

Rate Regulation in California: AB 2118 Makes Strides, But Falls Short of Comprehensive Rate Review

In the 2020 legislative session, the California legislature enacted AB 2118 to require insurance companies selling insurance plans in the individual or small group market in California to file additional information, including premiums, cost sharing, benefits, enrollment, and trend factors, with the state Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).[\[1\]](#) This new law reflects an effort to give state agencies better oversight of state healthcare markets by patching small holes in the rate review process of state regulators. However, the time may be ripe for more expansive rate review regulation to make a larger impact on controlling healthcare costs in the state. This post discusses existing rate review in California and how AB 2118 is yet another plodding step on the path to comprehensive oversight. We examine how other states use rate review to ensure affordability of health insurance and provide legislative recommendations for California that would authorize DMHC and CDI to use rate review to reduce healthcare costs in California.

What is Rate Regulation and How Has it Evolved?

Rate regulation is the process by which state departments of insurance (DOI) ensure that premiums charged by insurance companies are adequate to cover health expenses (or that premiums are sufficient to cover losses for other types of insurance, like fire insurance). Kansas passed the first rate

review law in 1909 that allowed its insurance commissioner to require changes to excessive or unjustified rate increases.[\[2\]](#) In 1944, Congress passed the McCarran-Ferguson Act (MFA) which exempted insurance from federal antitrust laws to the extent “regulated by state law.”[\[3\]](#) Following passage of the MFA, nearly every state passed a version of the National Association of Insurance Commissioners (NAIC) model law to allow state insurance commissioners to review rates using standards that require premiums to be adequate, not excessive, and not unfairly discriminatory.[\[4\]](#) Since that time, state governments have set health insurance laws and regulations. Furthermore, the Employee Retirement Income Security Act of 1974 (ERISA) explicitly saves any state insurance law from preemption of such laws,[\[5\]](#) so states may be able to pass laws to effectively control healthcare costs by passing insurance regulations to protect residents from excessive costs. Unfortunately, however, the standards for rate review in the NAIC model legislation as enacted in most states are primarily concerned with financial solvency of insurers – whether premiums are adequate to cover anticipated medical expenses – and not whether the cost of the premiums are justified or whether insurance companies are negotiating appropriate prices for those healthcare services.

Recognizing the limitations of rate review that is focused on solvency of insurers, the Affordable Care Act (ACA) required insurers in the individual and small group markets to file proposed rate increases with the Department of Health and Human Services (HHS) and to “justify” any increases in premiums above 10% beginning in 2011.[\[6\]](#) As part of this process, HHS determines whether a state has an effective review process.[\[7\]](#) If HHS determines that a state has an effective review process, it allows the state to conduct reviews and oversee insurance rate increases. For states without an effective review, HHS will review rates directly. Perhaps surprisingly, HHS may determine that a state has an “effective review” process, even if state regulators do not

have the authority to reject rate increases that it finds excessive or unjustified.[\[8\]](#) Under the ACA, the HHS also may not alter or prohibit rate increases that it finds unreasonable, but will publish the determination that a rate increase is unreasonable with the insurer's final justification for the rate increase on the department's website. As a result, the ACA brings transparency to rate increases and may shame insurers into lowering rate increases without giving state or federal regulators the authority to demand lower rates.[\[9\]](#)

The Path to Increasing Rate Regulation in California

The rate review process in California follows the rationale of the ACA to use transparency to shame insurers into lower rates. In 2010, California passed SB 1163 and SB 51 to meet the effective rate review standards of HHS. Recognizing the limitations of this "file and use" authority, some state policymakers recognized the limitation of this kind of rate review and introduced AB 52 in 2011 to require insurers to get "prior approval" of rate increases from DMHC or CDI.[\[10\]](#) While this bill passed the California Assembly, it failed to pass the Senate and never became law. As a result, DMHC and CDI lack the authority to deny any proposed rate increases and have had mixed success using transparency and public disclosure to control premium increases.[\[11\]](#) A report by CALPRIG found that in the 5 years following the passage of SB 1163 and SB 51, DMHC and CDI reviewed 565 rate increases. During this review, insurers reduced or withdrew 69 of the proposed rate increases that the agencies identified as needing additional justification, but insurers went forward with at least 26 rate increases that regulators found "unreasonable."[\[12\]](#) In the decade since the passage of the ACA, California legislators have tried to incrementally improve the rate review process. The passage of AB 2118 at the end of the 2020 legislative session made it the fourth law

passed by the California legislature since 2011 to increase oversight of the health insurance market by DMHC and CDI.[\[13\]](#)

The first expansion of rate review adopted by California following the ACA occurred in 2015 when the legislature passed SB 546 to increase reporting requirement for plans in the large group insurance market. While SB 1163 required large group plans to submit rate information required by the ACA and state regulations, the ACA's requirements were never applied to the large group market, and DMHC and CDI did not adopt any regulations demanding large group plans to submit rate review information.[\[14\]](#) As a result, the legislature passed SB 546 to require insurers to file information about increases in all large group plans and to compare rate increases to increases approved by the California Health Benefit Exchange or by the Board of Administration of the Public Employees' Retirement System.[\[15\]](#) The law also requires DMHC and CDI to hold annual meetings about changes to large group rates. The California Labor Federation, a sponsor of SB 546, said the law "is among the most comprehensive state statutes in the U.S. to require such disclosure in the large group health insurance market."[\[16\]](#)

The second expansion of the rate review process occurred the following year, in 2016, when the California legislature passed SB 908 to require insurers to send written notification to enrollees in individual or small group plans when DMHC or CDI determine a rate is unjustified or unreasonable. Earlier versions of the bill would have made determination of an "unreasonable rate increase" a trigger event that would allow individuals to purchase coverage on the state exchange, but that provision was amended and removed in the final version.

In 2019, the California legislature passed AB 731, its third effort to expand rate review, to impose additional rate filing requirements on large group plans.[\[17\]](#) The law requires insurers to justify rate increases and notify employers or other purchasers if DMHC or CDI determine an increase could be

unreasonable. While this law does not give DHMC or CDI prior authority to deny rates, the law increases the amount of information available to state regulators and gives policymakers additional information about the major cost-drivers in health care, including variation in provider payment rates by geographic region, prescription drug prices, and changes in utilization. The law further requires the insurers to disclose information to DMHC or CDI about the prices paid for services relative to the prices Medicare pays for the same services.[\[18\]](#) In an interview about AB 731, Kristof Stremikis, Director of Market Analysis and Insight for the California Health Care Foundation and Advisory Board Member for The Source, said “I wouldn’t discount the value of disclosure, transparency and data. Policy always gets better when there is more information.”[\[19\]](#) Unfortunately, however, this law does not allow much of this information to be disclosed to the public. In fact, AB 731 deems much of this information confidential, saying “[t]he contracted rates between a health care service plan and a provider shall be deemed confidential information that shall not be made public by the department and are exempt from disclosure under the California Public Records Act.”[\[20\]](#) As a result, this law may give DMHC and CDI important insight into the reasons for increases in health insurance premiums, but may harm their ability to inform the public about the underlying causes of the increases in healthcare costs.

Finally, AB 2118, the latest effort passed at the end of the 2020 session, requires DMHC and CDI to compile information about individual and small group plans and their enrollment to give policymakers and the public more information about the types of coverage offered and purchased by California residents. While AB 2118 will provide state policymakers additional information about health insurance coverage and costs in the state, it is only a small step toward better market oversight. Specifically, state lawmakers may consider expanding the authority of DHMC and CDI to ensure that health

insurance remains affordable for state residents.

Have Other States Used Rate Review to Ensure Affordability?

Two states, Rhode Island and Colorado, passed laws expanding the authority of the state agencies to review health insurance rates based on affordability. In 2010, Rhode Island created the Office of the Health Insurance Commissioner and that agency implemented regulations with affordability standards that require the health insurance commissioner to review provider payment rates if the risk-adjusted total cost of services exceeds a threshold.[\[21\]](#) The health insurance commissioner may then deny insurance contracts with proposed rate increases that exceed this threshold. A research study found that Rhode Island's affordability standards decreased quarterly fee for services payments by 4.8 percent, relative to a control group and that the reduction in spending was driven by lower prices, rather than reduced utilization.[\[22\]](#) The researchers claim that "[s]tate regulators in Rhode Island achieved among the largest total health care spending changes observed from payment reforms to date. Our analysis suggests that price inflation caps and diagnosis-based payments, which led to lower prices, drove a broad and sustained reduction in commercially insured health care spending growth."[\[23\]](#)

Colorado passed similar affordability standards in HB 19-1233 which passed in 2019.[\[24\]](#) Colorado's law states "[i]t is the duty and responsibility of the commissioner to supervise the business of insurance in this state to assure that it is conducted... to protect policyholders and the general public... The Commissioner shall... encourage policies... that decrease health disparities and improve the quality, efficiency, and affordability of health care service delivery and outcomes."[\[25\]](#) However, most of the law and the regulations adopted by the Colorado DOI focus on investments in primary care. Nonetheless, the experience in Rhode Island suggests

that granting the DOI the authority to review rates with an affordability standard may help reduce healthcare costs.

Where Could California Go From Here?

While AB 2118 was an incremental step toward allowing state policymakers and the public to better assess health insurance markets in California, the state could consider more fundamental reforms to health insurance rate review. Specifically, granting DMHC and CDI the authority to reject rates they deem “unreasonable” would align California’s rate review authority with the majority of states that require approval of premium rates before insurers may use them.[\[26\]](#) With prior approval, both providers and insurers will be aware that state regulatory agencies will not approve price increases that greatly increase premiums. Prior approval authority would thus help prevent excessive price increases in premiums, and perhaps more importantly, would give insurers additional bargaining power when negotiating contracts with providers.

In addition, the rate review process could be strengthened by allowing DMHC and CDI to use an affordability standard when reviewing contracts. Following Rhode Island’s example, California could consider establishing a threshold that requires insurers to justify rates or rate increases that exceed that threshold. For example, state lawmakers could consider requiring DMHC and CDI to review premium increases that exceed the consumer price index or provider payment rates that exceed 200% of Medicare rates. In either case, the threshold serves as a price cap and allows negotiation under that rate. Furthermore, if an insurer demonstrates that a provider has quality outcomes that justify a high rate, the agencies can review that claim and approve the higher rate if it is justified.

Overall, rate review has the potential to become an effective way for states to assess and restrain prices for healthcare services. As insurance laws are typically not preempted by ERISA, states have more flexibility to regulate insurance than many [other healthcare organizations](#). In addition, unlike more extensive reform efforts to create new commissions (similar to the Health Policy Commission in Massachusetts), increasing rate review authority uses existing state agencies and resources. While additional staffing and expertise is likely required for California to implement prior authority review or affordability standards, these costs are likely small relative to the potential for an effective and comprehensive rate review process to restrain healthcare costs for state residents and their employers.

[1] California is the only state with two separate agencies that oversee health insurance. DMHC regulates managed health plans, including HMOs and many PPO plans. CDI regulates indemnity health insurance and the remaining PPO plans. In 2019, DMHC regulated insurance plans covering 93% of Californian's with commercial insurance (13.4 of the 14.4 million Californians). Neither CDI nor DMHC regulate plans offered by self-funded employers, which cover about 5.5 million Californians.

See California Health Care Almanac Quick Reference Guide, July 2020. Available from:

<https://www.chcf.org/wp-content/uploads/2020/07/CAHealthInsurersEnrollmentAlmanac072020QRG.pdf>.

[2] See John Aloysius Cogan Jr., *Health Insurance Rate Review*, 88 Temple Law Rev. 411 ,433 (2016) including a discussion of the U.S. Supreme Court decision *German Alliance Ins. v. Lewis*, 233 U.S. 389 (1914) holding that states have the right to

regulate insurance.

[3] 15 U.S.C. § 1012.

[4] See Cogan at 436 and note 133 citing Kenneth J Meier, THE POLITICAL ECONOMY OF REGULATION: THE CASE OF INSURANCE 46–47 (1988) describing the development and adoption of the NAIC model law. Illinois was the only state not to pass the NAIC model law.

[5] 29 U.S.C. § 1144.

[6] 42 U.S.C. § 300gg–94(a)(1) and 45 C.F.R. §§ 154.200(a), 154.215(a)–(g).

[7] State Effective Rate Review Programs, CMS.gov, Updated March 17, 2017. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.

[8] See Cogan note 2 at 447 saying “Oddly enough though, despite the extensive list of data that states must review to have an “effective” review process, states are not required to have the authority to actually deny proposed rate increases. Thus, a state can have an “effective” rate review process even if it wholly lacks any authority—or does not exercise the authority it has—to prevent the implementation of a rate increase it finds unreasonable. In other words, the “review” part of the state’s rate review process must be sufficiently rigorous to detect an unreasonable proposed rate, but the enforcement part can be completely nonexistent.

[9] See Cogan note 2 at note 223 stating “Professor Timothy Jost has noted, ‘This disclosure requirement is the key to the regulation. Although the statute does not authorize HHS to reject proposed rate increases, Congress determined that public disclosure of information supporting rate increases would invite public scrutiny of rate increase proposals and might have a “sentinel effect,” deterring unreasonable

requests. In a number of instances in the past year, insurers have had rate increases rejected or have withdrawn proposed rate increases in the face of public criticism of the proposed increases.’ Jost, Implementing Health Reform, supra note 200. For a brief history of regulation by shaming and its shortcomings, see Mary Graham, Regulation by Shaming, ATLANTIC, Apr. 2000, at 36, 36–40.”

[\[10\]](#) A.B. 52, 2011-2012 Reg. Sess. (Cal. 2011).

[\[11\]](#) See Department of Managed Health Care, **Premium Rate Review Process**, CA.gov., <https://www.dmhc.ca.gov/HealthCareinCalifornia/PremiumRateReview/RateReviewProcess.aspx>

[\[12\]](#) California Health Insurance Rate Review: The First Five Years. An analysis of implementation and results for consumers. CalPIRG, <https://calpirg.org/sites/pirg/files/reports/California%20Health%20Insurance%20Rate%20Review%202011-2016.pdf>.

[\[13\]](#) In this count, we intentionally exclude SB 343 (2019-2020) that eliminates alternative reporting requirements for a plan or insurer that exclusively contracts with no more than 2 medical groups and SB 746 (2013-2014), which was passed by the legislature but vetoed by the Governor.

[\[14\]](#) Senate Health Bill Analysis for SB 546, April 21, 2015, Available from: file:///Users/katiegudiksen/Downloads/201520160SB546_Senate%20Health_.pdf

[\[15\]](#) S.B. 546, 2015-2016 Reg. Sess. (Cal. 2015).

[\[16\]](#) California Labor Federation, CALIFORNIA’S FULLY-INSURED LARGE GROUP MARKET: FINDINGS FROM THE FIRST YEAR OF SB 546 FILINGS, <https://calaborfed.org/californias-fully-insured-large-group-market-findings-from-the-first-year-of-sb-546-filings/>.

[17] A.B. 731, 2019-2020 Reg. Sess. (Cal. 2019).

[18] Cal. Health & Safety Code § 1385.03 (c)(3) and Cal. Ins. Code § 10181.3 (c)(3).

[19] Angela Hart, Large group health plans would face rate review under new transparency bill, Care 4 All California, February 20, 2019 <https://care4allca.org/in-the-news/large-group-health-plans-would-face-rate-review-under-new-transparency-bill/>.

[20] Cal. Health & Safety Code § 1385.07 (b)(1) and Cal. Ins. Code § 10181.7 (b)(1).

[21] 230 R.I. Code R. 20-30-4.10. The threshold is the US All Urban Consumer All Items Less Food and Energy CPI (“CPI-Urban”) percentage increase plus 1.5%.

[22] Baum, Aaron, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton, and Sanjay Basu. 2019. “Health Care Spending Slowed after Rhode Island Applied Affordability Standards to Commercial Insurers.” *Health Affairs* 38 (2): 237–45.

[23] *Id.* at 244.

[24] Colo. Rev. Stat. §10-1-108.

[25] *Id.*

[26] Mark Newsom and Bernadette Fernandez. **Private Health Insurance Premiums and Rate Reviews**. Congressional Budget Office. Jan 11, 2011 at 16.