors for grant allocation might include the number of fully insured (vs. self-insured) individual and group enrollments, participating issuers and products in the state. However, consideration should be given to whether a minimum grant amount should be provided to support the establishment of a rate review system for those states that have fewer enrollees and participating issuers.

- b. What weighting could be given to different factors and why?**

More weight may need to be given to the number of participating issuers in the state and other factors that trigger more rate filing reviews.

## **B. Information Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act**

- 1. What policies, procedures, or practices of health insurance issuers and States may be affected by Section 2794 of the PHS Act?**

For regulatory agencies, such as the DMHC, which have limited authority to review rates, Section 2794 may pose significant new review requirements.

- a. What direct or indirect costs and benefits would result?**

Benefits might include a greater understanding of the cost drivers in the current system that result in premium rate increases and greater scrutiny of premium increases. Costs might include additional compliance costs for issuers and regulators.

- b. Which stakeholders will be impacted by such benefits and costs?**

Impacted stakeholders likely will include health plans, insurance issuers, regulators, enrollees, employers, providers and related industries.

**c. Are these impacts likely to vary by insurance market, plan type, or geographic area?**

It is unclear as to what the impacts will be; however, individual and small group markets, as well as areas that currently have a high uninsured population, may be impacted.

**2. Are there unique costs and benefits for small entities subject to Section 2794 of the PHS Act?**

**a. What special consideration, if any, is needed for these health insurance issuers or plans that they sell?**

No comment at this time, as it is unclear what special considerations, if any, will be needed.

**b. What costs and benefits have issuers experienced in implementing requirements relating to rate review under State insurance laws or otherwise?**

This question is not applicable to the DMHC given the DMHC's limited rate review authority.

**3. Are there additional paperwork burdens related to Section 2794 of the PHS Act, and, if so, what estimated hours and costs are associated with those additional burdens?**

Plans will likely incur increased paperwork and costs associated with obtaining regulatory approval of rate changes. Additional costs to the states for performing rate reviews and approvals may also result, including additional cost to hire more actuaries, financial examiners, and legal staff. Accurate estimates of such possible additional costs are not available at this time.

The DMHC currently uses an electronic filing system for most plan filings. However, the hours and costs associated with hiring additional experienced staff to conduct rate reviews could be significant.