



California Department of Insurance
Response to Wakely Consulting Group Report
June 18, 2014

Health Insurers' Wakely Report of Health Insurance Rate Regulation is Fundamentally Flawed

I. Wakely Report Was Paid for by Health Insurers Political Campaign and Was Not Prepared By An Independent Expert

The Wakely Consulting Group report was commissioned and paid for by the political campaign committee funded by health insurers to oppose the Insurance Rate Public Justification and Accountability Act. The Insurance Rate Public Justification and Accountability Act is a citizen qualified initiative which is certified for the November 2014 ballot. Health insurers have contributed over \$24 Million to the political campaign committee opposing the ballot measure. The health insurers' political campaign paid \$50,000 to the Wakely consulting firm which prepared the "report."

The report was not prepared by an independent consultant or expert. It was created as part of a political campaign to further the position of the opponents of the ballot measure.

II. Author Did Not Bother To Contact State Agency With Rate Regulation Experience: CDI

The authors of the report failed to contact anyone at the California Department of Insurance (CDI). Had they done so, the numerous errors and omissions of the report could have been avoided.

The California Department of Insurance is charged with implementing the ballot measure, according to the ballot measure itself. The failure to contact the state agency responsible for implementing both the ballot measure and Proposition 103, which the report claims to be examining, is a fatal flaw in the preparation of the report.

The California Department of Insurance has a twenty-five year history of implementing and enforcing Proposition 103. CDI has a decade's worth of experience reviewing health insurance individual market rates. And CDI has had over three year's experience reviewing individual and small group health insurance rates under the federal Affordable Care Act and Senate Bill 1163, including experience last year completing review of health insurance rates in time to meet Covered California's deadlines to allow health insurers to offer health insurance in the California exchange.

As discussed in further detail below, the California Department of Insurance provided grant funding to public advocacy groups to "intervene" in the rate review by filing actuarial analysis and comments on the rates. The failure to contact the California Department of Insurance to obtain information about its experience with health insurance rate review, public "intervenors" in health insurance rate filings, and the Department's success in completing reviews with public

intervenors in time to meet Affordable Care Act and Covered California open enrollment deadlines is a fatal omission in the preparation of the report.

The California Department of Insurance is also the only agency in the state of California with experience implementing insurance rate regulation. CDI has implemented rate regulation for property and casualty insurance sold in California since the enactment by the voters of Proposition 103 in 1988. The report makes a series of erroneous assertions about property and casualty rate regulation and omits important aspects of that regulation and makes inapt comparisons between property and casualty insurance rate regulation and health insurance rate regulation, all of which could have been avoided had the authors contacted the California Department of Insurance.

III. Health Insurer's report ignores success of rate regulation in California under Proposition 103

The author of the report ignores the success of property and casualty rate regulation in California under Proposition 103, which was enacted by the voters over the opposition of property and casualty insurers in 1988. Proposition 103 requires property and casualty insurers to obtain "prior approval" of the Insurance Commissioner before raising rates.

The prior approval process ensures that rates are not inadequate, excessive, or unfairly discriminatory and has saved Californians \$100 billion since 1988.

The "report" commissioned by health insurers funding the campaign to oppose the health insurance rate regulation ballot measure that will appear on the November 2014 ballot criticizes the prior approval process by making unsupported and erroneous assumptions about what might happen if such a process is put in place for health insurance rates.

Yet this 38 page document fails to comment on the fundamental purpose of the prior approval process: to ensure that rates are not inadequate, excessive, or unfairly discriminatory.

And the report ignores all evidence of the success of the prior approval process. An independent report, not paid for by insurers but undertaken by the Consumer Federation of America, concluded that under Proposition 103 the prior approval or rate regulation process has saved consumers over \$100 Billion.¹

¹ Hunter, J. Robert "What Works: A Review of Auto Insurance Rate Regulation in America and How Best Practices Save Billions of Dollars." November 2013 Link: http://www.consumerfed.org/pdfs/whatworks-report_nov2013_hunter-feltner-heller.pdf

During Commissioner Jones' tenure alone, the implementation of rate regulation for property and casualty insurance has resulted in \$1.673 billion in savings for California consumers and businesses.

A recent independent report – one not prepared at the behest of and paid for by health insurers like the Wakely report – concluded that thanks to Proposition 103, California has seen a reduction in average auto insurance rates, compared to all other states in the nation which have seen an average 43 percentage increase.² There is no mention of this in the Wakely report.

The report maligns the prior approval or rate regulation process with no mention of the benefits it has provided to California consumers and businesses. This is another fatal omission in the report.

IV. Author of report ignores fact that health insurance rate regulation is being implemented in states consistent with the Affordable Care Act, including his home state, Massachusetts

The report fails to mention anything about the implementation of health insurance rate regulation in 35 other states, including the home state of the author: Massachusetts. This is a telling omission, given that rate regulation was enacted in Massachusetts because the Massachusetts health exchange was unable to rein in excessive rate increases without rate regulation.

The ACA requires rate review of proposed health insurance rates throughout the country and the majority of states also have state laws providing health insurance rate regulation authority. Thirty five other states have enacted health insurance rate regulation. There is no mention of this in the report.

The report's suggestion that health insurance rate regulation is not consistent with the Affordable Care Act or the operation of state exchanges under the Affordable Care Act flies in the face of the facts.

The report ignores the fact that the United States Secretary of Health and Human Services has found rate regulation to be consistent with the Affordable Care Act and called on states to enact rate regulation.

The report also ignores the fact that the thirty five states that have health insurance rate regulation also have state exchanges or use the federal exchange and are implementing the

² What Works: A Review of Auto Insurance Rate Regulation in America and How Best Practices Save Billions of Dollars

Affordable Care Act. Health insurance rate regulation is being implemented in states with exchanges like Covered California. There is no mention of this in the report.

The author also ignores the history of his own state and the state exchange that he led. Massachusetts established a health insurance exchange in 2006 under Governor Mitt Romney. Massachusetts at that time did not have health insurance rate regulation. The Massachusetts exchange was unable to rein in excessive health insurance rate increases without health insurance rate regulation.

Massachusetts, under the leadership of Governor Deval Patrick in 2009, enacted a new law establishing health insurance rate regulation because the exchange was unable to rein in excessive health insurance rate hikes by itself.

The author must be aware of this history given that he ran the Massachusetts exchange. Yet there is not even one mention of the fact that 35 other states have enacted health insurance rate regulation with exchanges or that Massachusetts enacted health insurance rate regulation because its exchange without rate regulation was unable to rein in excessive rate increases. This is a telling omission and one that is fatal to the report.

V. Report's assertion that there will be conflicts between rate regulation and Covered California ignores 2013 experience where rate review by CDI and DMHC was done in timely way meeting exchange market deadlines

The report's assertion that there is a conflict between rate regulation and implementing Covered California ignores the fact that in 2013 the California Department of Insurance and the California Department of Managed Health Care both reviewed individual and small group market rates and reached conclusions about those rates in time to meet Covered California deadlines for sale of health insurance through Covered California.

The author failed to contact anyone at the California Department of Insurance regarding the successful review of rates in time to meet Covered California's deadlines.

The author fails to acknowledge how the state law which requires insurance regulators to review all individual and small group rates has worked before and after the creation of the new Covered California marketplace.

Many of the statements in the report are based on the false premise that Covered California has regulatory authority over the individual and small group insurance markets. Covered California is not a regulator. Under the ACA and state law, state regulators (The Department of Insurance and the Department of Managed Health Care) maintain their regulatory role and are required to review health insurance rates before they are implemented. The federal

government even provides CDI and DMHC with grant funding for the rate review work. States, unlike California currently, that have rate regulation authority are eligible for additional federal funding. California will become eligible for this federal grant funding if the ballot measure passes.

SB 1163 was passed by the California State Legislature and signed by the Governor after the passage of the Affordable Care Act and requires the Department of Insurance to review all health insurance rates in the individual and small group markets and to make a determination of whether or not the proposed rate is unreasonable. The Department of Managed Health Care is charged with doing the same for health plans in the individual and small group markets.

Though the Department of Insurance reviewed individual market rates prior to the passage of SB 1163, the Department is now in its fourth year of reviewing rates under the requirements SB 1163. In 2013, the rates for all Qualified Health Plans (QHPs) to be sold through Covered California were reviewed by CDI or DMHC prior to the use of those rates during open enrollment. The two regulators worked with Covered California to develop timelines to ensure that the review of the rates, any determination of unreasonableness and rate adjustments called for by the regulators would happen prior to the start of Open Enrollment.

Both Departments reviewed the rates and determined whether rates were excessive or unjustified. Both Departments then communicated their conclusions to the health insurers. In some cases the health insurers voluntarily adjusted those rates in response to the regulators. Regulators were able to get rate reductions of some unreasonable rates prior to the sale of products through Covered California.

The two Departments communicated the results of their review to Covered California. Covered California accepted those rates, including those adjusted after the regulators' review, and health insurance was offered at those rates during the open enrollment period for health insurance both inside and outside of Covered California.

The review of rates by the California Department of Insurance and DMHC did not cause any delay for Covered California.

Both Departments also reviewed rates for sale of health insurance outside Covered California and those health insurance products outside of Covered California were also available in time for sale during open enrollment. There was no delay in the sale of these non-exchange health insurance products.

The report also fails to mention the successful experience with "public intervenors" in 2013. And the absence of any delay associated with public comment on rates by these consumer organizations and the public. This is a striking omission given report's criticism of the process

for intervention in the ballot measure. The report fails to mention that both CDI and DMHC were provided federal funds under the Affordable Care Act to provide grants to community based public entities to “intervene” or provide public comment and analysis of health insurance rate filings. Both Departments granted funds to public “intervenors”. Public advocacy and consumer organizations reviewed the rate filings and provided their analysis and findings to the regulators. The Departments reviewed these comments and actuarial analysis while conducting their review of the health insurance rate filings in 2013 for sale through Covered California.

The report suggests incorrectly that public comment in rate filings is unique to California. This is not accurate. Other states have also allowed public comment by consumer organizations on rate filings.

VI. Report incorrect that rate regulation fails to take into consideration regional cost variations, network costs and new infrastructure costs and competition

The report asserts without any supporting evidence that Covered California is able to take into account regional cost variations, network costs and new infrastructure costs, but that rate regulation is not able to take into account these variables. This is simply not accurate.

The Wakely Report applies a standard that simply stating something makes it true. As an example of this, the report states that Covered California might be focused on lowering rates in one region rather than another, or in responding to narrow networks in one region, or allowing rate increases as a means of adding more hospitals in certain regions. This is meant to depict Covered California as having the ability to take into consideration variables that rate regulation cannot. Yet, the report provides no supporting documentation of this Solomonian activity and it is simply not the case that rate regulation cannot take these factors into consideration.

The report then states that this is very different than the one-rate-at-a-time approach taken by the CDI in the prior approval of property-casualty rates. But the report fails to note that for health insurance rate review, the Department of Insurance already considers regional cost variations, network costs, and new infrastructure costs. And the Department of Insurance will be able to continue to consider these variables with health insurance rate regulation. The prior approval process recognizes legitimate expenses, and, in the health arena, can allow for the reasonable expenses in the actual construction of a new hospital in the rate formula, as an example, should health rates be reviewed under a similar structure as property and casualty rates.

The report asserts that Covered California is better able to foster competition by adjusting rates through negotiation, something which the report asserts CDI is not able to do. This assertion completely ignores the CDI’s success in fostering a competitive, property-casualty insurance marketplace. One need only watch a couple of hours of television in the evening to be exposed

to myriad of property and casualty insurer commercials all vying to increase their companies' California market share.

It is true that the CDI does not allow the fact that there may be competition in a given region to be a sufficient guarantee that the insurers doing business in that region are not making an excessive profit. What the Wakely report is actually proposing for Covered California, however, is a process that would condone cross-subsidies of one region paying for another, or attention being paid to one segment at the expense of another segment of the population, or the granting of a higher rate for the promise of future infrastructure that may or may not occur. That is not to say Covered California has actually done what the Wakely Report proposes. Covered California is not a regulator. But what the report is proposing is not inconsistent with rate regulation.

The report asserts that Covered California should attempt to get all the health insurers selling through the Exchange to charge the same premium for their products regardless of claims experience, which on its face would appear to violate anti-trust laws. It is worth noting that all of these products are sold both inside and outside the Exchange and people who are not eligible for a subsidy are required to purchase health insurance. Any action by Covered California to attempt to get an insurer to charge a higher premium than is warranted by their rate filing, would lead that product to be less affordable for the for the families that don't qualify for premium subsidies.

VII. Report mixes apples and oranges by assuming that the timing of health insurance rate regulation will be the same as property and casualty rate regulation.

The report makes a fundamental analytical error in assuming that property and casualty rate regulation timing and process will be the same as health insurance rate regulation. The report fails to recognize that regulation of property-casualty rates is far more complex than it would be for health insurance rates.

The report points to some delays in the prior approval process for property and casualty insurance rates. The timeframe for review of a property-casualty rate filing is not relevant to the timeframe for review of a health rate filing for a number of reasons.

A. Property and casualty insurance rates are very complex.

Property and casualty insurance rates are very complex. A homeowners rate, for example, is affected by construction costs, just like a health rate is affected by medical costs, but homeowners rates also have a loading for disasters, a separate loading for fire-following earthquake, is subject to increases in theft rates or in litigation, or to changes in claims

practices, and have multiple rating components based upon age of home, type of construction, protection class, condition of the plumbing, electrical, roof, occupancy, and on and on.

As property and casualty insurers became more sophisticated in their pricing, additional rating variables emerged in their rating plans over time. Each of these segmentation factors must be supported in the breakdown of the rates so that each segment of the insured population bears only its fair share of the rate. Further, as homeowners insurance typically covers multiple and varied perils, including fire, wildfire, wind, hail, water damage (which may be further split into weather- and non-weather related), theft, liability, and others, the data underlying a homeowners rate filing may be broken out by those individual perils or some subgroup thereof. Each subgroup of perils behaves differently in terms of how often claims tend to occur, how large those claims are on average, and how long those claims take to reach full settlement. And a homeowners rate filing is broken into separate coverages such as basic actual cash value homeowners coverage, a replacement cost homeowners coverage, a renters coverage, and a condominium unit owners coverage. So the regulator is really looking at 3 or 4 or 5 populations that may all be behaving differently for rate development depending on the predominant geographical location for each population of insureds, or the respective underwriting guidelines for each coverage, or in other differences in the average age of the homes or brush exposure of the homes in each population. If we add 6 to 8 peril differences to the mix of a regulator's review, our 3 to 5 populations become closer to 18 to 40. This is much more segmentation than is included in a standard health insurance rate filing.

B. The report ignores that the number of health insurers and HMOs in CA is far fewer than the number of property and casualty insurers

There are 500 plus active property casualty companies in over 100 insurer groups each with their own rate filing staff that is responsible for filing hundreds of different personal lines and commercial lines coverages that range from personal auto to commercial output policies to difference in conditions policies umbrella liability policies.

Compare that to the health insurance individual and small group marketplace which is unfortunately dominated by four health insurers and in which in total there are approximately 40 insurers and it is clear that the administrative task for property and casualty reviews is significantly greater.

The degree of complexity of the filings, the number of filings annually (7,000), and the large number of carriers account for any delays in the property and casualty rate regulation.

The reports' author ignores the vast differences in health insurance rate regulation. The property and casualty experience is not relevant to consideration of whether there will be delays for health insurance rate regulation that would jeopardize Covered California.

C. Report confuses the complexity of medical care with health insurance rating

The provision of medical care is complicated. Setting rates for health insurance is not the same as deciding what medical care is necessary.

While medical care is complex, rate setting for health insurance is considerably less so. The report confuses the complexity associated with decisions made by medical providers with regard to the provision of care with the process health insurers and regulators use to establish rates. Setting rates is not the same thing as deciding what medical care should be provided.

D. Rate setting for health insurance under the ACA involves far fewer factors than rate setting for property and casualty insurance. The Report ignores this.

The report once again ignores the experience both regulators and their actuaries have had in reviewing health insurance rates. The review, and future regulation of those rates, involves a limited set of factors which are far less complex than the factors used in the property and casualty context.

Health insurance rate regulation does not regulate medical provider costs, either globally or per procedure or per provider. Health insurers provide the regulator with aggregate costs and costs trends in seven basic categories of medical costs: Hospital Outpatient, Hospital Inpatient, Physician/Professional Services, Prescription Drug, Laboratory, Radiology and Other.

Additional factors reviewed include administrative costs, executive compensation, rates of return, and medical loss ratio. These are far fewer and far less complex factors than those used in property and casualty rate regulation.

Therefore the report's assumption that the process and timelines of health insurance rate regulation will be the same as property and casualty rate regulation is a fundamental flaw that renders the report's overall conclusions unsupported.

E. CDI receives 7,000 property and casualty filings a year. The number of health insurance rate filings for CDI and DMHC will be close to 100 at most

Another major difference between health insurance rate regulation and property and casualty insurance rate regulation ignored by the report is that the CDI receives roughly 7,000 property and casualty filings annually. The number of health insurance and HMO filings that are received currently by CDI and DMHC and which CDI will receive with the passage of the ballot measure is less than one hundred annually.

Both of these fundamental differences ignored by the report --that health insurance rate filings are far less complex than property and casualty rate filings and that health insurance rate filings

are a fraction of property and casualty filings --explains why both CDI and DMHC were able to complete the review of health insurance rate filings in time to meet Covered California deadlines.

F. The report ignores that the ACA limits the filings to once a year

The report also ignores another major difference between property and casualty filings and health insurance rate filings. There is no limit of the number of property and casualty filings a property and casualty carrier can make in a year.

The ACA and state law as of January 1, 2014, however, limits individual market health insurance rate increases to once per year.

G. The report's conclusions are based on extrapolating from the timelines and process of property and casualty rate regulation and are simply wrong

For all of these reasons, the report's extrapolation from property and casualty insurance rate regulation to health insurance rate regulation is simply not supportable. There are fundamental and major differences in complexity, quantity of filings, number of carriers, frequency of filings, among many other critical differences.

Had the report's authors contacted the Department of Insurance these differences could have been explained and the report's fundamentally flawed reasoning avoided.

VIII. Report's figures on intervention with property and casualty rate filings grossly overstate the frequency of intervention and hearings

As pointed out above, drawing from the experience with rate regulation for property and casualty insurance to draw conclusions about the process for rate regulation for health insurance is a fundamentally flawed comparison because of the major differences between the two.

The report takes the same flawed approach with regard to its analysis of the intervenor process under the ballot measure. The report, once again, incorrectly assumes that intervention under health insurance rate regulation cannot be accomplished consistent with Covered California deadlines by drawing on the vastly different experience with property and casualty insurance intervention.

And even given this flawed comparison, the report grossly overstates the number and percentage of interventions and hearings in the property and casualty insurance context.

The report uses outdated and inaccurate data and draws biased conclusions about the intervenor process. And it ignores any positive results from the intervenor process.

And the report ignores the express language of the ballot measure which authorizes the Commissioner to establish timelines so as to make sure that intervention and hearings can be accommodated with the timelines needed for Covered California. The timelines used for property and casualty insurance rate regulation, will not be used for health insurance if the ballot measure passes. The differences between health insurance and property and casualty insurance markets and rate development described above are some of the reasons why the timing will be different. The Department of Insurance will be able to reach determinations of health insurance rates under the ballot measure well within the deadlines for open enrollment and sale of health insurance in Covered California.

A. Report's authors failed to contact anyone at CDI for information about experience with intervenors

CDI has had experience with intervenors in the rate regulation process for decades. Once again, the report's authors did not bother to contact CDI for information about its experience.

B. At most only .2% of all property and casualty filings have had intervenors, not 5.6%

First, the 86 petitions cited in the report counts each individual intervenor petition for occasions when an insurer group with multiple insurance companies each requesting the same rate change makes a filing. While it's technically accurate to say that each company in the group and each petition is separate, it actually provides an overstated picture of the number of individual instances where a petition to intervene is filed.

Plus, the report inexplicably uses the 2005 to 2011 timeframe rather than a more comprehensive or current timeframe. More recently, for 2012, there were only 9 intervenor filings and 7,342 total filings. That's one tenth of 1% (or.1%). In 2013, there were 14 petitions from consumer groups seeking to intervene in filings. The Department received 6,764 rate, rule, and form filings in 2013. That equates to two tenths of a percent of all filings in 2013 had an intervenor.

The report indicates that 5.6% of filings had intervenors between 2005 and 2011. Assuming for the sake of argument that 86 intervenor petitions is an accurate total (about 12 petitions per year), and using the actual total of 47,795 filings during that time period, the intervention rate is .18%, again, less than a fifth of one percent. Not 5.6%. The report grossly inflates the percentage of rate filings with intervenors.

C. The Report also ignores that in the last ten years there have only been seven intervenor hearings

The report goes on at great length about hearings under Proposition 103, but fails to mention that in the last ten years there have only been twelve filings ordered to hearing and only seven of those resulted in full-blown evidentiary hearings by an Administrative Law Judge who then rendered a proposed decision which was then submitted to the Commissioner for decision.

Most important of all – the report does not mention that the premium reduction on rate filings with intervenors equated to over \$1.3 billion in savings to consumers in the last three years alone.

IX. Report makes fundamental error in asserting that new health insurance products will be delayed from being offered due to ballot measure

A. The report asserts incorrectly that new health insurance products will be delayed by rate regulation hearings

The report asserts incorrectly that new health insurance products will be delayed from being sold by rate regulation. The timelines used for health insurance rate regulation will be set by the Insurance Commissioner and will be shorter than those used for property and casualty insurance. The timelines will be set in accordance with meeting the statutory deadlines associated with open enrollment and the sale of products in and outside of Covered California.

B. Hearings under the ballot measure are only available by right if there is a rate increase of greater than 7 per cent

Under the provisions of the ballot measure, intervenors are entitled to a hearing only where a rate is being increased more than 7 per cent. So it is simply not the case that an intervenor can obtain a hearing in every health insurance rate filing, as the Report suggests.

C. New products are offering a rate for the first time. There is no rate change that would trigger the right to a hearing

For new health insurance products, those products would be filing a rate for the first time. There would be no rate change of 7 per cent or more to trigger the right of an intervenor to a hearing.

D. New health insurance products cannot be delayed by hearings

New health insurance products simply cannot be delayed by an intervenor seeking a hearing, because there is no rate change triggering a right to a hearing. The report's assertions in this regard are erroneous.

E. Existing product rates remain in effect

The report also asserts that existing health insurance product sales will be impeded by rate regulation.

First, the Department has the authority under the ballot measure to establish timelines so that intervention, hearings and rate decisions can be accomplished consistent with Covered California's timelines. As noted about, rate review was accomplished in 2013 with public "intervenors" in time to meet all of Covered California deadlines and the timelines the Commissioner will set for health insurance rate regulation will align with meeting the deadlines associated with open enrollment.

Second, the report ignores the fact that the existing product can still be sold at its existing rate until a new rate is approved. The prior rate of an existing health insurance product remains in effect until the new rate is approved. So it simply not the case that existing products cannot be sold until a new rate is approved. The report's assertion to the contrary is wrong

The prior approval process puts the burden on the insurer to prove that the proposed rates are fair and not excessive. Until new rates are approved, the existing rates and products remain on the market. There is no reason to believe the California public is anxious to pay excessive premiums for their health insurance; just the opposite, public opinion reflects that rising health care costs are a concern. A process that seeks to minimize any increase to the amount that is necessary to pay reasonable costs and allow for a fair but not excessive profit is consistent with the public interest. Rates for new products and rates for existing products remain in effect, when a proposed rate change is challenged.

X. Report is simply incorrect that 2015 health insurance rates would be delayed by ballot measure

The report suggests that health insurance rates in 2015 will be delayed by the passage of the ballot measure. This is simply not accurate. The ballot measure's prior approval provisions will not apply to rates that are filed with regulators prior to the passage of the ballot measure.

CDI and DMHC will review rates in 2014 for health insurance and HMO product sold inside and outside of Covered California for which open enrollment begins November 15, 2014. CDI and DMHC are required by law to review the rates prior to the rates being offered in or outside Covered California in order to make a determination of whether the proposed rates are

unreasonable. Just as in 2013, after they complete their review the two regulators will communicate the results to the new market, Covered California. These rates will be offered during open enrollment commencing November 15, 2014. The only impact the ballot measure will have on 2015 rates is that if rates determined to be unreasonable by the regulators in their 2014 review are implemented, rebates could be ordered. The rate review work for products that will provide coverage beginning on January 1, 2015 and determinations about whether the rates are unreasonable will be made prior to the voters having the opportunity to vote on the ballot initiative and prior to its effective date.

XI. Report makes fundamental error in asserting incorrectly that lawsuits will delay products from being offered by Covered California

The report also is in error when it asserts that lawsuits associated with rate regulation will delay products from being offered by Covered California.

A. Reports authors failed to contact CDI about number of lawsuits challenging rates

Once again, the reports author's failed to contact CDI regarding the number of lawsuits and the impact of such lawsuits on the rate regulation process. Had they done so, they could have avoided the erroneous statements in the report.

B. In last ten years there have been two lawsuits

In the last ten years, with 7,000 filings on average a year, there have only been two lawsuits actually litigated challenging a rate decision of the Insurance Commissioner. The report fails to mention this fact in its discussion of lawsuits. There have only been two lawsuits in the course of 70,000 or so rate filings.

C. The rate determined by the Commissioner remains in effect during a lawsuit.

The rate determined by the Insurance Commissioner remains in effect during a lawsuit, until such time as the court decides otherwise. The filing of a lawsuit challenging a rate does not stay the rate decided by the Commissioner. So the report's assertion that bad actors can bring down Covered California by filing lawsuits to challenge the rates determined by the Insurance Commissioner is simply not accurate. No one, not even opponents of the Affordable Care Act, can stop the offering of health insurance products on or off the Covered California market by simply filing a lawsuit.

It should be noted that even without rate regulation, a lawsuit has been filed by a state senator who is an opponent of the Affordable Care Act to challenge Covered California. The filing of that lawsuit has had no effect on Covered California's operations or the implementation of the Affordable Care Act.

To the extent the report is trying to scare readers into believing that lawsuits by opponents of the Affordable Care Act can be avoided by avoiding rate regulation, it is simply not true. Opponents are free to file lawsuits challenging Covered California and the Affordable Care Act without rate regulation and they are doing so.

D. In the two lawsuits in ten years, the rate decided by the Commissioner remained in effect during the lawsuits and the insurance was sold at that rate during the lawsuits.

In the two lawsuits actually litigated to challenge a rate decision of the Commissioner in the last ten years, the rate decided by the Commissioner remained in effect during the lawsuit. Insurance was sold in the market at the Commissioner's rate despite the lawsuits. The lawsuits did not impede the sale of the insurance or the rate.

E. CDI won decisively the two lawsuits challenging a rate decision

It should be noted that the Department of Insurance prevailed in the two lawsuits actually litigated in the last ten years challenging the rate. The court issued a sweeping ruling upholding rate regulation.

F. The courts give great deference to the Commissioner's determination of rates

California law provides that courts must give great deference to the Commissioner's determination of a rate. The standard to overturn a rate by a court is the highest possible standard – abuse of discretion. The burden is on the entity challenging the rate. This deference is one reason why only two lawsuits have been litigated in ten years and why the Department won the lawsuits decisively.

The report resorts to unsupported scare tactics in asserting that lawsuits will prevent health insurance products from being sold or rates being applied.

XII. Health insurance rate regulation can be completed by CDI in time for Covered California

In 2103, Covered California worked with regulators (CDI and DMHC) to set timelines for the completion of their review of rates so that Covered California could allow health insurers to sell inside the exchange. Both Departments met Covered California's timeline.

A. Report ignores experience with health insurance rate review in 2013

The report ignores the experience with health insurance rate review in 2013 and instead leaps to an unjustifiable comparison to auto and homeowners rate regulation timelines and processes. Had the report's authors really been interested in an objective, unbiased analysis,

the report would have avoided contorting itself by looking at property and casualty rate regulation and instead looked at the experience with health insurance rate review.

B. Report's reliance on property and casualty experience is mistaken

As discussed above in great detail, the report's focus on the property and casualty insurance rate regulation experience is flawed for a whole host of reasons. Property and casualty insurance rate factors are more complex, there are dramatically more rate filings, there are dramatically more carriers, the percentage of intervenors was grossly overstated, the number of actual hearings was limited – the list goes on and on.

C. Review, intervention and hearings can be completed in time to meet Covered California and Affordable Care Act timelines

The Department of Insurance knows from its experience in 2013 that it can complete its determination of a rate where there is intervention and a hearing (notwithstanding how few times this will occur) within the timelines established by Covered California.

Should Covered California decide it requires less time than regulators have had for rate review in 2013 and 2014 for the 2016 open enrollment periods for Covered California and outside the Exchange products, the Department can also accommodate this --the Department can review and approve health insurance rates under the ballot measure to meet Covered California and open enrollment deadlines. (Note: the 2015 rates, as discussed above, will not be subject to prior approval.)

CONCLUSION

The Wakely report was paid for by the health insurers who are opposed to the ballot measure. The authors of the report did not contact the one state agency with experience with rate regulation and which is charged with implementing the ballot measure.

Had the author simply picked up the phone and called the Department of Insurance, and asked whether the Department could complete its determination of a health insurance rate along with an intervenor and a hearing in a timely way to meet Covered California and open enrollment deadlines, they would have been provided an affirmative answer.

It would have saved \$50,000 and 38 pages of flawed analysis. But that was not the answer the health insurers who purchased the report wanted.