RESOLUTION 02-02-2010

DIGEST
Insurance: Establishes a Mechanism for Accessible and Affordable Healthcare Insurance
Renumbers Insurance Code section 12700 and adds a new section 12700 to establish accessible and affordable healthcare insurance plans for all Californians.

RESOLUTIONS COMMITTEE RECOMMENDATION
APPROVE IN PRINCIPLE

History:
No similar resolutions found.

Reasons:
This resolution renumbers Insurance Code section 12700 and adds a new section 12700 to establish accessible and affordable healthcare insurance plans for all Californians.
This resolution should be approved in principle because it promotes affordable healthcare insurance while limiting the escalation of costs.

Similar in many ways to the healthcare plan passed by the federal government, this resolution additionally provides for the supervision of rates by the State Insurance Commissioner. It limits a healthcare insurer's ability to reduce benefits without authorization from the Commissioner; allows for a tiered rate or premium classification system; and requires the Commissioner to notify the public when an application for rate change has been made.

The proposed plan would allow for a tiered rate classification system where rates can be increased based on a preexisting condition determined at the acquisition of the plan. Under this scheme, the highest tier can never exceed the lowest tier by more than 33 1/3 percent.

The California Assisted Healthcare Insurance Plan is established under this proposed plan that allows residents who meet certain disability, economic, or hardship criteria, and who cannot otherwise afford healthcare insurance, to be covered.

Though there are similarities with the recently enacted federal healthcare program, this resolution provides the cost containment measures missing from that program. Pending resolution of constitutional challenges to the federal program, it is difficult to determine whether certain portions of this plan will be seen as enhancing or conflicting with the federal program.

Though the increased regulations will likely drive some healthcare providers from the California market, this resolution should be approved in principle because it assures affordable healthcare insurance for all Californians while providing a mechanism to control costs.

TEXT OF RESOLUTION

RESOLVED that the Conference of California Bar Associations recommend that legislation be sponsored to renumber section 12700 of the California Insurance Code to section 12704, and add as a new section 12700 to read as follows:

§ 12700.

(a) The legislature finds and declares that there is a crisis in this state affecting the health, welfare and solvency of citizens in being able to secure and/or afford needed health care costs and services, including but not limited to medical, psychiatric, hospital, health care facilities, prescriptions, therapy and the like, and to obtain and/or afford healthcare insurance covering these needs. The legislature finds it is of critical importance that the state intervene to provide leadership and management for this crisis by enacting fair and reasonable measures under the circumstances. It is the policy of this state that no citizen should be denied or deprived of reasonable and affordable, adequately comprehensive healthcare insurance and protection. The legislature finds that healthcare insurers have demonstrated their prowess in managing medical, hospital and related healthcare costs and services in a reasonable way and by virtue of its large number of insureds, which also spreads the risks and costs to the insurers. It is the intent of the legislature to empower the Insurance Commission with the authority to regulate and facility accessible and affordable healthcare insurance with the aim and purpose of assuring that no citizen be denied coverage by reason of a physical, mental or medical condition, or unaffordable rates for reasonably adequate and comprehensive protection.

(b) California citizens are entitled to healthcare insurance coverage.

(1) Other than as allowed in subdivisions (4) or (5) of paragraph (c) of this section, no healthcare insurer shall deny coverage in any of its healthcare plans, or cancel insurance, or change coverage or the plan benefits, based on a preexisting or developed physical, mental or medical condition, nor shall any healthcare insurer discriminate in any way against an insured or applicant for insurance based on any other ground proscribed by the law and constitutions of California and the United States of America.

(2) A healthcare insurer may not substantially reduce or limit coverage, benefits and plans which have been offered by it since 2008, without authorization from the Insurance Commissioner and for good cause shown. A healthcare insurer may offer a variety of different healthcare plans and benefits, at fair and reasonable rates, with different deductible and co-pays, preferred provider programs, health maintenance organization plans, health saving account plans, and the like. All plans shall be open to all applicants, but an existing insured of the insurer may only change plans within the insuring company on the anniversary of the insured's policy.

(c) A healthcare insurer shall charge fair, reasonable and non-discriminatory rates for coverage, as approved by the Insurance Commissioner, whether for individual or group plans.

(1) No rate shall be charged, remain in effect or be approved which is excessive, inadequate, unfairly discriminatory or otherwise in violation of California law, as determined by the Insurance Commission, and subject to judicial review under section 1856.6. In considering whether a rate is excessive, inadequate or unfairly discriminatory, no consideration shall be given to the degree of competition and the Commissioner shall consider whether the rate mathematically reflects the insurance company's investment income.

(2) Every health care insurer which desires to charge or change any rate for any given benefit plan shall file a complete rate application with the Insurance Commissioner on a form

provided by the Commissioner and including the data reflected in, *inter alia*, sections 1857.7 and1857.9, and such other information as the Insurance Commissioner may require, including contracts and arrangements with health care providers, data, analysis and statistics concerning same, insurer administrative costs and overhead, employee, advisor and administrator compensation, costs and related operational data, analysis and statistics. Each health care insurer shall maintain records concerning same and as described in sections 1856, 1857 and 1857.3, and make those records and data available, and such other information as may be reasonably required, upon request to the Insurance Commissioner. The applicant shall have the burden of proving that the requested rates or rate change is justified and meets the requirements of this article.

(3) The Commissioner shall notify the public of any application by a health care insurer for a rate change or rate approval in the manner and procedure as described in sections 1861.04, 1861.05 (c) and (d), 1861.055, 1861.06, 1861.07, 1861.08, 1861.09 and 1861.10, with the Commissioner retaining authority under section 1861.11.

(4) A health insurer may offer rate or premium classification tiers for any insurance plan it offers, providing that the rate it charges in premium for its highest rated classification tier for the same coverage in the plan does not exceed the preferred, discounted or lowest rated classification tier, by more than 33 1/3 %. Such rating of the insured may be determined upon the issuance of the policy, and may be redetermined on the anniversary date of the policy issued, based on the plan's coverage benefits. The grounds for such uprating is a preexisting or developed condition that has, in the immediately preceding year, actually generated in submitted and insurance-paid covered medical costs and fees, as determined reasonable and necessary by any then existing healthcare insurer, net of deductible and co-pay, in excess of 50% the contemporaneous annual premium of the policy, or in the case of an uninsured, what would constitute such costs and ratio were the insured covered under the plan for which the insured is applying.

(5) A healthcare insurer may not deny coverage to any applicant, however it may require a 30-day waiting period from the date a fully completed and signed application for coverage is received by it or its authorized agent, and it may exclude coverage benefits for a pre-existing condition for up to six months from the effective date of coverage, after which full benefits shall apply for a preexisting condition. However, there shall be no exclusion for a preexisting condition upon proof that the applicant had in force another healthcare policy for at least one year preceding the effective date of the applied for coverage.

(d) The Insurance Commissioner has the authority, after a public hearing and subject to judicial review, to approve or issue a reasonable plan for the equitable apportionment, among health care insurers admitted to transact health care insurance in this state, with which they will be required to participate, for a health insurance coverage entailing coverage benefits for qualified residents of the state who meet certain disability, economic or hardship criteria to be determined by the Commissioner, and may not be otherwise able to reasonably secure and afford adequate health care insurance coverage by reason thereof. This plan shall be known as the California Assigned Healthcare Insurance Plan (CAHIP). The coverage terms of the plan or plans developed shall be determined by the Commissioner. The Commissioner shall determine any affordable, reasonable and responsible costs to the insured, co-pays or deductibles, without, in lieu of, or in conjunction with Medicare or Medicaid/ Medi-Cal programs or benefit, all factors to be considered, including fair and reasonable compensation to the insurers. The Commissioner shall determine a fair and reasonable compensation to the insurers for the

assigned coverage, under the circumstances and mindful of the prospect of some economic sacrifice associated with the need to implement and administer this needed plan, to be paid to the healthcare insurers mandated participation in this assigned healthcare insurance plan. The Commissioner shall promulgate a fair and reasonable program and procedure concerning the assignment of insureds to the participating insurers under this assigned healthcare insurance plan. The powers, protocol and procedures of the Commissioner may include but are not limited to those as outlined in sections 12711, 12711.5, 12712, 12713 and 12714, as well as judicial review under section 1856.6.

(Proposed new language underlined; language to be deleted stricken.)

PROPONENT: Beverly Hills Bar Association

STATEMENT OF REASONS

Existing Law: Unlike auto (see, e.g., *Ins. Code*, §§ 1861.05 [rate/form approval] 11620 [Calif. Assigned Risk]), healthcare coverage is poorly regulated. Health insurers are essentially free to cherry pick who they wish to insure, and charge what they want and manipulate plans. Existing law and regulation in place is inadequate. There is some protection for children and MediCal and Medicare recipients. COBRA coverage and a major risk plan exists for certain insureds (see, e.g., *Ins. Code*, § 12700); both are costly and the latter covers principally catastrophic loss.

The Problem: Those who are not covered through a group plan, especially those with a preexisting condition or medical/psychiatric history, find it difficult to secure adequate health coverage protection. Healthcare insurers cherry-picking who they will insure, what they will cover and charge. This is virtually unregulated. Insurers have cancelled on questionable accusations that the insured was not fully forthcoming on the application about past medical history. Health costs are expensive especially without coverage. A single medical crisis can generate formidable bills, unmediated by insurance, with the real prospect of bankruptcy from a major illness or injury. It's doubtful Congress will come up with reform anytime soon. The problem is real, needs to be addressed now.

This Resolution: This resolution would provide needed regulation to assure accessibility and reasonable cost for comprehensive healthcare coverage, and fairness to the insurers, fostering the health of our citizens and the economy. Applicants and insureds cannot be rejected, cancelled or significantly uprated because of medical conditions. Rates would be scrutinized and regulated by the insurance commissioner to assure fairness, subject to evidentiary analysis and judicial review. The plan guarantees accessibility and affordability of insurance to all Californians, a greater pool of insureds generating adequate premium for a cost-saving spreading of risk. Provision is made to protect insurers, with tiering options and waiting periods preventing uninsureds from buying insurance on the way to the hospital. Competition, choice and variety are fostered. The risk of financially devastating medical expenses are controlled. Incentives are provided for cost-effective plans and rating, and an opportunity for insurers to make a reasonable return, with the option for reasonable upcharges for heavy medical utilizers. A special program, which may also absorb the MediCal/Medicare programs, along with the poor who simply cannot afford current insurance rates, is also proposed. This is a Prop 33 approach to health insurance; it

proved widely successful in stemming cost and underwriting problems with automobile insurance. It's meant to start a dialogue, subject to refinement and specific regulation, but the resolution provides a reasonable approach and the leadership needed for a serious, hitherto unaddressed problem.

IMPACT STATEMENT

This resolution does not affect any other law, statute or rule.

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