

BUILDING the FUTURE

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CALIFORNIA LABOR FEDERATION * STATE BUILDING AND CONSTRUCTION TRADES COUNCIL

FACT SHEET AB 731 (Kalra)

SHINE A LIGHT ON HEALTH CARE COSTS AND REDUCE PREMIUMS

Purpose

To give unions more power to challenge health care premium increases from health plans like Kaiser, Blue Shield, Anthem, and others, by requiring state regulators to review all rate increase proposals annually in a public meeting.

Background

Every dollar that employers spend on health care is a dollar that comes out of workers' pockets. The skyrocketing cost of health care is contributing to wage stagnation and the affordability crisis in the state. Workers can't get raises when health care costs upwards of \$15 an hour per worker, nor can they afford more out-of-pocket costs.

Premiums for employer health insurance plans have risen 249% between 2002 and 2017—six times the rate of inflation. Workers are paying an increasing share of premiums and are faced with higher co-pays and deductibles, further eating up wages.

A recent study by the Economic Policy Institute (EPI) illustrates the impact rising health care costs have on working people. EPI estimates that if premiums had not increased as a share of average earnings, workers would have had an increase in annual pay of 8.6%, or \$3,032 for individuals, \$12,350 for families. That is \$3,032 that workers could have had to spend on food, housing, education, and other needs.

Health plans and insurers do not bear all the responsibility of rising premiums. The price of hospitals, doctors, and prescription drugs drive up costs and consequently premiums. A 2017 analysis of employer-sponsored insurance claims found that use of services declined by 0.2% between 2013 and 2017 while the average prices for doctors, hospitals, and prescription drugs increased 17.1% over the same time period.

In order to rein in rising premiums, we need to better understand how the prices charged by hospitals, doctors, and drug makers drive up premiums and overall system costs.

Current law, Chapter 661, SB 1163 of 2010, requires health plans and insurers that sell products in the individual and small group market to file a justification and documentation with state regulators—the Department of Managed Health Care or Department of Insurance—before a rate change is implemented.

State regulators can deem a rate as either unjustified or unreasonable based on the filing. Insurers and health plans must notify consumers if they go forward with a rate that's deemed unreasonable or unjustified. Since 2011, over 4.5 million Californians have saved at least \$417 million through rate review at both state regulators due to insurers and health plans reducing or rolling back proposed rate increases.

California also passed SB 546 (Leno) in 2015 that required rate reporting for the large group market, as well as an annual public meeting. Analysis of SB 546 rate filings showed that prescription drugs were a fast-growing driver of premium increases, providing the impetus for SB 17 (Hernandez), a bill requiring drug makers to provide justification for excessive price increases.

However, SB 546 does not require regulators to review rate filings in the large group. Employers with as few as 100 employees are left on their own to grapple with rising premiums as workers struggle with higher deductibles and co-pays. Rate review has the potential to save consumers in this market millions of dollars while shining a light on cost drivers' underlying increases.

What This Bill Will Do

This bill will extend rate review and determination of unjustified or unreasonable rates to the employer large group market, as well as requiring specific disclosures by health plans and insurers. Specifically this bill will:

- Apply existing rate review law to the large group market.
- Extend the determination of unjustified or unreasonable rates to the large group market.
- Require medical trend (prices & utilization) by benefit category and region.
- Require a comparison of rates for benefit categories to Medicare Rates, along with justification of excessively high or low rates.
- Level the reporting requirement between integrated delivery systems and other health plans.
- Result in a determination of an unjustified rate for failure to report required information.
- Exempt from public disclosure the negotiated rates between plans and providers.

AB 731 (Kalra) builds on what already works in California law. It simply extends existing rate review requirements to the large group market, where 17 million Californians get their coverage, and expands state regulators' ability to review rates. It also ensures that purchasers, consumers, and policy makers have adequate data to understand the cost drivers in our health care system, informing future policy proposals to contain costs throughout the system.

Sponsors

- California Labor Federation
- UNITE HERE
- SEIU State Council
- California Teamsters Public Affairs Council
- Health Access

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