DEPARTMENT OF Managed Healthcare

State of California

Application for an Award of Advocacy and Witness Fees

Entity Name:	Consumers Union of United States, Inc.
Proceeding:	Letter No. 8-K, Guidance Related to Premium Rate Filings
Date Submitted:	6/22/2011 11:26:49 AM
Submitted By:	Elizabeth Imholz
Application version:	Original App

1. For which proceeding are you seeking compensation?

   Letter No. 8-K, Guidance Related to Premium Rate Filings

2. What is the amount requested?

   $8,252.35

3. Proceeding Contribution:

   Provide a description of the ways in which your involvement made a substantial contribution to the proceeding as defined in California Code of Regulations, Title 22, Section 1010(b)(8), supported by specific citations to the record, your testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence.

   Consumers Union Application for an Award of Advocacy Fees June 22, 2011 Consumers Union of the United States, Inc., submits this request for reasonable advocacy fees for our substantial contribution to the adoption of the Department's Guidance Related to Premium Rate Filings (the "Guidance"). Under California law, a "substantial contribution" means that the participant "significantly assisted the Department in its deliberations by presenting relevant issues, evidence, or arguments which were helpful, and seriously considered, and the Participant's involvement resulted in more relevant, credible, and non-frivolous information being available to the Director." California Code of Regulations, Title 28, Section 1010(b)(8). Consumers Union made a substantial contribution to the Department's Guidance implementing SB 1163 by providing detailed and concise comments addressing rate filing and rate review issues on behalf of consumers. We were the primary drafters of two comment letters on the Guidance submitted by CU, Health Access, AARP, CALPIRG and CPEHN. Our comment letters significantly assisted the Department in developing the final Guidance, as evidenced by the Departments adoption some of our proposed changes. Consumers Union has studied health insurance rate filings and rate review processes in several states and has participated in rate hearings. We have worked with actuaries and regulators to understand the issues relative to how health plans set premiums. We bring a unique expertise to this complex area, in which consumers traditionally have been underrepresented. With respect to the Director's Letter 8-k, CU staff members Betsy Imholz and Sondra Roberto coordinated other advocacy groups to submit joint comment letters. We drafted the April 29, 2011 comment letter on the Guidance, and incorporated comments from the other advocates. We also drafted a follow-up letter providing comments on the Department's draft rate filing forms. We closely examined each line of the Guidance and compared it to the California Department of Insurance (CDI) Guidance on SB 1163. We brought our experience with rate filings and rate review to try to influence the Guidance so that the maximum amount of information about rate increases would be available to consumers, advocates and independent experts. We also made suggestions designed to bring a high level of accountability to health plans when setting rates by, for example, suggesting criteria for determining the reasonableness of a rate increase. While not all of our suggestions were adopted, the Department did incorporate some of them. For example, the Department adopted our suggestion to change the definition of actuarial soundness in paragraph 4.B.ii to require

rates be sound "in aggregate for the particular market segment," rather than just "in aggregate" in the draft version. Also based on our suggestion, this paragraph also now references "the cost of capital reserves required by Knox-Keene," rather than just "the cost of required capital" in the previous version. The final Guidance also adopts some language from the Guidance issued by the California Department of Insurance that was originally suggested by CU and the other advocate groups in our comments to CDI. For example, we urged CDI to consider "how rates are distributed across enrollees and the minimum and maximum increase for any policyholder." This language taken from the CDI Guidance was used in the Department's Guidance as well. Please see the attached staff biographies, time records, and comment letters in support of our application.

Document Name	Date Uploaded	Uploaded By	
Comment letter on Guidance	6/22/2011 11:24:23 AM	Elizabeth Imholz	View
Comment letter on draft rate filing forms	6/22/2011 11:24:57 AM	Elizabeth Imholz	View
Staff Biographies	6/22/2011 11:25:26 AM	Elizabeth Imholz	View

4. Please attach your Time and Billing Record in the "Add Attachment" box below. If you do not have your own Time and Billing Record, please use the DMHC template.

Document Name	Date Uploaded	Uploaded By	
Consumers Union Time Records Letter 8-k	6/21/2011 3:53:22 PM	Elizabeth Imholz	View

I am authorized to certify this document on behalf of the applicant. By entering my name below, I certify under penalty of perjury under the laws of the State of California that the foregoing statements within all documents filed electronically are true and correct and that this declaration was executed at San Francisco (City), CA (State), on June 22, 2011 .

Enter Name: Sondra Roberto

April 29, 2011

Edward G. Heidig, Interim Director
California Department of Managed Health Care
980 Ninth Street
Sacramento, CA 95814-2725

Re: Draft Guidance Letter No. 8-K concerning SB 1163

Dear Director Heidig:

AARP, the California Pan-Ethnic Health Network, CALPIRG, Consumers Union, and Health Access submit these comments regarding the Department of Managed Health Care (DMHC) Guidance Letter No. 8-K implementing SB 1163 on health care service plan rate review. Our organizations support those provisions of the Guidance that provide more transparency and accountability for health care service plan premium rates, consistent with Chapter 661 of 2010 (SB1163), as well as Section 2794 of the Affordable Care Act and 45 CFR Part 154. We note that public disclosure of rate information, and the underlying supporting documentation, is required under Chapter 661, which provides that all information submitted under Article 6.2 shall be made publicly available by the Department, with the sole exception of contracted rates between plans and providers. Health & Safety Code § 1385.07(a). DMHC's full compliance with this provision is of the highest importance to our organizations.

We appreciate that this Guidance generally tracks that of the California Department of Insurance (CDI), though with some notable exceptions, and recognize that guidance pursuant to SB 1163 is subject to additional refinement over time. We also understand that DMHC is developing the plain language and other forms and urge clarification that the public will have the opportunity to offer formal comments on those documents. However, we also offer here some comments, similar to those we presented to CDI, on the anticipated forms in order to provide you with early input.

The following comments and suggestions are formulated to assure that the Guidance is consistent with statutory authority, including the intent of the law, and to provide both the Department, consumer organizations, businesses and all interested members of the public the information necessary to permit analysis of rate filings. Our comments reflect our best thinking during this abbreviated comment period; as we review the Guidance and subsequent forms, we may provide further comments.

Filing and Notice

While the DMHC Guidance generally tracks the CDI Guidance related to filing and notice, there are some differences. We support the requirements in the Guidance that plans must submit filings for new product rates and rate increases for existing products. We agree that new product filings must be included so that rates can be tested for adequacy and supported with credible data. New products that are under-priced can lure new customers with attractive rates only to result in steep increases in the future. Also, the Department should remove "increases" and require filings for any rate "change" on existing products to assure review of all changes of rates consistent with SB1163 and to guard against attempts at market share grabs through under-pricing of products

The DMHC Guidance exempts large groups from coverage. However, SB 1163 explicitly requires filing by large group plans (section 1385.04) and we urge you to acknowledge that in the final Guidance. Most critically – and unlike the CDI Guidance section B, para 17 – this Guidance does not state the effective date in the statute, i.e. that it applies to all new products and rate increases implemented on or

after January 1, 2011.[1] The CDI Guidance requires that for those rate filings submitted prior to January 1, 2011 that include rate changes implemented after January 1, 2011 the insurer must give the 60-day notice to consumers and file policy information with CDI. Plans that filed with CDI, for example on Oct. 26, 2010 and Dec. 29, 2010 submitted actuarial justifications and supporting information for rates to take effect in March and April 2011, respectively.

It is critically important that rates implemented on or after January 1, 2011 comply with SB 1163 to adhere to the intent of the statute and provide immediate protections for consumers and small businesses that are struggling to afford increases going into effect on or after the first of this year. These include average increases of 37.5% over 18 months for individuals and families with Blue Shield plans, 16.10% for those with Anthem Blue Cross plans, and 15.90% for small businesses with Aetna plans. Further, we see no filings at all for Kaiser Permanente plans, although we understand that the company imposed rate increases effective January 1, 2011.

Californians simply cannot afford to have DMHC look the other way and decline to require full documentation for these huge rate hikes, as well as a thorough review, when it has full authority to do so. These same companies are already submitting filings that are undergoing review for their CDI products with rate increases effective on or after January 1. This inconsistency is detrimental to California consumers and small businesses. We urge you to reverse your decision to exempt 2011 rate increases that were filed on or before Jan. 1, 2011 from the provisions of 1163.

We also urge DMHC to adopt the CDI approach on the notice to consumers by requiring that plans include the specific date on which the proposed increase will be applied to the individual consumer and that if a rate filing is revised after its initial submission an additional 30-day notice be provided to the consumer reflecting the revised rate. See CDI Guidance section B, para 18. DMHC's draft does not provide such clarity for consumers, nor does it provide the additional notice if the rate filing is revised, consistent with federal guidance.

DMHC should also consider adopting CDI's provision for demonstrating compliance with the notice requirement. See CDI Guidance Section B, para 19. CDI requires that each plan submit by SERFF filing a "compliance report" stating the date the required information was filed with the Department, the date the notice was provided to consumers, and the date the rate filing was first implemented as to an insured. This information, filed electronically and in a standardized format, would facilitate DMHC in its monitoring and enforcement responsibilities.

Unreasonable Rate Increases

DMHC's Guidance Section 3 enumerating the factors that it will consider when determining whether a rate increase is unreasonable generally tracks with CDI's guidance – with one significant difference: DMHC *will* consider the five factors in Section 154.205 of the federal rule, but *may* consider the remaining factors listed in the CDI Guidance. This means that important factors that DMHC should consider when evaluating a rate increase are optional for DMHC and may be left out of the analysis, including:

- Factor vi: Whether the increase is "substantially justified by credible historical emerging experience data, including comparisons of experience data to projections submitted as support for prior rate filings." Rate increases are primarily based on projections of how much medical claims will increase, and those projections must be rooted in historical data that bears them out. DMHC must consider whether cost projections are substantially justified by historical, credible increases in claims.

[1] It is customary for California laws applying to health insurance to specify a delayed effective date of July 1 in order to allow regulators and industry time to come into compliance. Nothing in SB 1163 provides for delayed implementation. The law took effect on January 1, 2011 and applies to any rate in effect on or after that date.

- Factors vii, viii, xi, and xiii: These financial and solvency factors, including compensation, rate of return (with investment income), surplus, dividends, and transactions between health plan affiliates are critical to an evaluation of reasonableness. Some of the major health plans raising rates by double-digits on California consumers are experiencing strong profits and record surplus levels.[2] DMHC's reviews for reasonableness must consider whether more hardship on California consumers is warranted in light of the overall financial strength of these corporations.[3]
- Factor xii: Consideration of how rate increases are distributed across enrollees and the minimum and maximum increase for any policyholder is important while health plans are allowed to use health status as a rating factor, and will continue to be an important consideration after 2014 to ensure compliance the ACA's rating rules.
- Factor x: With any proposed increase, DMHC should consider the cumulative impact of the increase when combined with prior increases. We urge you to remove the language limiting the previous increases for consideration to 12 months. Blue Shield's Jan. 1, 2001 rate hikes resulting in an average of 37.5% increases for the prior 18 months, demonstrate the need for flexibility in this factor.
- Factor xiv: SB 1163 requires adoption of federal guidance and regulations, and CDI Guidance recognizes this in stating that CDI will consider the federal factors. DMHC should make clear that it will also consider all the factors set forth in the most current version of federal regulations, including the "effectiveness" factors in 45 C.F.R, section 154.301. Consistent consideration of these factors with each rate increase will make it more likely that HHS will determine that California has an effective rate review program.
- Factor ix: DMHC also should consider the degree to which a rate increase exceeds the rate of medical cost inflation as reported in the Consumer Price Index. We also recommend consideration of the degree to which an increase exceeds the Producer Price Index for the Direct Health and Medical Insurance Carriers Industry (PPI).

For the sake of consistency between the two regulators, certainty for the regulated industry, and thoroughness for the consumer and public interest, we urge that the final Guidance state that DMHC *shall* include all of the factors identified by CDI in its reviews for unreasonableness. We also recommend that DMHC adopt our specific suggested changes to these factors, as set forth in the paragraphs above and in footnote 3.

Actuarial Certification

The actuarial certification is statutorily required and is a key document for DMHC to assess the reasonableness of rate requests. For the Guidelines regarding actuarial certification, we urge you to add the following language to section 4(B)(ii) to clarify the level at which the definition of actuarial soundness will be applied:

> A statement of opinion that the proposed premium rates in the filing are actuarially sound in aggregate **for a particular market segment (i.e., small group or individual)**. (added language in bold type)

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[2] Blue Shield, for example, reported consolidated surplus of more than $3.5 billion at the end of the fourth quarter 2010. See, also, *WellPoint Raises Forecast After First-Quarter Earnings Beat Estimates*, Bloomberg News, April 27, 2011, available at http://www.bloomberg.com/news/2011-04-27/wellpoint-raises-forecast-after-first-quarter-earnings-beat-estimates.html

[3] DMHC's proposed Guidance provides that DMHC may look at "the health plan's surplus condition, which may include dividend history." For clarity, consistency, and greater consumer protection, we urge DMHC, again, to remove the language making consideration of dividends optional. DMHC could adopt CDI's language that it will consider "surplus condition and dividend history" or at a minimum change the language to "surplus condition, including dividend history."

This clarification is necessary to avoid an interpretation by plans that revenues must cover costs for each separate product or policy, which would only exacerbate risk segregation and lack of risk pooling in current markets.

Further, we support the definition of actuarial soundness in so far as it includes premium income, reinsurance and risk adjustment cash flows, and investment income in the calculation of actuarially soundness – all of these elements are important for an accurate revenue projection. However, we have concerns that on the cost side of the equation, "the cost of **required** capital" can result in plans adding to the cost projection unnecessary profit margins (such as "provisions for adverse deviation") or contributions to surplus, as they may view the meaning of *required* to be whatever they think is necessary. If this element is meant to provide for capital required under California's solvency standards, more specification to that effect is needed.

With respect to section 4(B)(iv), the proposed Guidance requires the actuary's opinion to address only the first five factors in determining if a rate increase is unreasonable, while the CDI Guidance requires all the factors in the CDI Guidance to be addressed. DMHC should get a thorough actuarial opinion and thus we urge requiring the actuarial opinion to be based on the full range of factors.[4]

Furthermore, we urge that the actuarial certification provide a breakdown of how the rating factors have been applied (e.g. geographic areas, age) and the expected effect on various populations, i.e. showing which consumers will have the greatest increase and which will have the least broken out demographically. The companion document hereto shows how this is displayed in the automobile insurance context.

Filing Requirements

This section of the DMHC proposed Guidance outlines the forms and spreadsheets that will be submitted pursuant to SB 1163. However, because DMHC has not yet released proposed forms, we are unable to comment specifically at this time. We will submit our comments relative to the DMHC forms when they are available. In the meantime, we offer the following suggestions which are based on the CDI California Rate Filing Form and Plain Language Filing Description as promulgated by CDI on April 5, 2011.

The California Rate Filing Form:

Under Chapter 661 of 2010, Section 1385.03 of the Health & Safety Code, an insurer is required to disclose certain information to the DMHC. In addition, the law authorizes DMHC to collect any other information required under the PPACA, and any other information required pursuant to any regulation adopted by DMHC to comply with Article 6.2. To permit DMHC to carry out its responsibilities under state and federal laws, as well as to provide adequate information and clarity to DMHC, we urge that the rate filing form clearly display these specific items, among the others required:

- Experience Period, Revenues and Costs: Dates and Duration for Experience Period, Total Premium Revenue, Total Incurred Claims, Total Admin Expenses, Total Profit or Reserve, Enrollment, Member Months [or show Per Member Per Month (PMPM) basis for each item]; Loss Ratio.
- Projected Revenue and Costs at Current Rates for the Rating Period: Total Projected Premium Revenue at Current Rates, Total Incurred Claims Projected [should correspond with the medical

[4] Section 4(b)(iv) also requires the statements of opinion to discuss the criteria in the federal rule, Sections 154.200 and 154.205. However, this additional requirement is almost superfluous, as Section 154.205 already incorporates the first five factors of the Guidance on unreasonableness, and Section 154.200 discusses the threshold for unreasonableness review under the federal rule. Thus, it appears this sentence only adds that the actuary must opine on whether the rate increase meets the federal threshold.

trend data], Total Projected Admin Expenses, Total Projected Profit or Reserve, Enrollment, Member Months [or show PMPM basis for each item]; Anticipated Loss Ratio.

- Projected Revenue and Costs with Rate Increase: Total Projected Premium Revenue for the Rating Period, with Proposed Increase, Total Incurred Claims Projected [should correspond with the medical trend data], Total Projected Admin Expenses, Total Profit or Reserve, Enrollment, Member Months [or show PMPM basis for each item]; Anticipated Loss Ratio.
- Development of Medical Trend: All factors applied to develop medical trends should be displayed.
- Expected change in enrollment for each product due to rate increases. This is important to assessing the stability of the risk pool: this information would also be appropriately added to question 8. In addition, CDI should ask for an estimate of the number of people expected to drop coverage if the increase takes effect and the number expected to "buy-down" to products with more narrow benefits and/or higher cost-sharing.
- Historical Claims Data, on a per member per month basis.

For closed blocks (CDI form question 7), DMHC should require a description of how the plan complied with statutory requirements regarding notice or blending of blocks.

For the "annual rate increase" (CDI form questions 13-15), plans should be required to provide a breakdown of their calculations, showing minimum and maximum increases and grouping to show how many people will be getting these rates. They should also disclose how much of the rate increase is targeted for profit, how much is due to medical trend, how much due to changes in the demographic composition of their risk pool, etc.

Additional items from the NAIC model form that DMHC should consider adding include those for:

- Insufficiency of prior rates
- Underwriting gain/loss both as an absolute number and as a percentage of premiums
- Annual average rate changes requested and implemented over past three calendar years.

The "California Plain Language Rate Filing Description"

SB 1163 recognizes that there is a strong need for translation of complex rate filings into plain language for the public and for individual consumers who will be confronted with rate increases. The detailed data and insurance terminology will be essential for DMHC to make its determinations and for organizations and their own actuaries to plumb the data to evaluate assumptions and conclusions. But average consumers, the media and others will need—and SB 1163 requires—simple to read and understand summary information, devoid of jargon and at an appropriate literacy level. This intent should be expressed explicitly in the Guidance. [5] Further, the plain language summary should be provided in languages other than English and the burden should be on the insurers to provide this important document in languages other than English.

Information on administrative costs and profit is critical and should be specified both in the aggregate as a percent of premium and as per member per month costs for the standard administrative costs (salaries, commissions, legal and consulting fees, lobbying expenses etc.). SB 1163 requires information on "cost containment and quality improvement efforts," along with an estimate of cost savings due to such

[5] The Oregon rate review statute provides an example of such plain language disclosures. See http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YjN1k

efforts[6], so these should be specified on the plain language form. As all levels of government seek to sustain and improve upon our health care system—and the health and well being of Californians—both containing the ever upward-spiraling costs and improving the safety and quality of health care delivery will be essential. This data element needs to be on both the plain language and rate filing forms.

Furthermore, the plain language filing should report two sets of contrasting numbers to convey the impact of any proposed increase. The first would include the projected total premiums collected, total claims paid, total administrative costs, and total profit, as dollars and percentages. The second set would illustrate the difference the rate increase will make by stating the same numbers (by dollars and percentages) under the proposed rate increase.

Conclusion

The undersigned organizations place the highest value on speedy and vigorous enforcement of SB 1163 with full public availability of information filed by plans, in accordance with Health & Safety Code section 1385.07(a). The tone and expectations set forth for the industry and the public in your Guidance will set the course of rate review for the coming years. We look forward to further refinements of this Guidance, and expect that we as well will have further suggestions to ensure that Californians have affordable, quality health care coverage.

Very truly yours,

AARP, by
Casey L. Young
Associate State Director-Advocacy

California Pan-Ethnic Health Network, by
Ellen Wu
Executive Director

CALPIRG, by
Michael Russo
Health Care Advocate

Consumers Union, by
Elizabeth M. Imholz
Special Projects Director

Health Access California, by
Anthony E. Wright
Executive Director

cc: Senator Mark Leno, author, SB1163
Assembly Member Mike Feuer, author, AB2244
Senator Ed Hernandez, Chair, Senate Health Committee
Assembly Member Bill Monning, Chair, Assembly Health Committee
Diana Dooley, Secretary of the California Health and Human Services Agency

[6] Health & Safety Code 1385.03(c)(3), 1385.04(c)(3)

AARP CALPIRG CPEHN California Pan-Ethnic Health Network Consumers Union Nonprofit Publisher of Consumer Reports HEALTH ACCESS

May 6, 2011

Edward G. Heidig, Interim Director
California Department of Managed Health Care
980 Ninth Street
Sacramento, CA 95814-2725

Re: Draft Forms concerning SB 1163

Dear Director Heidig:

AARP, the California Pan-Ethnic Health Network, CALPIRG, Consumers Union, and Health Access submit these comments regarding the Department of Managed Health Care (DMHC) Premium Rate Review Draft Forms, released on April 29, 2011, as part of the DMHC's implementation of SB 1163 on health care service plan rate review. We submitted some of these comments before the release of the draft forms in our letter of April 29, 2011, on Draft Guidance Letter No. 8-K, and we reiterate those here for your convenience. We also have added comments that became relevant after our review of the draft forms.

The California Rate Filing Form

Under Chapter 661 of 2010, Section 1385.03 of the Health & Safety Code, an insurer is required to disclose certain information to the DMHC. In addition, the law authorizes DMHC to collect any other information required under the PPACA, and any other information required pursuant to any regulation adopted by DMHC to comply with Article 6.2. To permit DMHC to carry out its responsibilities under state and federal laws, as well as to provide adequate information and clarity to DMHC, we urge that the rate filing form include additional fields for displaying the basic rate increase calculation.

Carriers calculate rate increases by estimating how much revenue will be earned at current rates during a future rating period. They then compare that projected revenue to an estimate of future claims, expenses and profits for the same time period. If projected revenue at current rates is expected to fall short of covering projected claims, expenses and profits, a rate increase will be needed to make up the difference. Projections are developed using data from a historical experience period. Therefore, the rate filing forms should include a clear display of relevant data for the experience period, the future rating period projected at current rates, and the rating period with the proposed increases. Specifically, the form should allow for display of:

- **Experience Period**: Total Premium Revenue, Total Incurred Claims, Total Admin Expenses, Total Underwriting Profit or Contribution to Surplus, Enrollment, Member Months [or show Per Member Per Month (PMPM) basis for each item]; Loss Ratio.
- **Rating Period at Current Rates**: Total Projected Premium Revenue at Current Rates, Total Incurred Claims Projected [should correspond with the medical trend data], Total Projected Admin Expenses, Total Projected Underwriting Profit or Contribution to Surplus, Enrollment, Member Months [or show PMPM basis for each item]; and Anticipated Loss Ratio.
- **Rating Period with Proposed Increase**: Total Projected Premium Revenue for the Rating Period with Proposed Increase, Total Incurred Claims Projected [should correspond with the medical trend data], Total Projected Admin Expenses, Total Underwriting Profit or Contribution to Surplus, Enrollment, Member Months [or show PMPM basis for each item]; Anticipated Loss Ratio.

In addition, carriers should report on the rate filing form the expected change in enrollment for each product due to rate increases. This is important to assessing the stability of the risk pool: this information would also be appropriately added to question 8. DMHC also should ask carriers for an estimate of the number of people

expected to "buy-down" to products with more narrow benefits and/or higher cost-sharing with the rate increase and carriers should describe the impact of those buy-downs on projected revenues, costs, and expenses.

Reserves, including claims and contract reserves, also should be reported to get a more accurate picture of the reasonableness and necessity for the rate increase. With respect to the underwriting gain / loss, information should also be provided regarding investment income as well as the return on surplus expected from the rates. Taking into account investment income and financial leverage, the return on surplus can be much bigger than the underwriting profit. Consumers should have this information to evaluate whether the profit included in the rate is reasonable.

Further, we urge you to require carriers to report the insufficiency of prior rates, and the annual average rate changes requested and implemented over past three calendar years, as is included on the NAIC's model rate filing form.

We urge to adopt these additional changes to the draft Rate Filing Form:

- Number 20: The comparison of claims cost and rate of changes over time should include a longer period for providing historical claims data. As written, the form would require reporting of annual claims cost per enrollee for three historical experience periods. We recommend at least five years, preferably on a rolling basis, to better discern trends and to help indicate whether the medical trend used is reasonable.
- Number 7: For closed blocks, DMHC should require a description of how the plan complied with statutory requirements regarding notice or blending of blocks.
- Numbers 13 and 15: For the "annual rate increase" plans should be required to provide a breakdown of their calculations, showing minimum and maximum increases and grouping to show how many people will be getting these rates. With respect to the Rate Filing Form and Spreadsheet, we applaud the requirement in number 13 that plans report the average increase weighted by number of covered lives and by total premium earned.

The "California Plain Language Rate Filing Description" and Spreadsheet

SB 1163 recognizes that there is a strong need for translation of complex rate filings into plain language for the public and for individual consumers who will be confronted with rate increases. The detailed data and insurance terminology will be essential for DMHC to make its determinations and for organizations and their own actuaries to plumb the data to evaluate assumptions and conclusions. But average consumers, the media and others will need—and SB 1163 requires—simple to read and understand summary information, devoid of jargon and at an appropriate literacy level. This intent should be expressed explicitly in the Guidance.

Further, the plain language summary should be provided in each of the health plans' threshold languages other than English, as established by their compliance with SB 853 and DMHC's language access regulations, and the burden should be on the health plans to provide this important document in those languages.

DMHC should include more descriptions in the plain-language form to make it easier for consumers to understand how the reported data is relevant and useful. For example, consumers would benefit from having a basic definition of "medical trend factor assumptions for all benefits" under number 2, of what is meant by "cost as percentage of Medicare" under number 3, and what is meant by "fees and risk" under number 4. This form is for use by policyholders and other consumers to help understand their rates, so these explanations are critical to making the form serve the use it was intended for under 1163.

Also, while we support number 1 requiring justification for any "unreasonable" rate increases, we think this heading might confuse consumers. We understand that the language tracks with SB 1163, but at the federal level, the Department of Health and Human Services has chosen to hold off on labeling rate increases unreasonable until a determination is made. DMHC should take the same approach. By including the word "unreasonable" the form suggests that a determination has already been made by DMHC that the rate is unreasonable. We suggest removing the word unreasonable.

In field number 3, actual costs by aggregate benefit category for prescription drugs are expressed as a dollar cost and as a percentage of Medicare. We recommend changing the second value to as a percentage of Average Sales Price.

We appreciate that the plain-language spreadsheet includes a breakdown of premium attributed to medical costs, administrative expenses, and profit/margin prior to the rate increase and after the rate increase. This information should be presented as actual costs from total premium, actual costs on an average per member per month basis, and on a percentage basis.

SB 1163 requires information on "cost containment and quality improvement efforts," along with an estimate of cost savings due to such efforts[1], so these should be specified on the plain language form. As all levels of government seek to sustain and improve upon our health care system—and the health and well being of Californians—both containing the ever upward-spiraling costs and improving the safety and quality of health care delivery will be essential. This data element needs to be on both the plain language and rate filing forms.

Conclusion

The undersigned organizations place the highest value on speedy and vigorous enforcement of SB 1163 with full public availability of information filed by plans, in accordance with Health & Safety Code section 1385.07(a). We look forward to further refinements of these forms, and expect that we as well will have further suggestions to ensure that Californians have affordable, quality health care coverage.

Very truly yours,

AARP, by
Casey L. Young
Associate State Director-Advocacy

California Pan-Ethnic Health Network, by
Ellen Wu
Executive Director

CALPIRG, by
Michael Russo
Health Care Advocate

Consumers Union, by
Elizabeth M. Imholz
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Health Access California, by
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Executive Director

cc: Senator Mark Leno, author, SB1163
Assembly Member Mike Feuer, author, AB2244
Senator Ed Hernandez, Chair, Senate Health Committee
Assembly Member Bill Monning, Chair, Assembly Health Committee
Diana Dooley, Secretary of the California Health and Human Services Agency

[1] Health & Safety Code 1385.03(c)(3), 1385.04(c)(3)

STAFF BIOGRAPHIES

ELIZABETH M. IMHOLZ
Special Projects Director

AREAS OF POLICY EXPERTISE

Health care policy issues, including managed care reform, quality and safety, conversions, and health insurance; consumer fraud and deceptive practices; and higher education, job training and financial aid policy.

BIOGRAPHY

Elizabeth (Betsy) Imholz is Special Projects Director of Consumers Union, nonprofit publisher of *Consumer Reports* magazine. Ms. Imholz is an attorney and recognized expert on health policy and consumer protection. Prior to her work at Consumers Union, Ms. Imholz was the Consumer Law Coordinator of Legal Services for New York City where she started her legal career as a staff attorney in 1980. From 1991 through 1997 she was Director of the Higher Education and Training Access Project, a non-profit advocacy and public policy project on student financial aid and vocational training. She began her focus on health policy for Consumers Union in 1997, and served on the Advisory Committee to the California Department of Managed Health Care when the Department was established in 2001, through 2006. She currently serves on the Advisory Committee to the U.C.L.A. California Health Information Survey; the Board of Health Access California; and as Co-Chair of the Steering Committee for the consumer coalition for California health insurance reform, "It's Our Healthcare."

EDUCATION

Ms. Imholz is a Phi Beta Kappa, magna cum laude graduate of Columbia University. She received her law degree in 1980 from Rutgers University in Newark, New Jersey where she was recipient of the University's G.A. Moore Prize for distinguished work in equal employment opportunity law.

AWARDS

In 1991, the Association of the Bar of the City of New York awarded her the Legal Services Award for outstanding work in providing civil legal assistance to the poor in New York City and equal access to justice. She was the 1996 recipient of the Vern Countryman Consumer Law Award from the National Consumer Law Center for outstanding efforts to strengthen the rights of low-income Americans through the practice of consumer law.

SONDRA ROBERTO
Staff Attorney

AREA OF POLICY EXPERTISE

Health care policy issues, including health reform, state regulation, consumer protection, health insurance markets, health insurance rates, and antitrust.

BIOGRAPHY

Sondra Roberto is a Staff Attorney at the West Coast Office of Consumers Union, nonprofit publisher of Consumer Reports magazine. She joined Consumers Union staff in February 2009. She specializes in issues related to non-profit insurer accountability, health insurance premium rates and state insurance regulation. She has researched and co-authored a report on non-profit insurer surplus and an advocate's toolkit on how insurers' set premiums, as well as numerous blogs about health reform, insurance rates, and state regulation. She also has advocated on behalf of consumers at rate hearings.

From 2003 to 2006, she was an Assistant Attorney General in the New York Office of the Attorney General, where she reviewed mergers and investigated violations of state and federal antitrust laws, with a focus on healthcare insurance and provider organizations. Prior to joining the Attorney General's Office, she was a litigation associate at Weil, Gotshal, and Manges in New York. She was a newspaper journalist before she attended law school.

EDUCATION

Ms. Roberto graduated magna cum laude from Brooklyn Law School and she has a B.A. in journalism from Arizona State University.

CONSUMERS UNION TIME RECORDS

SONDRA ROBERTO, STAFF ATTORNEY
RATE: $355/hour*

Date	Activity	Time Spent in Hours	Amount
4-22-11	Review Director's Letter 8-K, Guidance Related to Premium Rate Filings ["Guidance"]o	.5	$177.50
4-25-11	Read emailed notes from M. Russo, CalPirg, with initial impressions of Guidance	.25	$88.75
4-26-11	Read email from B. Capell, Health Access, with notes on Guidance	.03	$10.65
	Read email from B. Imholz with suggestions for commenting on Guidance	.02	$7.10
4-26-11	Draft notes on analysis of Guidance for email to M. Russo, B. Imholz, B. Capell, and other advocates	1	$355.00
4-27-11	Read emails from B. Capell and B. Imholz on strategy for joint comments on Guidance	.02	$7.10
4-27-11	Draft email to B. Capell and B. Imholz on strategy for joint comments	.03	$10.65
4-28-11	Review draft of comment letter, analyze differences between CDI and DMHC guidance, make edits (additions and rewrites) to comment letter	4.3	$1,526.50
4.28-11	Read email from M. Russo with edits to comments	.02	$7.10
4.29.11	Read email from B. Capell with edits to comments	.02	$7.10
4-29-11	Meet with B. Imholz on strategy and finalizing comments	.5	$177.50
4-29-11	Review final comment letter	.30	$106.50
5-03-11	Draft email to advocates regarding draft DMHC rate filing forms referred to in Guidance	.02	$7.10
5-03-11	Read email from B. Capell on draft rate filing forms	.02	$7.10
5-03-11	Read email from B. Imholz on draft rate filing forms	.02	$7.10
5-03-11	Draft email notes on draft rate filing forms	.33	$117.15
5-4-11	Read email from M. Russo on draft rate filing forms	.02	$7.10
5-4-11	Draft email to M. Russo with question about draft rate filing forms	.17	$60.35
5-4-11	Read email from M. Russo on question about rate filing forms	.02	$7.10
5-4-11	Research drug pricing questions regarding AWP versus WAC	.5	$177.50
5-4-11	Draft email to B. Capell, B. Imholz, and M. Russo regarding drug pricing questions	.25	$88.75
5-4-11	Draft comments on DHMC draft rate filing forms	2	$710.00
5-4-11	Email to B. Capell, M. Russon, B. Imholz and other advocates with draft comments on rate filing forms	.02	$7.10
5-6-11	Email to Sherrie Lowenstein with sign-on letter regarding draft rate filing forms	.02	$7.10
TOTAL			**$3,432.85**

BETSY IMHOLZ, SPECIAL PROJECTS DIRECTOR
RATE - $425/hour*

Date	Activity	Time Spent in Hours	Amount
4-26-11	Write email to advocates Casey Young, AARP, Mike Russo, CalPirg, and Beth Capell, Health Access and others regarding Director's Letter 8-K, Guidance Related to Premium Rate Filings ["Guidance"]o	.17	$72.25
4-26-11	Read emails from advocates M. Russo, S. Roberto, B. Capell regarding Guidance	.25	$106.25
4-26-11	Write email to Sherrie Lowenstein, Esq., DMHC	.08	$34.00
4-26-11	Preliminarily analyze DMHC draft Guidance compared to SB 1163	.5	$212.50
4-27-11	Read emails from B. Capell, M. Russo, and S. Roberto on joint comments on Guidance	.25	$106.25
4-27-11	Write emails to B. Capell, M. Russo, S. Roberto	.25	$106.25
4-27-11	Write email to Carol Pollard, CU, for administrative support in drafting comments	.08	$34.00
4.27-11	Phone call to and back from M. Russo	.17	$72.25
4.27.11	Re-read CDI guidance and CU comment letter thereto, DMHC draft Guidance, compare to SB 1163	1.5	$637.50
4.27.11	Draft CU joint comment letter on DMHC Guidance	4	$1.700.00
4-28-11	Finalize draft comment letter and send to advocates via email	1	$425.00
4-28-11	Read email comments from M. Russo, compare to draft	.17	$72.25
4-28-11	Read emails from M. Russo with edits and C. Young	.17	$72.25
4-28-11	Send email update to advocates group	.08	$34.00
4-29-11	Read email with comments from B. Capell, compare to draft	.17	$72.25
4-29-11	Meet with S. Roberto to strategize on comments	.5	$212.50
4-29-11	Edit and polish final comment letter and send to DMHC	2	$850.00
TOTAL			**$4,819.50**

Total for Sondra Roberto and Betsy Imholz **$8,252.35**

*** Hourly rates were determined based on the California Public Utility Commission adopted ranges for attorneys/**