

MAJOR REGULATIONS STANDARDIZED REGULATORY IMPACT ASSESSMENT SUMMARY

DF-131 (NEW 11/13)

STANDARDIZED REGULATORY IMPACT ASSESSMENT SUMMARY

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<p>1. Statement of the need for the proposed major regulation.</p> <p>A robust set of network and reporting requirements are needed to attain, assure, monitor, and enforce adequacy. Revision of the existing network adequacy regulation is needed to provide additional transparency of current information to consumers. This will assure that insureds have the opportunity to access needed health care services in a timely manner and without unacceptable financial burden.</p>		
<p>2. The categories of individuals and business enterprises who will be impacted by the proposed major regulation and the amount of the economic impact on each such category.</p> <p>Annual Savings (direct impacts, see SRIA pg. 8) Households - \$ 14.1 million</p> <p>Annual Cost (direct impacts, see SRIA pg. 11) Insurers - \$ 22.6 million</p>		
<p>3. Description of all costs and all benefits due to the proposed regulatory change (calculated on an annual basis from estimated date of filing with the Secretary of State through 12 months after the estimated date the proposed major regulation will be fully implemented as estimated by the agency).</p> <p>The California Department of Insurance (Department) estimates a savings of \$14.1 million to households over the first 12 months due to decreased medically related bankruptcies and a decrease in consumers' out-of network costs. The Department estimates a direct cost to insurers of \$22.6 million over the first 12 months as they expand networks and comply with reporting requirements.</p>		

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4. Description of the 12-month period in which the agency estimates the economic impact of the proposed major regulation will exceed \$50 million.

The Department estimates that because of the direct cost of the proposed regulation and the large multiplier associated with this industry, the total economic impact of this regulation will be above \$50 million in 2015.

The Department calculated the effect of the regulation on output. The RIMS II multiplier for output of 2.2583 represents a \$2.26 total economic impact for every \$1 impact to insurers (accounting for all direct, indirect, and induced costs). Multiplying the cost of the regulation by the RIMS output multiplier results in an estimated total economic cost of \$51 million ($2.2583 \times \$22.6 \text{ million} = \51 million).

The projected impact on output due to the \$14.1 million in direct savings to consumers becomes \$19.3 million when induced and indirect impacts are also factored in ($1.3694 \times \$14.1 \text{ million}$). The \$19.3 million is treated as an offset to determine the net impact.

The total projected net impact on output for the California economy is \$31.7 million ($\$51 \text{ million} - \19.3 million).

5. Description of the agency's baseline:

COSTS

In the Department's economic model, the year 2014 represents the baseline. The total cost impact on claims of the proposed regulation is defined as the difference between the total paid for medical services before and after the regulation. The Department started with estimated premium amounts for 2014 of \$3.36 billion for the individual, small group and large group markets that it regulates. The Department then applied the expected loss ratios and expected paid-to-allowed ratios to estimate the allowed cost before regulation. Based off of that calculation the baseline for 2014 total paid charges (what the insurers are assumed to pay for covered services) amounts to \$2.792 billion.

The Department then applied new post regulation assumptions (detailed on SRIA pg. 9) and found that the total paid charges would rise to \$2.813 billion. The new set of assumptions included network utilization percentages, the percent of billed charges for current contracts between insurers and providers, and the estimated cost of medical services if performed out-of-network. The new assumptions were applied to the baseline for allowed charges.

BENEFITS

To estimate the impact of medical bankruptcies in California for 2016, the Department used data from the US bankruptcy courts which indicated that there were approximately 136,500 bankruptcy filings. The Department expects that the extension of insurance coverage in 2014 and 2015 to those previously uninsured will lower medically related bankruptcy rates in California by about 5% from 2013 levels (see SRIA pages 5-8).

The lives saved estimate is based upon Department of Finance population estimates and a California Health Benefits Review Program Brief titled "Estimates of Sources of Health Insurance in 2014" (See SRIA Appendix A, pages 21-23).

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6. For each alternative that the agency considered (including those provided by the public or another governmental agency), please describe:
- All costs and all benefits of the alternative
 - The reason for rejecting alternative

Alternative 1: Follow Federal guidelines such as Medicare Advantage time and distance standards.

The Department considered changing the existing time and distance standard to use an approach similar to that of Medicare Advantage, which characterizes each county as being in one of five categories (large metro, metro, micro, rural, and Counties with Extreme Access Considerations), and within that framework sets different specialist access requirements for a range of specialties for each of the five categories of counties. In the Medicare Advantage approach, time and distance standards for some specialists outside urban areas may be less stringent than those within urban counties.

Primary advantage of the Medicare Advantage model proposed in this alternative is that its requirements vary based on the category assigned to a given county, which may correlate to a degree to the availability of providers and facilities within those counties. For densely urban counties, this would likely result in time and distance standards more stringent than those currently in the regulation, with a potential decrease in out-of-network claims which would save money for urban households and policyholders. Other benefits include improved access to and availability of in-network providers, better continuity of care, lower emergency room costs and utilization, higher utilization of clinically proven services, and fewer deterrents to routine care. In general, this proposed alternative would likely offer urban households a higher quality of care. However, as the Medicare Advantage access standard varies by county category, these potential advantages would not be realized statewide.

Using the same actuarial model as described above, but with different assumptions regarding the percentage of providers included in the network and their average discount, the estimated direct cost impact of this alternative on provider costs is \$60 million. The Department assumes that insurers would have to significantly expand their provider network to be in compliance with the Medicare Advantage alternative. As such, they are likely to have to negotiate higher cost contracts with a number of different providers in order to bring them into their network. Since the cost impact largely depends on how many additional providers an insurer will have to add to their networks and the Medicare Advantage standards set a broad network, it is assumed that costs would increase significantly.

Reasons for rejecting Alternative #1

The Department was concerned that the approach of designating entire counties as distinct network regions may not be appropriate in California, where large counties such as Riverside or San Bernardino have dense urban areas and are characterized as metropolitan, yet also have very large, sparsely populated areas where a metropolitan based standard may not be appropriate. Additionally, there are concerns that the Medicare Advantage model might unduly restrict availability of insurance plans because there are ten counties in California without Medicare Advantage plans (Butte, Glenn, Inyo, Lake, Lassen, Mono, San Benito, Sierra, Tehama, and Tuolumne). The Department was also concerned that Medicare Advantage mostly serves a population of consumers over 65, and that therefore the number of specialists required to serve a Medicare population would not be a representative model for the general population.

The Department determined that the above concerns coupled with the cost of using the Medicare Advantage model make it unrealistic as a cost-effective alternative for California at this time.

Alternative #2: Adopt the DMHC network adequacy regulations without modification

The Department considered adopting the Department of Managed Health Care (DMHC) provider network adequacy regulation language in its entirety. Department representatives met with counterparts at DMHC regarding its network adequacy regulations and discussed what has worked the best for DMHC. The Department then applied its expertise in the regulation of Preferred Provider Organizations (PPO) and determined that not adopting certain exemptions in the DMHC regulation, such as provision for alternative timeliness standards in 28 CCR 1300.67.2.2(f), and the alternate quality assurance processes in 28 CCR 1300.67.2.2(d)(2)(F), provided better consumer protection in a marketplace transformed by the Affordable Care Act. The Department conducted an economic analysis of this alternative and found no discernable difference between the cost-and-benefit estimates of this alternative compared to the estimates for the proposed regulation.

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Reasons for rejecting Alternative #2

This alternative was not fully rejected, as many of the DHMC guidelines are in the proposed regulation. However, as noted above, the Department determined that a complete adoption of DMHC guidelines would be undesirable due to changes in the health coverage marketplace since DMHC's adoption of its revision to its network adequacy regulation in 2009. These marketplace changes result from the new federal ACA and related state legislation. Also, the Department determined that the differences between the respective regulated markets called for variation in approach. This led the Department to develop its proposed regulation considering, in part, the DMHC regulation, as well as other sources such as feedback from two public discussions, and laws in other states that have already adopted network provisions related to the ACA.

The Department determined that, in addition to using many provisions of the DMHC regulations, it was important to consider subsequent changes in state and federal law, current market conditions resulting from federal and state health reform, and the network adequacy approaches used by other states in response to new federal requirements in developing the proposed regulation.

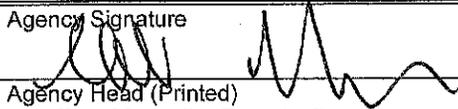
7. A description of the methods by which the agency sought public input. (Please include documentation of that public outreach).

Prior to noticing permanent regulations, the Department sought public input and held two pre-notice public discussions. Additionally, the Department received and considered public input when noticing the corresponding emergency regulations. (See attached pre-notice invitations and emergency regulation notice)

8. A description of the economic impact method and approach (including the underlying assumptions the agency used and the rationale and basis for those assumptions).

The Department consulted industry experts, university researchers, and the most current available studies published on the adequacy of health care provider networks, and the effects of delayed medical treatment. The Department's actuarial office provided empirical data and developed the model to determine the future impact on insurers. The Department utilized RIMS II multipliers, published by the Bureau of Economic Analysis to calculate the indirect and induced economic impacts and job gains/losses.

Agency Signature



Date
7/16/2015

Agency Head (Printed)

Geoffrey Margolis, Deputy Commissioner & Special Counsel to the Commissioner