

## Insurance Rate Public Justification and Accountability Act: Potential Operational Questions Outline

### I. Scope of Analysis

In November 2014, California voters will decide whether to enact a ballot initiative – the Insurance Rate Public Justification and Accountability Act (the “Insurance Rate Act”) – that would require health care insurance rates to undergo rate review and obtain prior approval by the California Department of Insurance (CDI).<sup>1</sup> To prepare for the potential operational and budget impacts of the initiative and in order to be responsive to public inquiries regarding those impacts, Covered California is preparing an analysis of the initiative.

In addition to doing its internal review, Covered California intends to meet with the California Department of Insurance, the Department of Managed Health Care and others to better understand potential ways the Insurance Rate Act could have operational impacts. The scope of this analysis is limited: Covered California is not assessing the potential positive or negative impacts of the public rate setting process itself. Rather, the questions Covered California plans to explore how rate review could impact our operations. The following outline presents the issues and questions Covered California will be considering as it conducts its analysis.

### II. Summary of the Insurance Rate Act

The Insurance Rate Act subjects health insurance to the set of laws originally enacted by Proposition 103 in 1988 to regulate property and casualty insurance (including auto and homeowners insurance). The text of the proposed initiative is attached as Appendix 3. Under the Insurance Rate Act, health insurance rates would be subject to review and approval by the Insurance Commissioner, as follows:

#### 1) Rate Review by the CDI under Proposition 103 Standards, Including Authority to Reject Rates

Section 2 of the Insurance Rate Act would require all health care insurance products to be reviewed by the Insurance Commissioner under existing Cal. Insurance Code § 1861.04, *et seq.*, which give the CDI the authority to reject a rate bid that is deemed excessive or otherwise in violation of the Act (“prior approval” authority): “no rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory, or otherwise in violation of this

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<sup>1</sup> See “Insurance Rate Public Justification and Accountability Act,” California Secretary of State, Initiative No. 11-0070 (received Nov. 8, 2011): [http://ag.ca.gov/cms\\_attachments/initiatives/pdfs/i1013\\_11-0070\\_\(insurance\\_affordability\).pdf](http://ag.ca.gov/cms_attachments/initiatives/pdfs/i1013_11-0070_(insurance_affordability).pdf).

chapter.”<sup>2</sup> Currently, the statutory provisions of Proposition 103 are implemented by the Insurance Commissioner through the regulations at Cal. Code of Regulations, Title 10, § 2641, *et seq.*, which set forth the criteria for determining whether a rate is excessive.

Additionally, under the same section, the proposed ballot initiative provides for retroactive review and approval by the Commissioner of rates that were proposed after November 6, 2012, and provides that rates in effect on November 6, 2012 and are found to be excessive are subject to refunds under the proposed initiative.

## **2) Review by Two Regulators**

By giving the Department of Insurance prior approval authority over all health care insurance products, the proposed ballot initiative would require a proposed rate action for any DMHC regulated products to receive two reviews, though DMHC would not have the authority to reject rates.

## **3) Definition of “Rates”**

The Insurance Rate Act defines “rate” to include not only the monthly premium to be charged for the coverage offered under the policy contract, but also “anything that affects the charges associated with health insurance, including but not limited to benefits, premiums, base rates, underwriting relativities, discounts, co-payments, coinsurance, deductibles, premium financing, installment fees and any other out of pocket costs of the policyholder.”

## **4) Hearings, Consumer Participation (Intervenors) and Judicial Review**

In addition to the review by CDI and its authority to reject rates, the initiative would make health care insurance rate actions subject to the intervenor provisions of Proposition 103 (as codified at Cal. Insurance Code § 1861.10), as follows:

- *Hearings:*

Under the Proposition 103 framework, as codified at Cal. Insurance Code § 1861.05(c), the Commissioner may elect to hold a hearing within the 60 day period following the rate filing, or an intervenor may request a hearing to challenge a rate action within 45 days of the rate filing.

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<sup>2</sup> Cal. Insurance Code § 1861.05(a).

- *7% Threshold for Mandatory Hearings:*

Under the Proposition 103 framework, if the requested rate action is an increase of over 7%, the commissioner must hold a hearing upon a timely request by an intervenor.

- *Consumer Participation (Intervenor):*

In addition to requesting a rate review hearing as described above, under the Proposition 103 framework as codified at Cal. Insurance Code § 1861.10(a), “Any person may initiate or intervene in any proceeding permitted or established pursuant to this chapter, challenge any action of the commissioner under this article, and enforce any provision of this article.”

- *Judicial Review:*

Additionally, the intervenor provisions of Proposition 103 provide for judicial review of the decision reached by the Commissioner or an Administrative Law Judge appointed by the Commissioner.<sup>3</sup>

Under the Proposition 103 statutory framework, the costs incurred by the intervenor may be awarded to the intervening party.<sup>4</sup> These costs, along with the overall administrative expenses related to rate review, are paid collectively by a fee levied on all insurers under Cal. Code of Regulations, Title 10, §2647.1. The proposed ballot initiative requires health plans to similarly pay this fee.

## 5) Future Modifications to the Initiative

Under Section 3 of the proposed ballot initiative, “This Act [...] shall not be amended, directly or indirectly, by the Legislature except to further its purposes by a statute passed [by a two-thirds vote], or by a statute that becomes effective only when approved by the electorate.” The commissioner is “granted the powers necessary to carry out the provisions” of the Act, which would include promulgating and implementing regulations to carry out the Act. Covered California intends to meet with the Department of Insurance to better understand how the Commissioner intends to implement those regulations, which will inform this analysis.

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<sup>3</sup> Cal. Insurance Code § 1861.09.

<sup>4</sup> Cal. Insurance Code § 1861.10(b).

### III. Context for Analysis

Covered California is preparing its analysis of the proposed ballot initiative in the context of the legal, policy, and operating environment within which the Exchange operates, including:

#### 1) Annual Open Enrollment Window

Consumers in Covered California's marketplace for individuals – and in the off-exchange individual market – can only sign up during an open enrollment window (November 15, 2014 to February 15, 2015 for the 2015 benefit year), unless they experience a qualifying event. Under federal rules, a qualified health plan must set its rates for an entire benefit year, and under state law all plans in the individual market must set their rates for the entire benefit year (January 1 to December 31).<sup>5</sup>

#### 2) Federal Premium Assistance Subsidies

Nearly 9 out of 10 Covered California consumers receive premium assistance in the form of advanced premium tax credits from the federal government. For these consumers, the value of their premium assistance tax credit depends on their income, household size, and the cost of the second-lowest silver plan in the rating region where they live. For a given consumer, the purchasing power of the tax credits and the actual net premium cost for coverage is therefore determined in part by the relative spread of prices for silver plans within a rating region and the cost of plans at other "metal levels" to which the consumer can apply their tax credit.

#### 3) Standardized Benefit Designs

To assist consumers in making comparisons between plans on price and value, Covered California's Board adopted a policy of requiring standardized benefit designs from its qualified health plans. As a result, all qualified health plans are required to conform to the same (or nearly identical) benefit structure in their Bronze, Silver, Gold, Platinum and minimum coverage offerings in the Covered California marketplace; they must offer an identical off-exchange product. Because of the board making that policy determination, health plans that are not offered in Covered California's marketplace are still required to offer the standard benefit design in the individual market.

#### 4) Active Purchaser Model and Existing Rate Review Processes

Covered California's authorizing statute directs that it act as a selective contractor to provide choices "that offer the optimal combination of choice, value, quality, and service" for

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<sup>5</sup> 45 C.F.R. § 156.210(a), Cal. Insurance Code § 10965.3(c), and Cal. Health and Safety Code § 1399.849(c); Cal. Insurance Code § 10965.9(d) and Cal. Health and Safety Code § 1399.855(d).

California's consumers.<sup>6</sup> Covered California implements a "triple aim" framework in its model contract with qualified health plans issuers that includes quality and satisfaction, improvement in the health of the population, and reduced per capita cost of covered services.<sup>7</sup> Covered California actively negotiates with health plans to get the best possible value for consumers. This process considers the mix of premium price, benefit designs, networks and other factors. In addition, under California law, after Covered California's negotiations are completed, rates are subject to review by the carriers' respective regulator (either DMHC or CDI). This review does not include specific authority to reject rates, but rates have been modified under prior reviews by both the DMHC and the CDI.

### 5) Regulatory Oversight by the CDI and the DMHC

Covered California relies on the respective regulators for their licensure, oversight and ongoing monitoring of the qualified health plans it contracts with. California uses a bifurcated structure to regulate health care insurance products, with the California Department of Insurance regulating traditional insurance products like disability, accident, and health, and the Department of Managed Health Care regulating managed care products. Both regulators review a health plan's rates, policy forms, and financial adequacy, but different bodies of law cover the plans licensed by the respective regulators (the California Insurance Code and the California Health and Safety Code), which have differences in areas such as network adequacy and timely access standards. These differences are rooted in the historical distinction between regulation of payment-based indemnity disability insurance (Cal. Insurance Code), and regulation of pre-paid, managed care contracts (Cal. Health and Safety Code). Currently, over 95% of Covered California's enrollment is in products regulated by the DMHC.

To implement Section 1003 of the Affordable Care Act, California's SB 1163 (Leno), Chapter 611, Statutes of 2010, requires 60 day advance filing and public notice of any rate action for a health care insurance product in the individual or small group market. Additionally, California's regulators have each received grants under the Affordable Care Act and have created searchable, online databases through which the public can view and comment on any rate filings. To implement the new rate review, the DMHC has contracted with Consumers Union and the CDI with CalPIRG and Consumer Watchdog to provide resources under their respective federal grants for active consumer engagement in the rate review process.

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<sup>6</sup> Statutes of 2010, Chapter 655 (AB 1602 – Perez), Section 2(d).

<sup>7</sup> See Article 1, Covered California, and "Covered California Qualified Health Plan Contract for 2014," (July 3, 2013 version): <http://hbex.coveredca.com/solicitations/QHP/library/QHPModelContract-Final.pdf>.

## 6) Changes to Insurance Regulation and Oversight under the Affordable Care Act

The Affordable Care Act enacted major changes in the structure and regulatory environment of the individual health insurance marketplace in which Covered California operates. In addition to the provision of federal subsidies through the Advanced Premium Tax Credits, some of the major provisions include: establishing standard essential health benefits and actuarial values that all plans must comply with; removing the ability of insurance companies to screen applicants for pre-existing conditions (when consumers apply for coverage during open enrollment); creating risk adjustment processes that make transfer payments among plans based on which plans have more or fewer high cost enrollees; and establishing standards requiring health plans to spend 80% or 85% of premiums collected on health care or refund to consumers the difference (the Medical Loss Ratio provisions).

## 7) Current Contracting and Operational Calendar for Open Enrollment

Having completed its first open enrollment period, Covered California is now implementing special enrollment for individuals who experience a qualifying life event. It is also preparing for the first “renewal” of those who enrolled and the new opportunity for those who did not enroll in the initial year to sign-up for insurance in the second open enrollment period that starts this coming November. To prepare for open enrollment each fall, the current contracting and operational calendar includes a tightly choreographed sequence that begins anew at the beginning of each calendar year. Under the current timelines, there is very little flexibility in the event there are major delays (see Attachment 1 – Covered California Contracting Timeline for additional details). The major operational elements that must be fully developed in advance of the start of open enrollment period (November 15 in 2015, October 7 each year thereafter) include:

- **Plan Contracting:** revising the standard benefit designs; bid submissions by health plans; review of plan bids and negotiations; submission of final negotiated plans to regulators;
- **Marketing, outreach and consumer notifications:** developing printed material and training for both renewal and new enrollment information; training sales channels in products, benefits and prices (Covered California uses a network of more than 12,000 licensed agents, more than 5,000 certified enrollment counselors, county eligibility workers, customer service staff and plan-based enrollers); sending renewal notices with both product prices and the available federal subsidy that is calculated based on the consumer’s income and the second lowest cost silver plan in their area; paid media; and community outreach; and

- **Information Systems:** the loading into the California Health Eligibility, Enrollment & Retention System (CalHEERS) of plan information, benefit design and prices – along with changes in the display of that information – is all complex and has relatively limited flexibility. Insofar as new standard benefit designs are part of consumers’ choices, the information system designs for such changes need to occur by August.

#### IV. Implementation Questions – Rules and Procedures Potentially Impacting Operations

Given the tight timelines to prepare new product offerings in time for open enrollment, there are a number of operational questions that need to be considered in the context of implementing the Insurance Rate Act. The section that follows details questions that relate to the administration of the Insurance Rate Act that Covered California will be exploring in order to assess the operational impacts on Covered California. These questions are organized around whether or not a rate change application is subjected to a hearing under the Proposition 103 framework and the potential impacts on Covered California if rate review is not completed in time for open enrollment.

##### 1) Timeline of Review for Rates Without a Hearing

- a) How does review under two regulators proceed?*
- b) Does the Insurance Rate Act change the timeline within which CDI would conduct rate oversight compared to the current rate review timeline?*
- c) If the CDI rate approval results in a change to rates, benefits or has an effect on other element of the plans operations (e.g., networks, solvency), to what extent do the changes require new licensing review on the part of the DMHC if the plan is subject to its regulatory oversight?*
- d) What actions by intervenors are permitted if the CDI decides to not hold a hearing, and what effects could these actions have on the timeline to approval for rate change applications that do not go to a hearing?*
- e) To what extent are the timing and processes for review of rates without hearing subject to clarification by regulations that will be issued subsequent to passage of the Insurance Rate Act or litigation to construe how to interpret the Act?*

## 2) Timeline of Review for Rates with a Hearing

Under the Proposition 103 statutory framework – which would apply to health insurance under the proposed ballot initiative – the commissioner must hold a hearing for a rate change application of over 7% upon timely request by an intervenor. On the other hand, if the rate change application is under 7%, the commissioner can exercise discretion about whether or not to hold a hearing.

- a) *Will all health insurance filings over 7% be subject to mandatory hearing upon timely request by intervenors and what are the likely timelines for such hearings?*
- b) *Can health filing review hearings proceed on a shorter timeframe than those currently used for Proposition 103 hearings in the property and casualty context?*
- c) *What happens to a rate filing while it is undergoing administrative review? What about judicial review?*
- d) *At what point(s) in the hearing or review process would Covered California and health plans know that rates proposed for the coming year would not be able to be approved for the next plan year pending the review process? If rates cannot be approved pending the hearing, at what point would the determination be made that last year's rates would need to apply for open enrollment and next year's full special enrollment period?*
- e) *To what extent are the timing and processes for review of rates with a hearing subject to clarification by regulations that will be issued subsequent to passage of the Insurance Rate Act or litigation to construe how to interpret the Act?*
- f) *What percentage of health insurance rates have historically been over 7% and potentially subject to a hearing? Is there data on the portion of rate increases that reflects underlying medical costs/trends?*



### 3) Any Rate Change – If the Rate Is Not Approved in Time for Open Enrollment

Covered California needs to better understand its options if a rate change is not approved in time for open enrollment. Under federal law, carriers cannot change rates or re-enter the market mid-way through the benefit year. Additionally, under federal regulations, qualified health plan recertification must be completed by September 15.

a) *Can Covered California allow an issuer to sell last year's product at last year's rate?*

i. *Could offering last year's product at last year's rate trigger a requirement to file a licensing review with the DMHC? If so, how long would this review take?*

ii. *What are the implications if last year's product is not compliant with new benefit mandates from the legislature?*

iii. *What are the implications if last year's product is not compliant with new Covered California standardized benefit designs (implications for both Covered California and off-exchange products)? (For example, in 2015, Covered California encouraged plans to submit a standardized benefit design with an "embedded" pediatric dental benefit.)*

b) *Can Covered California allow an issuer to sell the new year's product at last year's rate?*

i. *Would the regulators permit an issuer that does not have a new rate approved to offer the new product at the old rate?*

ii. *What would be the regulatory approval process for this product? Would the 60-day advance filing of the new product with the DMHC be sufficient if the rate were held to the last year's level?*

c) *Can a carrier decide to withdraw rather than offer a product at last year's rate?*

i. *Could an issuer choose to withdraw its Covered California product offering from the marketplace if its rates will not be ready in time for open enrollment? What consumer notice requirements would be in effect for the plan?*

ii. *If an issuer chose to withdraw from the market altogether, would it be required to provide 90 or 180 day notice to consumers, and at what point would carriers know that its proposed rates could not apply for the coming year to decide to withdraw?*

#### 4) Implications of the Initiative for 2015 Plan Year

If the Insurance Rate Act passes, it would take effect on November 5, 2014 (ten days before the formal beginning of open enrollment) and potentially cover rates for products proposed after, or in effect on, November 6, 2012 (with provisions for potential refund if the CDI were to find the rates excessive).

- a) *To what extent, whether by regulatory action, hearing request or judicial action, would the portfolio of products being marketed for new and renewal enrollment for 2015 be subject to potential challenge that could require their removal or re-pricing?*
- b) *Would the transitional period contemplated by the Insurance Rate Act apply to rates that are planned to go into effect on January 1, 2015?*

### V. Implementation Considerations – Impacts on Premium Assistance, Tax Credits, Standard Benefit Designs, Networks, and Quality Initiatives

As an active purchaser, Covered California seeks to offer a diversity of qualified health plan choices that are selected and structured to maximize the benefit for consumers. This approach is embodied in Covered California's contracting – including offering a mix of plans for each region, negotiating for the best value and optimum prices (including maximizing the purchasing power of premium assistance tax credits), and requiring standardized benefit designs to facilitate competition on price and value. Depending on the number and characteristics of health plans that might be affected by the Initiative, what follow are questions Covered California needs to consider regarding its operations and the impacts on its consumers.

#### 1) Premium Assistance Tax Credits

The vast majority of Covered California's consumers (over 85%) receive a tax credit based on household size, income, and the cost of the second-lowest silver plan available in the region. As a result, the net price for most consumers for the coverage they purchase through Covered California is determined in part by the relative prices for silver plans within a region and the costs of plans at other metal tiers. Under a scenario in which one or more plans have their premiums held at the prior year's level, subsidized consumers could see their tax credit amount change relative to what the credit would have been at the conclusion of Covered California's negotiations with the health plans, with complex consequences for the purchasing power of the tax credit.

- a) *What modeling can Covered California do to assess the potential impacts on federal subsidy and total net premium cost for its consumers?*
- b) *When one or more rates are held or reduced, for subsidized consumers, what are the effects on the affordability of the plan that has its rates held or reduced?*
- c) *When one or more rates are held or reduced, for subsidized consumers, what are the effects on the affordability of the plans that did receive approval for their new year's rates due to an impact on the tax credits?*
- d) *Is there a basis to predict how frequently plans may have their rates kept constant for the year?*

Unsubsidized consumers through Covered California would experience any rate changes that result from the Insurance Rate Act in the same way as consumers in the market outside of the Exchange. An evaluation of how the Insurance Rate Act would affect rates and product offerings throughout the market is beyond the scope of this operational analysis.

## **2) Standard Benefit Designs, Networks, and Quality Initiatives**

Contracting decisions under Covered California's "triple aim" framework, benefit designs, networks, and quality initiatives play an important role in defining the choice, affordability, and value received by consumers. These contracting elements include: standardized benefit designs (e.g. coinsurance versus copayments); network composition and the inclusion of essential community providers; and quality initiatives related to delivery, access and consumer experience, including coordination of care, initiatives to address health disparities, improvements to customer service, and quality reporting.

- a) *To the extent that the proposed initiative's definition of "rates" include the authority to alter benefit designs and other elements of plan features, what is the effect for consumers' comparison shopping of not having standardized benefit designs (either because rate review results in a modification to the design, or because an issuer ends up offering last year's product)?*
- b) *Does the proposed initiative's definition of "rates" include the authority to consider or alter networks? To the extent it does, what are the implications for DMHC licensure and oversight of network adequacy and timely access to care standards?*
- c) *What, if any, are the implications of the proposed initiative on Covered California's efforts to negotiate on a "triple aim" framework, including efforts to assure network adequacy, promote quality and reduce health disparities?*

## VI. Implementation Considerations – Impact on Operations

### 1) Marketing and Outreach

Covered California’s marketing and outreach is essential to ensure that all Californians have access to affordable health care coverage. In light of a short open enrollment period each year, the preparation, timing, and execution of both paid and earned media, advertising, community outreach and enrollment assistance efforts are critical. In particular, Certified Insurance Agents and Certified Enrollment Counselors must be trained on each year’s new product offerings. In 2014, Covered California was able to announce new rates shortly after filing with the regulators and begin delivering consumer tools (like the Shop and Compare Calculator) to drive consumer awareness and momentum in the lead up to open enrollment.

- a) *How early could Covered California go to market under the proposed ballot initiative?*
- b) *If benefit designs may change shortly before open enrollment, how quickly can Covered California’s Certified sales force and marketing adapt:*
  - i. *Need and timeline to change IT tools like the Shop and Compare Calculator?*
  - ii. *Need and timeline to modify training materials and communicate changes to call center representatives and certified sales force?*
  - iii. *Need and timeline to modify advertising copy that is already under development?*

### 2) Eligibility and Enrollment

Renewal notices from both Covered California and qualified health plans must be sent to existing consumers prior to open enrollment. In order to generate complete notices with new prices, Covered California must re-run consumers’ eligibility and determine their new tax credit amounts, which are based on the new rates. Covered California is currently structuring the timing and process for these renewal notices, which include a notice from Covered California informing a consumer of their eligibility determination for the new plan year, as well as notices from qualified health plans to each of their enrollees. At a minimum, however, renewal notices must be sent by the qualified health plans to their current enrollees at least 60 days ahead of the new coverage period (i.e., by November 1).

- a) *In order to ensure timely renewal notices, what is the last possible date for an approved rate to be finalized to allow for communication to consumers in time for the next year’s open enrollment?*

### 3) Choice Structure and IT Systems

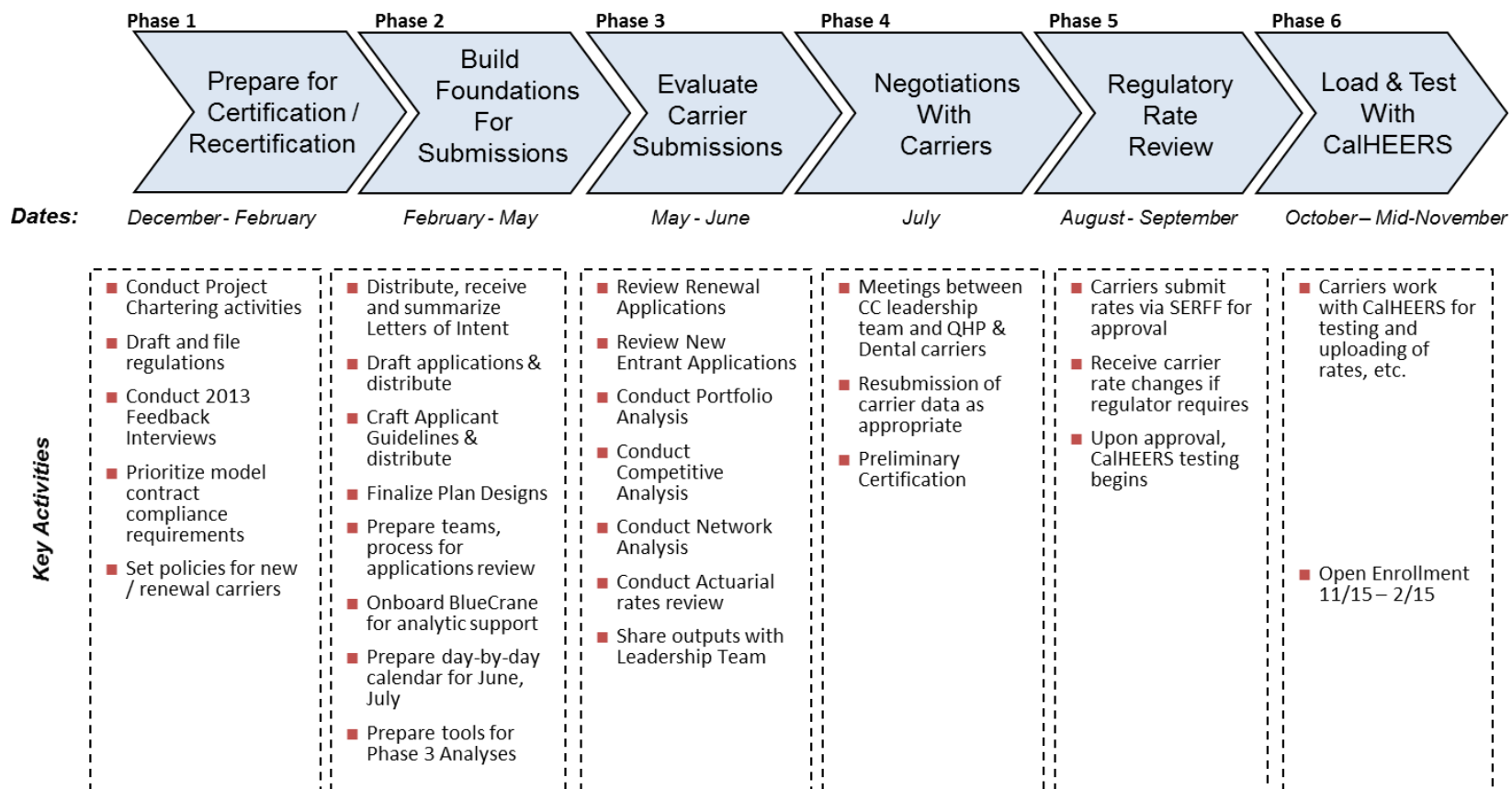
Covered California's "choice architecture" is carefully designed and tested to promote a consumer experience that structures the consumers' decision based on factors such as potential total financial exposure to the consumer and availability of providers. While the IT systems are able to alter pricing on a relatively quick timeframe, change to benefit designs may require more reprogramming.

- a) *How quickly can CoveredCA.Com (CalHEERS) adapt to the potential offering of multiple benefit designs? What programming is needed to accommodate the offering of non-standard designs?*

Attachment 1 – Covered California Contracting Timeline

Certification / Recertification Program Summary Timeline

Timeline for activities conducted by Covered California in 2015 related to Qualified Health Plan certification and recertification.





## Attachment 2 – Initiative Text

### Insurance Rate Public Justification and Accountability Act

California Secretary of State, Initiative No. 11-0070 (received Nov. 8, 2011):

[http://ag.ca.gov/cms\\_attachments/initiatives/pdfs/i1013\\_11-0070\\_\(insurance\\_affordability\).pdf](http://ag.ca.gov/cms_attachments/initiatives/pdfs/i1013_11-0070_(insurance_affordability).pdf).

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Insurance Rate Public Justification and Accountability Act

#### Section 1. Findings and Purpose.

Health insurance, home insurance and auto insurance are mandatory for Californians due to economic necessity or the force of law. In such cases, government has an obligation to guarantee that the insurance is affordable, available, competitive and fair.

The purpose of this measure is to ensure fair and transparent rates for health, home and auto insurance by: (1) requiring health insurance companies to publicly disclose and justify their rates, under penalty of perjury, before the rates can take effect; (2) prohibiting unfair pricing for health, auto and home insurance based on prior coverage and credit history; and (3) requiring health insurance companies to pay a fee to cover the costs of administering these new laws so that this initiative will cost taxpayers nothing.

#### Section 2. Public Scrutiny and Review of Insurance Rates.

Section 1861.17 is added to Article 10 of Chapter 9 of Part 2 of Division 1 of the Insurance Code to read:

Sec. 1861.17. (a) Sections 1861.03(a) and (b) and 1861.04 through 1861.14 shall apply to health insurance, notwithstanding Sections 1851(e) and 10181-10181.13, Sections 1385.01-1385.13 of the Health and Safety Code, or any other provision of law. Health insurance rates proposed after November 6, 2012 shall be approved by the commissioner prior to their use, and health insurance rates in effect on November 6, 2012 are subject to refund under this section. Applications for health insurance rates shall be accompanied by a statement, sworn under penalty of perjury by the chief executive of the company, declaring that the contents are accurate and comply in all respects with California law.

(b) There shall be a transitional period during which the commissioner may permit, on a conditional basis and subject to refund as required by subdivision (c), rates for new health insurance that have not been approved pursuant to section 1861.05, provided (i) that the rates have an implementation date on or before January 1, 2014 and (ii) that the new health insurance has not previously been marketed in California and contains provisions mandated by federal law, or state law in effect as of January 1, 2012.

(c) In a proceeding pursuant to the authority of Section 1861.10(a), including a proceeding under Sections 1861.03 or 1861.05, where it is determined that a company charged health insurance rates that are excessive or otherwise in violation of this article, the company shall be required to pay refunds with interest, notwithstanding any other provision of law and in addition to any other penalty permitted by law.

(d) With respect to health, automobile and homeowners insurance, the absence of prior insurance coverage, or a person's credit history, shall not be a criterion for determining eligibility for a policy or contract, or generally for rates, premiums or insurability.

(e) Notwithstanding any other provision of law, the commissioner is granted the powers necessary to carry out the provisions of this section, including any and all authority for health care service plan rate review granted to the Department of Managed Health Care by Section 1385.01 et seq. of the Health and Safety Code.

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## Attachment 2 – Initiative Text (Page 2)

(f) Health insurance companies shall pay the filing fees required by Section 12979, which, notwithstanding Section 13340 of the Government Code, are continuously appropriated to cover any operational or administrative costs arising from this section. The commissioner shall annually report to the public all such expenditures and the impact of this section.

(g) For purposes of this section:

(1) "Health insurance" means a policy or contract issued or delivered in California (i) as defined in Section 106(b) or (ii) a health care service plan, as defined by Section 1345(f) of the Health and Safety Code.

(2) "Rate" means the charges assessed for health insurance or anything that affects the charges associated with health insurance, including but not limited to benefits, premiums, base rates, underwriting relativities, discounts, co-payments, coinsurance, deductibles, premium financing, installment fees and any other out of pocket costs of the policyholder.

(3) The following shall not be subject to this section: A large group health insurance policy or contract as defined by Section 10181(a) or Section 1385.01(a) of the Health and Safety Code, or a policy or contract excluded under Section 10181.2 or Section 1385.02 of the Health and Safety Code, as those provisions were in effect on January 1, 2011.



## Attachment 2 – Initiative Text (Page 3)

### Section 3. Technical Matters.

This Act shall be liberally construed and applied in order to fully promote its underlying purposes, and shall not be amended, directly or indirectly, by the Legislature except to further its purposes by a statute passed in each house by rollcall vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate. If any provision of this Act or the application thereof to any person or circumstances is held invalid or unenforceable, it shall not affect other provisions or applications of the Act which can be given effect without the invalid or unenforceable provision or application, and to this end the provisions of this Act are severable.