California Under Prop 45
A Look at Our Possible Future

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Presented by Mary Powers Antoine

nossaman.com
What is Proposition 45?

- Secretary of State official summary:
  - “Requires Insurance Commissioner’s approval before health insurer can change its rates or anything else affecting the charges associated with health insurance. Provides for public notice, disclosure, and hearing, and subsequent judicial review. Exempts employer large group health plans. Fiscal Impact: Increased state administrative costs to regulate health insurance, likely not exceeding the low millions of dollars annually in most years, funded from fees paid by health insurance companies.”

- Californians will vote in two weeks
Will Prop 45 pass on November 4?

- Democrat Dave Jones, who has endorsed Proposition 45, is on the ballot for a second term as Insurance Commissioner.
- Republican candidate Ted Gaines: Jones’s “power-grabbing support for rate control over health insurance would choke off the supply of medical care.”
- Senators Feinstein and Boxer endorse Proposition 45 (Wall Street Journal, 10/9/14)
The “Yes” Rhetoric

- “Health insurance premiums in California have increased 185 percent since 2002”
- “Five health insurance companies control 88% of the market”
- “At least 35 other states require insurers to justify and get approval for rate increases”
- “Prop 103 has saved drivers $100 billion since 1988”
The Facts: An Overview from Californians Against Higher Health Care Costs

- Gives Insurance Commissioner unprecedented, unchecked power
- Creates an entirely new bureaucracy dedicated to scrutinizing rates
- Researcher: Prop 45 would conflict with Covered California by undercutting its authority, taking a different regulatory approach to premium review, and disrupting deadlines
What Prop 45 Will Actually Do

- Adds a new statute, Cal. Ins. Code § 1861.17
- Current and future *individual* and *small group* health insurance rates become subject to the rate approval process established by Prop 103
Cal. Ins. Code § 1861.17 in Detail

- Overrides other laws to make health insurance rates proposed after November 6, 2012, subject to Prop 103 rate review
- Creates “ease-in” period for rates implemented on or before January 1, 2014
- Requires that insurers found to have excessive rates must pay refunds to consumers with interest
Cal. Ins. Code § 1861.17 in Detail

- Forbids health, auto and homeowners’ insurance to consider lack of prior coverage or credit history in determining eligibility or rates/premiums
- Grants CDI all necessary authority to implement these new provisions, including jurisdiction over health plans
Cal. Ins. Code § 1861.17 in Detail

- Imposes the same fees on health insurers that other insurers pay under Prop 103
Time Out: What *Are* Prop 103 Fees?

- Determined by Cal. Code Regs. tit. 10, § 2647.1, and billed quarterly
- Pegged to CDI’s *actual costs* of administering Prop 103 for the prior year, adjusted for projections re: next year
- Separate fee for each line of insurance
- Maximum fee in 2014 (for a line of insurance deriving premiums greater than $250 million): $154,500
- Another sample calculation: fee for derived premiums between $7 and $12 million: $10,815
Prop 103 Fee Schedule

*(current base rate=$309.00)*

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Cal. Ins. Code § 1861.17 in Detail (cont’d)

- Broadly defines “health insurance” and “rate” and exempts large group health insurance policies from all of Proposition 45’s provisions
Prop 103 Review Timeline

The statute and regulations impose the following timetable from the date of a carrier’s application:

- **45 days** for outside parties to notify CDI that they intend to intervene

- If CDI doesn’t challenge within **60 days**, rates deemed approved
Prop 103 Review Timeline (cont’d)

- **180 days** for CDI to make a decision on challenge to the filing or to start the hearing before an administrative law judge
- Interveners can appeal CDI’s decision to the California Superior Court
- No time limit on judicial proceedings
Prop 103 Review Timeline (cont’d)

- At least 30 days after a judicial decision for the Commissioner to approve or disapprove the carrier’s application for a rate change
Prop 103 Review: How Long Can It Take?

- A study of property and casualty insurance rate increase applications filed with CDI between 2005 and 2011 found that the average time between filing and resolution was approximately *four and a half months*.
Prop 103 Review: Who Are Interveners?

- Under Prop 45, interveners (“any person”) may:
  - review rate filings
  - demand additional information from the carrier
  - demand CDI hold an administrative hearing
  - file suit in Superior Court over the filing

- In the 5.6% of Prop 103 filings in which a third party intervened, the average time between filing and final disposition was nearly a year.
Prop 103 Review: Prior Approval Hearings

- Burden of proof is on the insurer to justify the rate change (Cal. Code Regs. tit. 10, § 2646.5)
- Insurer must present its evidence and witnesses first (Cal. Code Regs. tit. 10, § 2655.7)
Prop 103 Review: Prior Approval Hearings

- Hearings incorporate litigation features, such as:
  - discovery (including motions to compel) (Cal. Code Regs. tit. 10, §§ 2654.1 & 2655.1)
  - sworn witness testimony and cross-examination (Cal. Code Regs. tit. 10, § 2655.6)
  - post-hearing briefs (Cal. Code Regs. tit. 10, § 2657.1)
What about DMHC?

- For enrollees in individual or small group health plans, Prop 45 will add CDI rate review \textit{in addition to} DMHC’s reviews → dual process

- Plans subject to conflicting refund requirements - CDI is not limited by the MLR refund requirements of H&S Code § 1367.003(c) [will be point of litigation]

- CDI given all powers needed to enforce the statute, including the same authority for rate review granted to DMHC – conflict?
Unanswered Questions

- Uncertain how reviews by other agencies such as DMHC and DHCS (network adequacy, financial strength) would factor (or not) into CDI’s review

- Increased compliance costs may affect MLR, and become a further incentive to raise rates
Special Considerations

- MLR will take center stage as plans are required to justify rates publicly
- Expect interveners to challenge every line item
- Will lay open plans’ internal financial and operational cost calculations – subject to discovery and cross-examination (is your CFO prepared?)
Conclusion

“[S]hall not be amended, directly or indirectly, by the Legislature except to further its purposes by a statute passed in each house by rollcall vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.”
UPDATE: Narrow Networks and CA’s Fair Procedure Doctrine

- The common law doctrine of fair procedure protects against arbitrary decisions by private organizations under certain circumstances…. When the doctrine applies, private entities may not expel or exclude qualified persons without acting in a manner that is *substantively rational* and *procedurally fair*.

Physician sues private health insurer after “delistment” as a preferred provider

CA Supreme Court treats private insurance company as a quasi-public entity, extending fair procedures from hospital setting to private insurers with sufficient economic power

Fair procedures apply if “the insurer possesses power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine or a medical specialty in a particular geographic area, thereby affecting an important, substantial economic interest.”

At the heart of the matter…

- Previously confidential credentialing and contracting decisions based on legitimate and reasonable factors, including business and economic considerations, are now subject to scrutiny in an adversarial proceeding the results of which are subject to review by a court.

- The inquiry is “focused on the practical power of the entity in question to affect substantially an important economic interest.”
Nossaman recommended:

- Adopt a fair hearing procedure immediately
- Follow it
- Take credit on your next performance evaluation for saving the company $3 million (Potvin recovery)
Fast forward one year:

- Accountable Health Care IPA vs. Molina Healthcare of California, John C. Molina, James Novello and Does 1 through 25 No. BC551052 (Los Angeles Superior Court, filed July 9, 2014)
- Plan terminated IPA’s provider contract without cause
- Complaint contains many allegations stemming from defendants’ failed efforts to buy the IPA
Accountable Health Care IPA vs. Molina allegations:

- Five of nine causes of action include allegations of violation of Accountable IPA’s right to fair procedure
- Intentional interference with prospective economic advantage, negligent interference with prospective economic advantage, unfair business practices, violation of fair procedure, civil conspiracy
What Now?

▪ Adopt a fair hearing procedure immediately - at least for terminations – doesn’t have to be complicated
▪ Follow it
▪ Narrow networks may be particularly vulnerable to this challenge – must have rational basis for rejecting a provider (e.g., price)
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