STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
EXECUTIVE OFFICE
300 CAPITOL MALL, SUITE 1700
SACRAMENTO, CA 95814
(916) 492-3500
(916) 445-5280 (FAX)
www.insurance.ca.gov

Dave Jones, *Insurance Commissioner*

July 17, 2014

Peter Lee
Executive Director
Covered California
1601 Exposition Blvd
Sacramento, CA 95815

Dear Mr. Lee:

At Covered California's June 19, 2014 Board meeting, your staff detailed a list of questions they had developed about the Insurance Rate Public Justification and Accountability Act (known as Proposition 45). At the July 2, 2014 joint hearing of the Senate and Assembly Health Committees the Department of Insurance provided detailed written answers to each of those questions to Covered California and the Committees. Attached is another copy of the detailed written answers to your questions.

After multiple attempts to pass health insurance rate regulation through the Legislature, California voters now have the opportunity to decide whether to adopt health insurance rate. Proposition 45 gives the Insurance Commissioner the authority to regulate individual and small group market rates. If the voters pass Proposition 45, the Department of Insurance will work closely with Covered California as we implement the law that would give us the authority to prevent excessive health insurance rates. The Department of Insurance and Covered California have worked closely together to ensure that the Affordable Care Act is successfully implemented in California. I look forward to the prospect of working with Covered California on implementation of Proposition 45 if the voters pass it in November.

The Department of Insurance has a twenty-five year history of successfully implementing and enforcing rate regulation for property and casualty insurance after the voters approved Proposition 103 in 1988. The Department has reviewed Proposition 45, including the intervenor and hearing provisions, and concluded that it can be implemented consistent with the Affordable Care Act and without delays to open enrollment for health insurance and HMO products sold on and off of California's Exchange, Covered California.

Sincerely,

DAVE JONES
Insurance Commissioner

Covered California Questions	California Department of Insurance Responses
IV. Implementation Questions - Rules & Procedures Potentially Impacting Operations	
1) Timeline of Review for Rates Without a Hearing	
a) How does review under two regulators proceed?	All health insurance and HMO rate increases are filed with the Department of Insurance (CDI). The Department of Managed Health Care (DMHC) retains its current advisory role with regard to rates for its licensees and would also receive its licensee's rate filings until such time as the Legislature decides otherwise. DMHC can and should provide input into the CDI rate regulation process. DMHC would make its review of proposed rates available to CDI to consider, in the timelines established by CDI to meet the deadlines associated with open enrollment for on and off exchange health insurance and HMO product offerings. CDI would determine the rates and those rates would be provided to Covered California in time to meet the deadlines associated with open enrollment.
b) Does the Insurance Rate Act change the timeline within which CDI would conduct rate oversight compared to the current rate review timeline?	Yes. The Insurance Commissioner is empowered by the Act to issue any rules necessary to implement his or her prior approval authority -- including new timelines needed to make sure that the timing of rate regulation is consistent with the deadlines associated with offering health insurance and HMO products on and off the Exchange. The Department of Insurance has reviewed the Insurance Rate Public Justification and Accountability Act ("Act") and concluded that CDI can accomplish rate regulation with intervenors and hearings in time to meet deadlines associated with the sale of health insurance on the Exchange (Covered California) and off the Exchange.

c) If the CDI rate approval results in a change to rates, benefits or has an effect on other element of the plans operations (e.g., networks, solvency), to what extent do the changes require new licensing review on the part of the DMHC if the plan is subject to its regulatory oversight?	The Act does not authorize the Insurance Commissioner to alter benefits or other elements of plans' operations (e.g. networks). The Act only authorizes the Commissioner to approve or deny rates. Licensees subject to DMHC regulatory review would continue to submit policy forms and networks to DMHC. Under existing law, if either regulator finds that benefits offered or networks filed are inadequate or otherwise fail to comply with the law, the licensee can be required to revise its policy forms and networks to reflect changes needed to comply with law and, to the extent these changes have a rate impact, modify their rate filing. Currently, policy form, network adequacy, and rate reviews occur contemporaneously and such would continue to be the case under the Act. If a DMHC licensee is required by DMHC to revise its benefits or networks, these changes would be reported to CDI and an adjustment made to the rate as part of the rate regulation process if there is a rate impact. This is how DMHC and CDI policy form and network adequacy interacts with rate review currently and how it would continue to interact with the enactment of the Act. As Covered CA has noted, both DMHC and CDI have negotiated rate modifications under the current rate review process, including rate modifications for products sold through Covered CA. Rate approval by CDI cannot change benefits, or affect other elements of a plan's operations.

d) What actions by intervenors are permitted if the CDI decides to not hold a hearing, and what effects could these actions have on the timeline to approval for rate change applications that do not go to a hearing?	Intervenors, whether they are granted a hearing or not, will not delay the timeline for CDI to approve rates in time for the offering of health insurance and HMO product on and off the Exchange. CDI has reviewed the Act and the intervenor and hearing provisions and concluded that intervention with or without hearings can be accommodated in time to meet timelines associated with the offering of health insurance and HMO products through Covered CA and outside Covered California (on and off Exchange). If an intervenor's request for a hearing is denied, CDI makes a rate decision without a hearing which is final and takes effect. An intervenor could challenge that denial in court, but the filing of a lawsuit does not stay the rate from going into effect. Since the rate has already taken effect, such a court challenge would have no impact on the timeline for rate approval. Long established and well settled California law provides that the Commissioner's decision with regard to a rate is given great deference by the court and anyone bringing a legal challenge has to overcome the highest legal burden (abuse of discretion) to challenge the rate determined by the Commissioner. That is why, notwithstanding CDI receives approximately 7,000 property and casualty filings a year under Proposition 103, there have been only two lawsuits actually litigated to challenge the Commissioner's rate decision in the last ten years and the Commissioner won those lawsuits. While those lawsuits were pending, the rate approved by the Commissioner remained in effect, as would be the case for health insurance and HMO rates decided by the Commissioner under the Act.

e) To what extent are the timing and processes for review of rates without hearing subject to clarification by regulations that will be issued subsequent to passage of the Insurance Rate Act or litigation to construe how to interpret the Act?	CDI has the authority to adopt regulations necessary to implement the Act, including all timelines and processes for regulation of rates. Emergency regulations can be issued immediately. Procedural regulations have never been challenged to our recollection, because the Commissioner is given great deference under California law in promulgating procedural regulations necessary to effectuate law enacted by the voters or the Legislature. Litigation does not stay automatically implementation of regulations issued by the Commissioner.
2) Timeline of Review for Rates with a Hearing	
a) Will all health insurance filings over 7% be subject to mandatory hearing upon timely request by intervenors and what are the likely timelines for such hearings?	Yes, intervenors are only entitled to a hearing under the Act where a rate filing exceeds 7%, which should substantially limit the number of hearings which are required to be held. But even those rate filings where there is a right to a hearing can be and in almost all cases are resolved without proceeding to a full hearing. A settlement can be reached between the intervenor, insurer and Department actuaries which is then independently reviewed and approved by the Commissioner. That is how almost all Proposition 103 rate filings with intervenors are resolved. In fact, although the Department of Insurance receives 7,000 rate filings a year, there are only on average 12 intervenors a year, which is .2% of all filings have an intervenor. And there have been only a very limited number of full blown hearings with the rate decided after hearing by the Commissioner in the last ten years. Hearings are extremely rare. As noted above, the Commissioner has authority to set necessary timelines to meet deadlines associated with the offering of health insurance and HMO product inside and outside the Exchange. CDI has reviewed the Act and the timelines for intervenors and hearings and concluded that even if more hearings are required than has been the experience under Proposition 103, CDI can hold those hearings and decide rates in time to meet timelines associated with the sale of health insurance and HMO product inside and outside the Exchange.

b) Can health filing review hearings proceed on a shorter timeframe than those currently used for Proposition 103 hearings in the property and casualty context?	Yes, the timeframes will be much shorter for health insurance rate regulation that those used for rate regulation of property and casualty insurance. The comparison of timelines associated with property and casualty insurance to health insurance rate regulation timelines is an inappropriate comparison for numerous reasons. First, there are 7,000 property and casualty filings a year. There will be less than 100 health insurance and HMO rate filings a year. Second, there are over 500 property and casualty insurers. There are only 40 or so health insurers and HMOs. Property and casualty insurance rates can be filed more than once a year, while health insurance individual market rates can only be filed once a year. The rating factors for health insurance are far fewer and less complex than the rating factors for property and casualty insurance. For all these reasons and more, property and casualty insurance rate regulation timelines cannot be used to determine the time it will take to accomplish health insurance rate regulation. The Commissioner has and will set new timelines for health insurance regulation consistent with timelines needed to offer on exchange and off exchange product.

c) What happens to a rate filing while it is undergoing administrative review? What about judicial review?	The rate approval process is "administrative review." A rate does not take effect until administrative review is complete. Rates "shall be approved by the commissioner prior to their use" Sec. 1861.17. A rate takes effect after the administrative review is complete. A rate is deemed to take effect if there is no action in 60 days. There is no judicial review unless a lawsuit is filed. The rate approved remains in effect during judicial review, until such time as the court changes the rate. Again, there have been only two lawsuits actually litigated in ten years despite 7,000 property and casualty filings a year under Proposition 103. And the Department won those lawsuits. The courts are required to give great deference to the Commissioner's rate determination and litigants face the highest possible legal burden to challenge the decision. And during the pendency of that lawsuit the rate approved remained in effect.
d) At what point(s) in the hearing or review process would Covered California and health plans know that rates proposed for the coming year would not be able to be approved for the next plan year pending the review process? If rates cannot be approved pending the hearing, at what point would the determination be made that last year's rates would need to apply for open enrollment and next year's full special enrollment period?	There will be no rates that are not approved in time for on exchange or off exchange product, including those requiring a hearing. CDI has reviewed the Act and its intervenor and hearing provisions and concluded that it can review and determine all rates, including those with intervenors and hearings, in time to meet on-exchange and off-exchange deadlines. As noted above, a judicial challenge to a rate approval would not prevent a final rate decision from taking effect.
e) To what extent are the timing and processes for review of rates with a hearing subject to clarification by regulations that will be issued subsequent to passage of the Insurance Rate Act or litigation to construe how to interpret the Act?	CDI has the authority to adopt regulations necessary to implement the measure, including all timelines and processes for regulation of rates.

f) What percentage of health insurance rates have historically been over 7% and potentially subject to a hearing? Is there data on the portion of rate increases that reflects underlying medical costs/trends?	CDI is not aware of a study or analyses of the number or percentage of health insurance rate filings over 7%. When Proposition 103 was passed, property and casualty insurers reduced the excessivity of their rate filings and as a result there were far fewer filings above 7%. In the last ten years there have only been a very limited number of full blown hearings where the hearing officer reached a decision which then went to the Commissioner for final decision, despite 7,000 filings a year. For health insurance and HMO product, there are fewer than 100 filings a year and even if a high percentage of these limited number of rate filings are over 7%, the Commissioner can hold hearings and reach rate decisions quickly enough to accommodate the timelines associated with offering products on and off the exchange. With regard to the portion of rate increases associated with medical costs and utilization trend, it varies by product, by carrier and by filing.
3) Any Rate Change If the Rate Is Not Approved in Time for Open Enrollment	
(options if a rate change is not approved in time for open enrollment)	CDI has reviewed the Act and the intervenor and hearing provisions and concluded that it will be able to determine rates with intervenors and hearings in time to meet open enrollment for health insurance and HMO product both on and off the Exchange. The remaining questions in this section are not answerable because they assume incorrectly that rate determinations cannot be made in time for open enrollment.
a) Can Covered California allow an issuer to sell last year's product at last year's rate?	This question assumes mistakenly that CDI will not be able to accomplish rate determinations in time for open enrollment. As CDI will determine rates, there is no need to consider whether an issuer can offer last year's rates in the current year's open enrollment, but it is the case that the rate remains in effect until a new rate is approved by CDI under the Act.

i. Could offering last year's product at last year's rate trigger a requirement to file a licensing review with the DMHC? If so, how long would this review take?	No. There is no additional licensing review other than what is already required by law whenever a health insurer or HMO changes its policy forms or networks. Assuming that last year's product continues to be sold in the current year at last year's rate, this does not trigger a new licensing review.
ii. What are the implications if last year's product is not compliant with new benefit mandates from the legislature?	Whenever there are new benefit mandates, the health insurers and HMOs must amend their policy forms to accomplish the new mandates. Those policy forms and networks would be filed with each regulator for review. The rates associated with those products would be filed CDI. CDI has reviewed the Act and concluded that with intervenors and hearings it can meet the timelines associated with open enrollment inside and outside the Exchange.
iii. What are the implications if last year's product is not compliant with new Covered California standardized benefit designs (implications for both Covered California and off-exchange products)? (For example, in 2015, Covered California encouraged plans to submit a standardized benefit design with an embedded pediatric dental benefit.)	If Covered California changes its standard benefit design, then the current year's products have to conform to that design and those policy forms and networks would be filed with the regulators for review. The rates associated with the current year policies under the new standard benefit design would be filed with CDI. CDI does not have authority under the Act to change the benefit design. CDI has reviewed the Act and concluded that with intervenors and hearings it can meet the timelines associated with open enrollment inside and outside the Exchange.
b) Can Covered California allow an issuer to sell the new year's product at last year's rate?	The health insurer or HMO will file rates with CDI. CDI will review those rates in time to meet open enrollment deadlines. The rate determined by CDI will be provided to Covered California. The health insurer or HMO will file rates with CDI. If it is a new product, it will not have a prior rate or a rate increase greater than 7% so there is no right to a hearing. CDI would review and determine the new product rate in time to meet open enrollment deadlines.

i. Would the regulators permit an issuer that does not have a new rate approved to offer the new product at the old rate?	Again, this question assumes incorrectly that CDI will not be able to approve rates in time for open enrollment. CDI has reviewed the Act and concluded that with intervenors and hearings it can meet the timelines associated with open enrollment inside and outside the Exchange. The question also does not make sense. If a new product is being offered, it does not have an existing or "old" rate because it is a new product. New products have a new rate, which while subject to prior approval by the Commissioner are not entitled to a hearing because there is no rate increase, let alone one of greater than 7% which would trigger a hearing.
ii. What would be the regulatory approval process for this product? Would the 60-day advance filing of the new product with the DMHC be sufficient if the rate were held to the last year's level?	If an identical product, no need for rate approval. If rates increase or benefits decrease that could trigger prior approval process.
c) Can a carrier decide to withdraw rather than offer a product at last year's rate?	There are specific rules for withdrawal of policies from the market that include specific time requirements of notice. We don't believe insurers can withdraw after open enrollment until the following plan year based on principles of contract law. CDI would not just reject a rate increase. It would order a rate that is not excessive. At that juncture, the carrier could withdraw from the market, but as the rate cannot by law be inadequate and it has to provide them with a reasonable return, administrative costs, and cover claims costs, there would be no economic reason to withdraw from the market because the carrier will be getting a rate that covers their costs and a reasonable return but which is not excessive. Based on our experience with rate regulation, carriers have not withdrawn products from the market when their excessive rate increases are rejected and a rate is approved that is not excessive.

i. Could an issuer choose to withdraw its Covered California product offering from the marketplace if its rates will not be ready in time for open enrollment? What consumer notice requirements would be in effect for the plan?	There will be no rates that are not approved in time for on exchange or off exchange open enrollment. CDI has reviewed the Act and its intervenor and hearing provisions and concluded that it can review and determine all rates, including those with intervenors and hearings, in time to meet on exchange and off exchange deadlines.
ii. If an issuer chose to withdraw from the market altogether, would it be required to provide 90 or 180 day notice to consumers, and at what point would carriers know that its proposed rates could not apply for the coming year to decide to withdraw?	There will be no rates that are not approved in time for on exchange or off exchange open enrollment. CDI has reviewed the Act and its intervenor and hearing provisions and concluded that it can review and determine all rates, including those with intervenors and hearings, in time to meet on exchange and off exchange deadlines. In the event of a withdrawal, current legal requirements would apply.
4) Implications of the Initiative for 2015 Plan Year	
a) To what extent, whether by regulatory action, hearing request or judicial action, would the portfolio of products being marketed for new and renewal enrollment for 2015 be subject to potential challenge that could require their removal or re-pricing?	The 2015 rates will not be subject to the Act's prior approval because the 2015 rates will be filed in 2014 before the ballot measure is voted on. None of the 2015 products are subject to potential challenge that could require their removal or re-pricing.
b) Would the transitional period contemplated by the Insurance Rate Act apply to rates that are planned to go into effect on January 1, 2015?	The 2015 rates will not be subject to the Act's prior approval because the 2015 rates will be filed in 2014 before the ballot measure is voted on. None of the 2015 products are subject to potential challenge that could require their removal or re-pricing.
V. Implementation Considerations - Impacts on Premium Assistance, Tax Credits, Standard Benefit Designs, Networks, and Quality Initiatives	
1) Premium Assistance Tax Credits	
a) What modeling can Covered California do to assess the potential impacts on federal subsidy and total net premium cost for its consumers?	To the extent that Covered California is doing such modeling now with rates that are filed for review with both regulators, Covered California will be able to continue to undertake such modeling.

b) When one or more rates are held or reduced, for subsidized consumers, what are the effects on the affordability of the plan that has its rates held or reduced?	If a rate is reduced, the level of federal taxpayer subsidy required to make that rate more affordable for a income eligible household is reduced.
c) When one or more rates are held or reduced, for subsidized consumers, what are the effects on the affordability of the plans that did receive approval for their new years rates due to an impact on the tax credits?	The federal taxpayer subsidy available to income eligible consumers will depend on the rate approved. If the rate is reduced, less government subsidy will be necessary. For health insurers where rates are reduced and less subsidy is needed, the amount of the subsidy paid to the insurer will be reduced of course, because less federal taxpayer subsidy is needed given that the rate itself was reduced. Without rate regulation, health insurers and HMOs are free to charge excessive rates, and a larger federal tax credit subsidy is then paid to them than would be needed under rate regulation. Health insurance rate regulation therefore will save federal taxpayer dollars and preclude health insurers from taking unnecessary advantage of those federal taxpayer dollars and from charging consumers excessive premiums. As state law limits individual market rate filings to once a year, the federal taxpayer subsidy will not change in mid-year.
d) Is there a basis to predict how frequently plans may have their rates kept constant for the year?	The question assumes incorrectly that rates in the individual market are filed more than once a year. Under the ACA, rates in the individual market can only be filed once a year. So by law the rates will be kept constant for the entire year, until the next years filing, assuming there is a change of rate sought in that filing.
2) Standard Benefit Designs, Networks, and Quality Initiatives	

a) To the extent that the proposed initiative's definition of rates include the authority to alter benefit designs and other elements of plan features, what is the effect for consumers comparison shopping of not having standardized benefit designs (either because rate review results in a modification to the design, or because an issuer ends up offering last years product)?	There is no authority in the Act to alter benefit designs or other elements of plan features. Consumers will not lose standard benefit design because CDI is not authorized to change standard benefit design or any benefit design. To the extent the insurer changes benefit design, that may have an impact on the proposed rate and so changes in benefit design are considered as a part of determining the rate, but CDI cannot change benefit design.
b) Does the proposed initiatives definition of rates include the authority to consider or alter networks? To the extent it does, what are the implications for DMHC licensure and oversight of network adequacy and timely access to care standards?	No. There is no authority in the initiative to alter networks. As such there is no impact on network adequacy or timely access to care standards.
c) What, if any, are the implications of the proposed initiative on Covered California's efforts to negotiate on a triple-aim framework, including efforts to assure network adequacy, promote quality and reduce health disparities?	There are no impacts on Covered California's efforts to negotiate for improved network adequacy, promote quality and reduced health disparities. Carriers are required by law to have adequate networks. If they do not, they can be required to add providers to their networks.
VI. Implementation Considerations Ð Impact on Operations	
1) Marketing and Outreach	
a) How early could Covered California go to market under the proposed ballot initiative?	Covered California will be able to offer products on the same timeline as it has done prior to the ballot measure.
b) If benefit designs may change shortly before open enrollment, how quickly can Covered California's Certified sales force and marketing adapt:	Nothing in the initiative gives the Insurance Commissioner the power to alter benefit designs.
i. Need and timeline to change IT tools like the Shop and Compare Calculator?	There will be no need to change these tools related to the ballot initiative.
ii. Need and timeline to modify training materials and communicate changes to call center representatives and certified sales force?	There will be no need to modify training materials that is related to the ballot initiative.
iii. Need and timeline to modify advertising copy that is already under development?	Covered California will not need to modify these based upon the ballot initiative.

2) Eligibility and Enrollment	
a) In order to ensure timely renewal notices, what is the last possible date for an approved rate to be finalized to allow for communication to consumers in time for the next year's open enrollment?	Rate can be determined under the same timelines used the previous year, so that renewal notices can be sent in a timely fashion.
3) Choice Structure and IT Systems	
a) How quickly can CoveredCA.Com (CalHEERS) adapt to the potential offering of multiple benefit designs? What programming is needed to accommodate the offering of non- standard designs?	The Act does not authorize the Commissioner to establish new benefit designs. It does not empower the Commissioner to change benefits. The ballot initiative will not impact these issues.