17-0048 Amdt. # 1

December 22, 2017

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INITIATIVE COORDINATOR
ATTORNEY GENERAL'S OFFICE

Ashley Johansson
Initiative Coordinator
Office of the Attorney General
State of California
1300 I Street, 17th Fl.
Sacramento, CA 95814

Re: Submission of Amendment to the "Accountability in Managed Health Insurance Act" (No. 17-0048)

Dear Ms. Johansson:

On November 16, 2017, the proponents of a proposed statewide initiative titled "Accountability in Managed Health Insurance Act" (the "Initiative") submitted a request that the Attorney General prepare a circulating title and summary pursuant to Article II, Section 10(d) of the California Constitution. Pursuant to Elections Code §9002(b), the proponents hereby submit timely amendments to the text of the Initiative. As the proponents of the Initiative, we approve the submission of the amended text to the Initiative and we declare that the amendments are reasonably germane to the theme, purpose, and subject of the Initiative. We request that the Attorney General prepare a circulating title and summary using the amended Initiative.

Please continue to direct all inquiries and correspondence regarding this proposed initiative to:

Peder J. V. Thoreen
Altshuler Berzon LLP
177 Post Street, Suite 300
San Francisco, CA 94108
Phone: 415-421-7151
Email: pthoreen@altber.com

George M. Yin
Kaufman Legal Group
777 S. Figueroa St., Suite 4050
Los Angeles, CA 90017
Phone: 213-452-6565
Email: gyin@kaufmanlegalgroup.com

Sincerely,

Mylka Rodriguez, Proponent

Michael Borges, Proponent

Enclosures: Amended Initiative language

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8, of the California Constitution.

This initiative measure adds sections to the Health and Safety Code and the Insurance Code.

Text: *Be it Enacted by the People of the State of California:*

SEC. 1. Title.

This act shall be known as the "Accountability in Health Insurance Act."

SEC. 2. Findings and Purpose.

The People of the State of California find that access to affordable health care is of vital importance and that health care premiums charged by health insurance companies should reasonably reflect the actual costs of providing care. Health care premiums in the individual market in California, including for plans regulated by both the Department of Managed Health Care and the Department of Insurance, increased by an average of 10% in 2017 and an annual average of 9% over the period from 2011 to 2017. Premiums for health plans sold on Covered California increased by an average of 13% in 2017 and are set to increase by an average of 12.5% in 2018. At the same time, the surpluses of health insurance companies in California have continued to rise – in 2011, health plans regulated by the Department of Managed Health Care had accumulated surpluses of more than $20 billion in excess of the minimum reserve requirements set by the State, with this figure more than doubling to over $46 billion by September 2017. While health insurance companies should maintain reasonable amounts of revenue to protect against unknown future liabilities, when a health insurance company accumulates excessive surplus, it should not be permitted to raise premiums or impose additional costs on subscribers until it reduces its excessive surplus. The People find that surpluses in excess of five times the minimum reserve requirements set by the State are excessive and unnecessary, and that allowing health insurance companies to increase subscriber rates while maintaining such excessive surpluses is contrary to the State's interest in ensuring accessible and affordable health care.

It is the purpose of this act to promote affordable health care and to ensure accountability in the health insurance industry.

SEC. 3. Article 6.3 (commencing with Section 1385.20) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

1385.20. Definitions.

As used in this article:

(a) "Covered policy" means a health care service plan contract offered in California in the individual or group market, including the small and large group markets, and including a contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35) or Article 11.5 (commencing with Section

1399.801), but excluding all other contracts identified in Section 1385.02 as excluded from Article 6.2 of Chapter 2.2 of Division 2.

(b) "Excessive surplus" means a managed health insurance company's surplus that equals or is greater than five (5) times the minimum reserve requirements.

(c) "Managed health insurance company" means any health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975.

(d) "Minimum reserve requirements" means:

(1) requirements for tangible net equity set forth in California Code of Regulations, Title 28, Section 1300.76, as that section was in effect on November 1, 2017, or any successor minimum financial responsibility requirements for capital or net worth as the director may subsequently establish pursuant to Section 1376; or

(2) for an entity licensed by the National Blue Cross/Blue Shield Association, the greater of the requirements of paragraph (1) or 300 percent of the health risk-based capital authorized control level, calculated pursuant to the standards adopted by the National Association of Insurance Commissioners.

(e) "Rate" means the charges assessed for a managed health insurance company contract or anything that affects the charges associated with such a contract, including, but not limited to, premiums, base rates, underwriting relativities, discounts, copayments, coinsurance, deductibles, and any other out-of-pocket costs.

(f) "Surplus" means tangible net equity as that term is defined in California Code of Regulations, Title 28, Section 1300.76, as that section was in effect on November 1, 2017.

1385.21. Limits on excessive surplus.

A managed health insurance company with excessive surplus may not increase the rate charged for any covered policy in existence at the time of any report it submits pursuant to subdivision (c) of Section 1384 that reflects excessive surplus until such time as the managed health insurance company demonstrates and submits a report pursuant to subdivision (c) of Section 1384 reflecting that its surplus is less than five (5) times the minimum reserve requirements. Notwithstanding the annual reporting obligations of subdivision (c) of Section 1384, a managed health insurance company may submit a report at any time, so long as the report satisfies the substantive requirements of subdivision (c) of Section 1384 and the regulations promulgated thereunder as they exist on November 1, 2017, for purposes of demonstrating that its surplus is less than five (5) times the minimum reserve requirements. A managed health insurance company with fewer than 100,000 commercial covered lives shall be exempt from this section; provided that if this exemption is declared invalid, it shall be severed.

1385.22. Transfers within an integrated health system; prohibition on evasion of excessive surplus limits.

(a) A managed health insurance company that is part of an integrated health system shall report in any annual financial statement required by subdivision (c) of Section 1384 any transfers of cash or assets made to any other entity within its integrated health system during the time period covered by the report.

(b) For purposes of determining whether a managed health insurance company that is part of an integrated health system has excessive surplus, the director shall treat as surplus of the managed health insurance company any cash or assets transferred within the time period covered by its report to any other entity within the integrated health system, unless the managed health insurance company demonstrates in its report submitted pursuant to subdivision (c) of Section 1384, and the director determines, that any such cash or assets represent the fair market value of goods or services the managed health insurance company received in exchange for such transfers from the other entity within the integrated health system during the same time period.

(c) A managed health insurance company may not unreasonably increase negotiated reimbursement rates for entities within an integrated health system with the intent to avoid reporting that the managed health insurance company has excessive surplus.

(1) If a managed health insurance company that is part of an integrated health system substantially increases negotiated reimbursement rates for any single risk pool either over the course of a calendar year or at any time during which the managed health insurance company has excessive surplus, the director shall refer the matter to the Attorney General for investigation. The director may refer such a matter on his or her own initiative or in response to a complaint by an affected patient, subscriber or any other person. The director shall provide an appropriate complaint procedure.

(2) Upon receipt of a referral pursuant to paragraph (1), the Attorney General shall conduct an investigation into whether the increase in negotiated reimbursement rates was intended to avoid reporting that the managed health insurance company has excessive surplus.

(3) If the Attorney General determines, after notice to the managed health insurance company and a hearing, that the managed health insurance company's negotiated reimbursement rates to entities within the integrated health system were increased, in whole or in part, to avoid reporting that the managed health insurance company has excessive surplus, the director shall revoke the managed health insurance company's license as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975. Notice of hearing shall be accomplished and a hearing conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director shall have all of the powers granted therein. The remedies available to the director pursuant to this section are not exclusive, and may be sought and employed in any combination with other remedies deemed advisable by the director to enforce the provisions of this article.

(d) For purposes of this section, "integrated health system" means any managed health insurance company and either a medical group or three or more hospitals that together satisfy at least one of the following requirements for each hospital's and medical group's most recently concluded fiscal year:

(1) The managed health insurance company and medical group or hospitals that are part of the integrated health system are owned, operated, or substantially controlled

by the same person or persons or other legal entity or entities, including but not limited to by a shared corporate parent;

(2) The managed health insurance company and the medical group or any one or more hospital that are part of the integrated health system are jointly, or jointly and severally, liable, through a master indenture or other agreement or agreements, for one or more debt obligations, including but not limited to loans, leases, commercial bonds, municipal bonds, or other debt instruments owed to a third party outside the integrated health system, and the debt obligations individually or collectively are material under generally accepted accounting principles to any financial statement of the managed health insurance company, medical group or one or more hospital that is part of the integrated health system;

(3) If the integrated health system includes one or more hospitals, in the most recently concluded fiscal year for each hospital, the managed health insurance company was the primary payer for 75 percent or more of all annual inpatient discharges from hospitals that were part of the integrated health system on the date of the discharge, excluding inpatient discharges where the primary payer was Medicare, Medi-Cal, or a County Indigent program (commencing with Section 17000 of the Welfare and Institutions Code), where the patient was a self-pay patient (as that term is defined in subdivision (f) of Section 127400), or where the care was provided as unreimbursed charity care, as defined by the hospital's written charity care policy; or

(4) The managed health insurance company has an exclusive contract with fewer than three medical groups for medical services provided in California.

1385.23. Report to Legislature.

(a) Any managed health insurance company reporting excessive surplus in a report submitted pursuant to subdivision (c) of Section 1384 shall, within 30 days of making that report of excessive surplus, also submit a statement under oath to the Senate Health Committee and the Assembly Committee on Health setting forth the position of the managed health insurance company, if any, regarding any risk-based need for the excessive surplus and whether maintaining the excessive surplus is consistent with its license as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975.

(b) Any statement to the Senate Health Committee and the Assembly Committee on Health submitted pursuant to subdivision (a) by a tax-exempt managed health insurance company shall set forth the position of the managed health insurance company, if any, regarding whether maintaining the excessive surplus is consistent with its tax-exempt status. Any such report by a tax-exempt managed health insurance company shall also be submitted to the Franchise Tax Board.

1385.24. Regulations.

The director may promulgate reasonable regulations to carry out the purposes of this act.

SEC 4. Article 5.5 (commencing with Section 10192.01) is added to Chapter 1 of Part 2 of Division 2 of the Insurance Code, to read:

10192.01. Definitions.

As used in this article:

(a) "Covered policy" means a health insurance policy offered in California in the individual or group market, including the small and large group markets, and including a policy offered to a federally eligible defined individual under Chapter 9.5 (commencing with Section 10900), but excluding all other policies identified in Section 10181.2 as excluded from Article 4.5 of Chapter 1 of Part 2 of Division 2.

(b) "Excessive surplus" means a health insurer's tangible net equity that equals or is greater than five (5) times the minimum reserve requirements.

(c) "Health insurer" means any insurer licensed to transact the business of health insurance, as defined in Section 106, in this state.

(d) "Minimum reserve requirements" means:

(1) the greater of the amounts set forth in paragraphs (1), (2) and (3) of subdivision (a) of California Code of Regulations, Title 28, Section 1300.76, as that section was in effect on November 1, 2017, or any successor minimum financial responsibility requirements for capital or net worth as the director of the Department of Managed Health Care may subsequently establish pursuant to Section 1376 of the Health and Safety Code; or

(2) for an entity licensed by the National Blue Cross/Blue Shield Association, the greater of the requirements of paragraph (1) or 300 percent of the health risk-based capital authorized control level, calculated pursuant to the standards adopted by the National Association of Insurance Commissioners.

(e) "Rate" means the charges assessed for a health insurance policy or anything that affects the charges associated with such a policy, including, but not limited to, premiums, base rates, underwriting relativities, discounts, copayments, coinsurance, deductibles, and any other out-of-pocket costs.

(f) "Tangible net equity" has the meaning set forth in California Code of Regulations, Title 28, Section 1300.76, as that section was in effect on November 1, 2017.

10192.02. Annual tangible net equity reporting.

Each health insurer subject to this act shall, at the same time it files with the commissioner its annual report pursuant to subdivision (a) of Section 900, file with the commissioner a report demonstrating its tangible net equity.

10192.03. Limits on excessive surplus.

A health insurer with excessive surplus may not increase the rate charged for any covered policy in existence at the time of any report it submits pursuant to Section 10192.02 that reflects excessive surplus until such time as the health insurer demonstrates and submits a report pursuant to Section 10192.02 reflecting that its surplus is less than five (5) times the minimum

reserve requirements. Notwithstanding the annual reporting obligations of subdivision (a) of Section 900, a health insurance company may submit a report pursuant to Section 10192.02 at any time for purposes of demonstrating that its surplus is less than five (5) times the minimum reserve requirements. A health insurer with fewer than 100,000 commercial covered lives shall be exempt from this section; provided that if this exemption is declared invalid, it shall be severed.

10192.04. Report to Legislature.

(a) Any health insurer reporting excessive surplus in a report submitted pursuant to Section 10192.02 shall, within 30 days of making that report of excessive surplus, also submit a statement under oath to the Senate Health Committee and the Assembly Committee on Health setting forth the position of the health insurer, if any, regarding any risk-based need for the excessive surplus.

(b) Any statement to the Senate Health Committee and the Assembly Committee on Health submitted pursuant to subdivision (a) by a tax-exempt health insurer shall set forth the position of the health insurer, if any, regarding whether maintaining the excessive surplus is consistent with its tax-exempt status. Any such report by a tax-exempt health insurer shall also be submitted to the Franchise Tax Board.

10192.06. Regulations.

The commissioner may promulgate reasonable regulations to carry out the purposes of this act.

SEC. 5. Amendment.

Pursuant to subdivision (c) of Section 10 of Article II of the California Constitution, this act may be amended by a subsequent measure submitted to a vote of the People at a statewide election.

SEC. 6. Competing Measures.

Any provision of this act that is not contrary to the provisions of a separate measure covering the same subject area that receives more affirmative votes on the same statewide ballot, shall be valid and become enacted. In the event this measure receives a greater number of affirmative votes than a measure deemed in conflict with it, the provisions of this act shall prevail in their entirety, and the other measure shall be null and void. Any other measure appearing on the same statewide ballot that regulates either the surplus of managed health insurance companies or the tangible net equity of health insurers, as those terms are defined herein, or the ability of managed health insurance companies or health insurers to increase rates, as that term is defined herein, when they exceed a certain level of surplus or tangible net equity, shall be deemed to be in conflict with this measure. Another measure shall not be deemed to be in conflict with this measure solely because it regulates other aspects of managed health insurance companies or health insurers not addressed by this measure.

SEC. 7. Severability.

It is the intent of the People that if a phrase, clause, sentence or provision of this act or application thereof to a person or circumstance is held to be invalid, the validity of the remainder

of this act shall not be affected thereby, and to this end the provisions and applications of this act are severable.