



Joint Hearing on Proposition 45:

**Insurance Rate Public Justification and Accountability Act:
Approval of Healthcare Insurance Rate Changes.**

**Senate Health Committee
Assembly Health Committee**

July 2, 2014

1:30 pm

**State Capitol, Room 4203
Sacramento, CA**

On November 4, 2014, voters will consider the Insurance Rate Public Justification and Accountability Act, which requires health insurance rate changes in the small group and individual market to be approved by the Insurance Commissioner before taking effect. Amongst other things, Proposition 45 requires a sworn statement by health insurers as to accuracy of information submitted to the Insurance Commissioner to justify rate changes and provides for public notice, disclosure and hearing on health insurance rate changes, as well as subsequent judicial review. This joint informational hearing has been scheduled pursuant to Elections Code Section 9034, which requires the appropriate policy committees of the Legislature to hold public hearings on each initiative measure that qualifies for the ballot.

The Insurance Rate Public Justification and Accountability Act requires health plan and health insurance rates proposed after November 6, 2012, notwithstanding any other provisions of law, to be approved by the Insurance Commissioner prior to their use, and subjects rates in effect on November 6, 2012 to refund, as specified.

1. Existing rate regulation law under Proposition 103:
 - a. Establishes a comprehensive system of rate regulation for property-casualty insurance rates administered by the Insurance Commissioner.

- b. Prohibits a property-casualty insurer from charging any rate unless and until it has obtained the prior approval of the Insurance Commissioner. Prohibits, in considering whether a rate is excessive, inadequate or unfairly discriminatory, consideration being given to the degree of competition and requires the Insurance Commissioner to consider whether the rate mathematically reflects the insurance company's investment income.
- c. Establishes when hearings may or must be held by the Insurance Commissioner on rate change requests, and requires that specified provisions of the Administrative Procedures Act apply at these hearings. Requires the Insurance Commissioner to notify the public, through distribution to the news media, of any application by an insurer or health plan for a rate change and deems the application approved 60 days after the public notice unless:
 - i. A consumer or their representative requests a hearing within 45 days of public notice and the Insurance Commissioner grants the hearing, or determines not to grant the hearing and issues written finding in support of that decision;
 - ii. The Insurance Commissioner, on his or her own motion, determines to hold a hearing; and,
 - iii. The proposed rate increase exceeds 7 percent in the individual market and 15 percent for the small group market.
- d. Requires an application to be deemed approved 180 days after it was submitted unless the application has been disapproved by order of the Insurance Commissioner subsequent to a hearing or extraordinary circumstances exist, as specified.
- e. Authorizes consumer participation in these rate change proceedings, specifically authorizing "any person" to intervene in any proceeding permitted or required by Proposition 45.
- f. Requires the Insurance Commissioner or a court to award reasonable advocacy and witness fees to a person who demonstrates that he or she represents the interests of consumers and has made a substantial contribution to the adoption of any order, regulation or decision of the Insurance Commissioner or a court.
- g. Establishes through regulations that a proceeding within the meaning of the rate regulation law commences with the filing of a rate change request.
- h. Establishes through regulations that the right to intervene will be granted to any party that has a relevant issue to raise. The issue of "substantial contribution" which entitles the intervener to compensation is determined at the end of the proceedings.
- i. Requires all information provided to the Insurance Commissioner pursuant to the rate regulation law to be made available for public inspection.
- j. Requires all hearings required by the rate regulation law to be conducted in accordance with laws governing state administrative hearings, including that the hearing be conducted by an administrative law judge (ALJ) in the Department of General Services Office of Administrative Hearings, that the regulators be subject to required notices and discovery and that the decision of the ALJ is subject to review

- by the regulators. Requires the right to discovery to be liberally construed and requires discovery disputes to be determined by the ALJ.
- k. Establishes parameters for judicial review, and ensures the right of consumers to challenge final decisions by the regulator in court.
 - l. Permits any person to initiate or intervene in any of the proceedings or challenge any action of the Insurance Commissioner and requires the Insurance Commissioner or a court to award reasonable advocacy or witness fees to any person who demonstrates that they represent the interest of consumers and has made a substantial contribution to the adoption of any order, regulation, or decision by the Insurance Commissioner or court.
 - m. Permits, in addition to other penalties in the rate regulation law, the Insurance Commissioner to suspend or revoke the certificate of authority of any insurer that fails to comply with provisions of the law.
 - n. Requires, upon request, the Insurance Commissioner to provide consumers with a comparison of the rate in effect for each personal line of insurance for every insurer.

2. The Insurance Rate Public Justification and Accountability Act (Proposition 45):

- a. Requires health plan and health insurance rates proposed after November 6, 2012, notwithstanding any other provisions of law, to be approved by the Insurance Commissioner prior to their use, and subjects rates in effect on November 6, 2012 to refund, as specified.
- b. Requires applications for health insurance rates to be accompanied by a sworn statement under penalty of perjury by the chief executive of the company, declaring that the contents are accurate and comply in all respects with California law.
- c. Requires a transition period during which the Insurance Commissioner may permit, on a conditional basis and subject to refund, rates for new health insurance that have not been approved provided that the rates have an implementation date on or before January 1, 2014 and the new health insurance has not been previously marked in California and contains provisions mandated by federal and state law, as specified.
- d. Requires the company to be required to pay refunds with interest, notwithstanding any other provision of law and in addition to any other penalty permitted by law, in a proceeding where it is determined that health insurance rates are excessing or otherwise in violation of the law.
- e. Prohibits as a criterion for determining eligibility for a policy or contract, or generally for rates, premiums or insurability, the absence of prior insurance coverage, or a person's credit history. Applies to health, automobile and homeowners insurance.
- f. Grants the Insurance Commissioner, notwithstanding any other provision of law, the powers necessary to carry out the provisions of Proposition 45, including any and all authority for health plans rate review granted to the Department of Managed Health Care (DMHC).
- g. Requires health insurance companies to pay the filing fees for administrative and operational costs arising out of the rate regulation provisions.
- h. Requires the Insurance Commissioner to annually report to the public all such expenditures and the impact of Proposition 45.

- i. Defines “rate” as the charges assessed for health insurance or anything that affects the charges associated with health insurance, including but not limited to benefits, premiums, base rates, underwriting relativities, discounts, copayments, coinsurance, deductibles, premium financing, installment fees and any other out of pocket costs of the policyholder.
- j. Exempts large group and specialized health insurance policy or health plan contracts from Proposition 45, as specified.

Health care costs. For many years, health spending growth has outpaced inflation. The United States spends a larger share of its gross domestic product (GDP) on health care than any other major industrialized country. Expenditures on health care represent 17 percent of the nation’s GDP. In 1960, health care expenditures accounted for about 5 percent of the GDP. By 2019, the federal Centers for Medicare and Medicaid Services project health care expenditures will account for 19 percent of GDP. As costs have risen, health care coverage has become more unaffordable. The 2010 California Employer Health Benefits Survey found that between 2002 and 2010 premiums increased at five times the rate of overall inflation in California. Some researchers indicate the U.S. pays more for health care because prices are higher, technology is more readily available, and Americans have greater rates of chronic disease.

However, reports indicate healthcare costs are increasing at a slower pace in recent years. According to a 2013 Health Care Almanac report on health care costs published by the California HealthCare Foundation (CHCF), the average annual growth rate has declined since 1981 and has remained flat over the last three years at a historic low of 3.9 percent. Health spending in 2011 was only slightly higher than inflation. Annual average health care spending has been in the single digits (as compared to double digits) for the last two decades, influenced recently by the recession.

Health insurance regulation in California. Regulation and oversight of health insurance in California is split between two state departments, DMHC and the California Department of Insurance (CDI). There are over 14 million Californians with health insurance coverage regulated by either DMHC or CDI. DMHC regulated plans cover over 2 million enrollees (1.6 million in the small group market and 450,000 in the individual market) and CDI regulated policies cover just fewer than 2 million insureds (800,000 in the small group and 1 million in the individual markets). Another 9 million enrollees are in plans regulated by the DMHC for large group coverage and another 1.6 million insureds are in policies regulated by the CDI for large group coverage. Another 2 million insureds and enrollees are expected to gain small group and individual coverage by 2015. DMHC regulates health plans, including HMOs and some Preferred Provider Organization (PPO) plans. CDI regulates multiple lines of non-health related insurance and health insurance, including disability insurers offering health insurance, generally PPO plans and traditional indemnity coverage.

A 2001 CHCF published report on Health Insurance Regulation in California indicates that although DMHC and CDI both regulate carriers providing health coverage, each department approaches that regulation very differently. At the heart of the difference between health plans and health insurers is the “promise to pay” versus the “promise to deliver care.” DMHC-licensed

plans, often referred to as Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene) health plans, arrange for and organize the delivery of health care and services through contracted or owned providers and facilities and are required to cover all medically necessary services. Disability insurers protect against the expense or charges associated with illness or injury and typically provide coverage for defined benefits that may be specifically limited in the policy. CDI regulatory structure is based on the more traditional model of insurance emphasizing the obligation to pay claims. The distinction between the two regulatory frameworks has blurred because of the historical exceptions made for two large PPO carriers, Blue Cross and Blue Shield, who offer PPO products under both DMHC and CDI. However, fundamental differences remain in the expectations and regulatory approach by each regulator. In general, DMHC has greater authority and responsibility to review and approve health plan products and benefit designs than CDI has to review health insurance products under its purview.

Proposition 103. In 1988, California voters approved Proposition 103, which requires the Insurance Commissioner to review and approve rate changes for auto/property/casualty insurance before such changes take effect. Proposition 103 also requires that the rate changes not be excessive, inadequate, or unfairly discriminatory. In general, the Insurance Commissioner is required to hold public hearings on proposed rate changes whenever they exceed certain percentages. In addition, a consumer can request that a hearing be held on a particular rate change and an intervenor can request a hearing be held on a consumer's behalf. Consumer advocates point out that during the decade after Proposition 103 was adopted, auto insurance rates in California went down by 4 percent while auto insurance products remain broadly available and competitive, and the uninsured motorist population declined by 38 percent.

Proposition 103 regulates multiple lines of property and casualty insurance, such as: personal automobile, dwelling fire, earthquake, homeowners, inland marine, and umbrella, commercial aircraft, automobile, boiler and machinery, burglary and theft, business owners, earthquake, farm owners, some fidelity, fire, glass, inland marine, medical malpractice, miscellaneous, multi-peril, other liability, professional liability, special multi-peril, umbrella, and coverage under the United States Longshoremens' & Harbor Workers' Compensation Act. Proposition 45 extends the current rate regulation authority for these lines of insurance to health insurance products, which can be a very different model of insurance.

Intervenor process. According to CDI, Proposition 103 authorized a process for consumer participation in the administrative process for setting insurance rates, and permitted consumer "intervenors" to recover advocacy and witness fees and expenses under certain circumstances. Under the law, consumers that provide a substantial contribution to a rate decision by providing valuable technical input may recover their costs and expenses as well as reasonable attorney's fees. Information available on the CDI Web site indicates consumer intervenors were compensated for their participation in rulemaking and rate hearings 47 times since 2010, for a total of \$5,503,301.63. Consumer Watchdog has been the recipient of 87 percent of that total amount.

Patient Protection and Affordable Care Act (ACA). Millions of people are expected to obtain health care coverage or switch to more comprehensive coverage because of the ACA. The ACA

makes private insurance more available and affordable for many and includes a simplification and expansion of Medicaid for lower income populations, including adults without children and the adoption of major reforms of the health insurance market. Most transformational are changes to the small group and individual insurance markets, such as mandating guaranteed issuance of coverage, eliminating pre-existing condition exclusions, limiting factors upon which premium rates can be developed, and authorizing the creation of health benefit exchanges either at the state or federal level. Beginning in 2014, individuals are required to maintain health insurance or pay a penalty, with exceptions for financial hardship (if health insurance premiums exceed eight percent of household adjusted gross income), religion, incarceration, and immigration status. Small businesses with generally fewer than 100 employees can shop in an exchange for qualified health benefit plans. To stabilize health insurance rates during this market transition and to spread health risk across health plans and insurers, the ACA established programs of risk adjustment, reinsurance and risk corridors. The coverage expansions of the ACA should reduce the need for cost shifting where providers charge more to commercial coverage to make up for losses associated with patients without health coverage or those in underfunded public programs. The ACA also requires rate review of individual and small group health insurance products as well as medical loss ratio (MLR) standards to ensure 80 to 85 percent of health insurance premiums are dedicated to health care benefits as opposed to administrative expenses and profits.

Medical Loss Ratio. According to the federal Center for Consumer Information and Insurance Oversight, prior to passage of the ACA many insurance companies spent a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing. The ACA requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the MLR. It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80 or 85 percent of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases. If they fail to meet these standards, the insurance companies are required to provide a rebate to their customers.

According to a 2013 report by the Kaiser Family Foundation, consumers and businesses realize savings in two ways as a result of the MLR requirement: by paying lower premiums than they would have been charged otherwise (as a result of lower administrative costs and profits), and by receiving rebates after the fact. So while insurers paid out \$1.1 billion in 2012 as a result of MLR rebate requirements, this is not the whole story for consumers. This report found that premiums would have been \$856 million higher in 2011 and \$1.9 billion higher in 2012 if MLRs remained at 2010 levels, which is the year before the MLR provisions took effect. For 2012, in California, \$85 million in total rebates were paid out benefitting 1.4 million consumers.

Rate review. One way the ACA aims to control health care costs is through the rate review program, in which states and the federal government review proposed premium increases above a threshold amount (currently ten percent or more) in the small group and individual markets in order to determine whether the increase is reasonable. According to an October 2012 report by the Kaiser Family Foundation, 44 states (including California) and the District of Columbia have rate review programs that have been deemed by the federal Department of Health and Human

Services to be effective in at least one insurance market, meaning they have authority to determine the reasonableness of a rate increase, they have a transparent process for making the information publically available and they allow public comment on the proposed rate change.

California does not currently require prior approval of rate increases, as proposed by Proposition 45, but does have a file-and-use rate review process that was established by SB 1163 (Leno), Chapter 661, Statutes of 2010. This process requires health plans and insurers to submit 25 specified types of rate information at least 60 days prior to implementing any rate change (not just those above the 10 percent threshold established by the ACA) with the relevant regulator (DMHC or CDI). Some of the significant information plans and insurers must submit in their rate filings, include, but is not limited to, the following:

- a. Annual rate and average rate of the increase;
- b. Number of people affected by the filing;
- c. Total earned premiums and incurred claims;
- d. Overall annual medical trend factor assumptions by annual benefit category;
- e. Amount of the projected trend attributable to the use of services, price inflation, or fees and risk for contract trends by annual benefit category;
- f. A comparison of claims cost and rate of changes over time; and
- g. Any changes in enrollee cost-sharing associate with the filing.

Additionally, the current rate review process requires that the rate filing be actuarially sound and requires a certification by an independent actuary or actuarial firm that the rate increase is reasonable and that the justification for the increase is based on accurate and sound actuarial assumptions and methodologies. The regulators and the health plans/insurers are required to make all rate filing information, other than contracted rates between a health plan/insurer and a provider, readily available to the public on their Internet Web sites, in plain language and in a manner and format specified by the regulators.

An April 2014 review of California's rate review process in the first three years conducted by the California Public Interest Research Group found that: Health insurance carriers have filed 369 proposed rate changes in the individual and small group markets. As a result of objections raised in the rate review process, carriers have voluntarily reduced or withdrawn 44 rate hikes. At least 14 times, health insurance carriers have moved forward with rate increases that regulators found unreasonable. Rate review has saved California consumers and small businesses \$349 million in health insurance premiums since 2011, according to estimates by state regulators. An estimated 1.3 million Californians benefited from reduced or withdrawn rate increases on average in each of the first three full years of rate review. An estimated 923,237 Californians have been subject to rate hikes that were declared unreasonable but still went into effect.

Summary of Rate Review Results by Regulator

Agency	Total Number of Filings Reviewed	Number of Filings Reduced after Review	Number of Filings Declared "Unreasonable"	Consumer Savings Estimated by Agency Staff
CDI	160	33	13	\$291,058,970
DMHC	209	11	3	\$58,000,000
Total	369	44	16	\$349,058,970

Proposition 45 does not repeal any of the statutory requirements for CDI or DMHC to review health insurance rates and benefit packages.

Covered California. The ACA established health insurance exchanges to provide individuals and small businesses in states a virtual market place to compare policies and purchase insurance with the help of a government subsidy, if certain eligibility standards are met. The law purposely gives states flexibility to craft their own insurance exchanges. California took advantage of the flexibility in the federal health reform law to create an Exchange, known as Covered California, which functions as an active purchaser in the marketplace. Under the active purchaser model, Covered California can selectively contract with specific insurance carriers and exclude others as long as criteria for selection are consistent with seeking to promote “optimal combination of choice, value, quality, and service.” According to Covered California, this process allows them to actively negotiate with health plans to get the best possible value for consumers. Officials at Covered California have said that 33 health plans applied to sell their products on the Exchange in 2014. Thirteen of those 33 applicants were selected by Covered California to participate. California’s annual open enrollment period for purchasers in the individual health insurance market for the policy year beginning on January 1, 2015, is from November 15, 2014 to February 15, 2015 inclusive.

On June 18, 2014, Covered California released a document called the Insurance Rate Public Justification and Accountability Act: Potential Operational Questions Outline that raises more than three dozen potential operational issues and questions it plans to analyze about Proposition 45. Specifically, the report asserts that California needs to better understand its options if a rate change is not approved in time for open enrollment, since federal law requires recertification of Exchange plans to be completed by September 15 and prohibits rate changes mid-way through the benefit year. The report also notes that it is unclear to what extent rates could be challenged for the 2015 plan year, should Proposition 45 pass and take effect on November 5, 2014. The report outlines additional questions about how Proposition 45, if passed, would impact Covered California’s timeline for rate reviews, enrollment for the 2015 plan year, active purchaser model, marketing and outreach, rate changes that are not approved by the beginning of open enrollment, premium assistance tax credits, standard benefit designs, and networks.

Rate Regulation Studies. In response to a request by the Senate Health Committee for a literature review of health insurance rate regulation studies, the California Research Bureau concluded that it will be difficult to forecast how Insurance Commissioner prior approval of rate changes might affect the California market in light of the complex changes already taking place

due to the ACA. The ACA includes several provisions that may significantly affect the applicability of past research on health insurance rate regulation the United States to the current and future contexts. Some studies are summarized below.

According to the National Association of Insurance Commissioners:

- a. 11 states (including California) have either a “file and use” notice requirement for rate changes, but no rate approval process per se, or no requirement at all (one state, Missouri);
- b. 15 states have an open-ended rate prior-approval regulatory process (i.e., it has no mandated deadline for completion of the rate review);
- c. 3 states have a rate prior-approval regulatory process only for HMOs - Alabama, Michigan, and Mississippi;
- d. 21 states plus the District of Columbia have a rate prior-approval process with a time deadline for the individual and/or small-group markets. These time deadlines vary from 30 days (if the regulator has not completed review within 30 days, the rate proposal is deemed approved) to 90 days.

Further, 31 states (including California) and the District of Columbia employed an “actuarial justification” standard for approval of proposed rates or rate changes in the individual market prior to implementation of the ACA’s adjusted community ratings requirements. These states, in other words, did not prohibit use of a policy applicant’s medical status or history in the underwriting process. Of these, 22 (including the District of Columbia) had some sort of prior approval regulatory requirement for rate changes. The other nine are “file and use” states that required only notification.

A 2012 report by the Berkeley School of Public Health, titled *Health Insurance Premium Rate Review Regulation: Case Studies to Inform California*, provided a case study of health insurance rate review regulation in Minnesota and Massachusetts, to illustrate prior approval authority. Prior approval can improve transparency in the setting and approval of health care premiums, which informs the consumer. It can also reduce the instances of premiums being raised to rates that are not actuarially justified. However, prior approval as a policy may cause some insurance carriers to leave the market or decline to enter the market. The authors recommend that if California adopts the prior approval method, guidelines should be as transparent as possible, with clear standards that are kept simple to avoid litigation. Additionally, prior approval should be designed to correct market failure, such as insurance carriers leaving the market due to rates adjusted to such low levels that it is not economically viable to conduct business in the state.

In December 2010, the Kaiser Family Foundation released a report on the rate review/approval process in all 50 states. The report concludes that states with prior approval authority over rates appear to be better positioned to negotiate reductions in rate requests filed by carriers. In states that do not have this type of authority, it generally took an egregious and unjustified rate increase for them to ask for reductions. The report also points out that regulatory resources and a culture

of active review may be equally important. Other key findings of the report include the following:

- a. **A state’s statutory authority often tells little about how rate review is actually conducted in the state.** The report found that having prior approval authority does not necessarily protect consumers from large rate increases, and often the rigor and thoroughness of the regulator’s review varies widely, depending on motivation, resources, and staff capacity. Conversely, some states that do not have rate regulation have been able to get carriers to agree to rate reductions through informal negotiations.
- b. **Few states regulate large group rates and most concentrate on individual and small group markets.** A number of states only require certain carriers (i.e., non-profit Blue Cross Blue Shield plans or HMOs) to undergo rate review, and exempt other commercial carriers. Other states regulate rates through other mechanisms such as an MLR standard, which allows carriers to avoid a state review of their rates as long as they meet the standard. In most states, rate regulation or review is limited to the individual and small group markets.
- c. **Most states use a subjective standard to guide the review and approval of rates.** Common standards are that rates cannot be “excessive, inadequate, or unfairly discriminatory,” or that “benefits are reasonable in relation to premiums charged.” The report found that such subjective standards allow states to regulate rates with more flexibility, but can make the process appear arbitrary and opaque to consumers and the public.
- d. **Few states make rate filing information publicly available.** Generally, states require the public to physically visit the regulator to access the documents in a rate filing. Many states allow carriers to designate some portions of the rate filing to be “trade secret” and thus not available to the public, and two states have statutes that explicitly label all information in a rate filing as proprietary. Only a few states allow a policyholder to request a public rate hearing. There is no precedent for policyholders or third party representatives to participate in the informal back-and-forth between regulators and carriers that underpins the actual practice of rate review, but a number of states have proposed using federal grant funds to make rate filings more accessible and understandable to the public.
- e. **Many states lack the capacity and resources to conduct an adequate review.** Rate review is not a mechanical function, and requires significant expertise and nuanced judgment calls. Many states do not have a sufficient number of trained actuaries to review all filed rates. States that do not have adequate resources or staffing may miss those judgment calls or even mistakes made by a carrier in its filing. States often do not have enough resources to review all rates in a timely way and even in fairly vigilant states, like Colorado, only 25 percent of rate increases are reviewed.

In 2004, CHCF commissioned a RAND study to analyze the likely effect of premium regulation on the California health insurance market. RAND researchers found no compelling need to regulate health insurance premiums in California and noted that such regulation could have unintended, adverse consequences on consumers, such as reduction in the quality or quantity of

care, stricter utilization management, and discouraging expensive technologies from coming to market while motivating the introduction of cost-saving technologies. The study recommended a number of steps to mitigate the potential adverse consequences of rate regulation by:

- a. Monitoring coverage and the quality of health care that enrollees and insureds receive;
- b. Using objective indicators, such as insurers' profits, over a two- or three-year period to judge whether premium increases are appropriate;
- c. Monitoring market participation among insurers; and,
- d. Monitoring technology adoption in California and in states without premium regulation.

Legislative Analyst's Office (LAO) fiscal effects. According to the LAO, this measure would result in increased state administrative costs for CDI to conduct health insurance rate reviews and hearings pursuant to the provisions of this measure. These additional administrative costs would likely range in the low millions to low tens of millions of dollars annually. Under the measure, these costs would be funded from the revenue collected by filing fees on the insurance industry.

This measure could also change health insurance rates and therefore affect insurance premium tax revenues. For example, if rate regulation had the effect of lowering insurance rates, then this would tend to lead to a reduction in those revenues. The amount of change, if any, in taxes that health insurance companies pay is unknown and would depend on whether or not this measure resulted in lower insurance rates.

Related legislation. SB 1331 (Gaines), of 2014, would have eliminated advocacy and witness fees for intervenors who make a "substantial contribution" to the adoption of any order, regulation, or decision by the Insurance Commissioner as provided under the Insurance Rate Reduction and Reform Act (enacted by Proposition 103, 1988 statewide general election) including the rate review process. *Failed passage in the Senate Insurance Committee.*

SB 1173 (Gaines), of 2014, would have required the Insurance Commissioner to automatically accept rate decrease applications without review or hearing filed by insurers with the California Department of Insurance. *Failed passage in the Senate Insurance Committee.*

Previous legislation. AB 2406 (Buchanan), Chapter 100, Statutes of 2012, requires the Insurance Commissioner to publish on the CDI Web site all requests for a finding of eligibility to seek compensation, and all findings of eligibility to be compensated, with respect to parties intervening in rate change request proceedings.

AB 52 (Feuer and Huffman) of 2011, AB 2578 (Jones and Feuer) of 2010, AB 1218 (Jones) of 2009, and AB 1554 (Jones) of 2008 would have required health plans licensed by DMHC and health insurers certificated by CDI, to annually submit for prior approval to the respective regulator any increase in the rate charged to a subscriber or insured, as specified, and would have imposed on DMHC and CDI specific rate review criteria, timelines, and hearing requirements. *AB 52 died on the inactive file in the Senate, AB 2578 failed passage on the Senate Floor, AB 1218 failed passage in the Assembly Health Committee, and AB 1554 failed in the Senate Health Committee.*

SB 1163 (Leno), Chapter 661, Statutes of 2010, requires carriers to file, with regulators, specified rate information for individual and small group coverage at least 60 days prior to implementing any rate change, as specified.

SB 425 (Ortiz), of 2006, would have required carriers to obtain prior approval for a rate increase, defined in a similar manner to rates under AB 1218 of 2009. *SB 425 did not have a hearing, at the author's request, and died in the Senate Health Committee.*

SB 841 (Perata), Chapter 169, Statutes of 2003, allows insurers to use persistency of automobile coverage as an optional rating factor was found to be invalid in the case of *Foundation for Taxpayer and Consumer Rights v. Garamendi* (App.2 Dist 2005). The court rejected legislative findings in the bill that the provision furthered the intent of Proposition 103 and deemed it invalid.

SB 26 (Figueroa), of 2004, would have required carriers to obtain prior approval of rate increases from DMHC and CDI, as specified, and would have potentially required significant refunds of premiums previously collected. *SB 26 died in the Senate Insurance Committee.*

Arguments in support. Consumer Watchdog, the proponent of Proposition 45, argues that health insurance is unaffordable for too many California families, and there is no transparency in how health insurance companies set their prices. Consumer Watchdog argues that just four health insurance companies control 71 percent of California's health insurance market, and they set premiums behind closed doors, leading to unreasonable rates. Consumer Watchdog claims that this year, one insurance company raised rates as high as 20 percent for 77,000 employees of small businesses, despite the fact that the state Insurance Commissioner found that the rate increase was excessive. Consumer Watchdog notes that Proposition 45 is based on existing California law that requires rate approval for auto, homeowners, medical malpractice, and other business and liability insurance. Consumer Watchdog claims rate regulation has saved Californians \$62 billion on auto insurance premiums, which it contends have gone down 13.4 percent since the passage of Proposition 103, during a time when rates increased an average 38.6 percent nationally. Consumer Watchdog further contends that despite these savings, rate regulation has not made the insurance industry unprofitable. Consumer Watchdog argues that public justification and accountability have prevented excessive auto insurance rates in California and will give consumers the same protection against excessive health insurance rates. The California Nurses Association asserts that nurses regularly struggle with insurance companies over what the insurance company will pay rather than what is the best care option for patients and suggests Proposition 45 will allow Californians to confront the bottom line mentality of insurance companies by reining in out of control price hikes.

Arguments in opposition. Californians Against Higher Health Care Costs (a coalition of doctors, hospitals, health insurers and California employers) argues this measure will just increase costs for consumers and harm the quality of our health care. They state that the Insurance Rate Public Justification and Accountability Act gives one politician sweeping new powers over rates, co-pays and benefits for millions of small business employees; creates another expensive bureaucracy when we can least afford it that will ultimately be paid for with higher

insurance premiums; and is sponsored by special interest lawyers who included a hidden provision allowing them to charge up to \$675/hour and make tens of millions in fees off costly health care lawsuits. The Bay Area Council (a coalition of hundreds of California's largest and most innovative employers) maintains this ill-conceived initiative will compromise our ability to implement health care reform in California. They state that Jon Kingsdale, the first executive director of the first individual health insurance exchange in the nation, put it bluntly but accurately: "Opponents of the Affordable Care Act could routinely intervene to bring the whole annual open enrollment to a grinding halt." The Bay Area Council goes on to argue, as the Kingsdale report points out, the process of getting health insurance rates approved for offer during a three-month open enrollment period is very complex. This is especially true in a state such as California that has chosen to be an "active purchaser." They argue that California has standardized health insurance policies and are actively promoting a delivery system reform agenda to improve quality and drive down costs. Proposition 45 would throw a monkey wrench into the works of the health reform machine just as California has gotten it up and running.