

**ASSEMBLY BILL**

**No. 1749**

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**Introduced by Committee on Health (Dymally (Chair), Bass, Berg, De Leon, Gaines, Hancock, Hayashi, Huff, Jones, Lieber, and Salas)**

March 22, 2007

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An act to amend Sections 1341.4, 1342.5, 1343, 1347.15, and 1352 of, and to repeal Section 1342.1 of, the Health and Safety Code, and to amend Sections 106 and 10113.95 of, and to repeal Section 12693.365 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1749, as introduced, Committee on Health. Committee on Health: Health care coverage.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care.

This bill would make technical, nonsubstantive changes to various provisions pertaining to the regulation of health care service plans and would also delete certain obsolete provisions.

(2) Existing law provides for the regulation of health insurers by the Department of Insurance and defines health insurance as an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. Under existing law, a health insurer that markets and sells individual health insurance policies is required to maintain underwriting guidelines, as specified, and to file annually with the Insurance Commissioner a general description of its rating and underwriting guidelines for individual health insurance policies.

This bill would specify that the requirements applicable to a health insurer that markets and sells individual health insurance policies apply to a health insurer that issues, renews, or amends an individual health insurance policy. The bill would provide that, effective January 1, 2008, the term “specialized health insurance policy” means a policy of health insurance for covered benefits in a single specialized area of health care.

(3) Existing law establishes the Healthy Families Program administered by the Managed Risk Medical Insurance Board to provide health care services to eligible children. Existing law authorizes certain geographic managed care plans, as defined, that do not have a commercial license from the Department of Managed Health Care to contract with the board for a maximum period of 12 months.

This bill would repeal that provision.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 1341.4 of the Health and Safety Code is  
2 amended to read:

3 1341.4. (a) In order to effectively support the Department of  
4 Managed *Health* Care in the administration of this law, there is  
5 hereby established in the State Treasury, the Managed Care Fund.  
6 The administration of the Department of Managed *Health* Care  
7 shall be supported from the Managed Care Fund.

8 ~~(b) For the 2004–05 and 2005–06 fiscal years only, up to three~~  
9 ~~hundred sixty-four thousand dollars (\$364,000) from the Managed~~  
10 ~~Care Fund may be used annually to support staff and related~~  
11 ~~functions associated with the California Health Care Quality~~  
12 ~~Improvement and Cost Containment Commission established~~  
13 ~~pursuant to Chapter 8 (commencing with Section 127670) of Part~~  
14 ~~2 of Division 107.~~

15 (e)  
16 (b) In any fiscal year, the Managed Care Fund shall maintain  
17 not more than a prudent 5 percent reserve unless otherwise  
18 determined by the Department of Finance.

19 SEC. 2. Section 1342.1 of the Health and Safety Code is  
20 repealed.

1     ~~1342.1. (a) The Legislature finds and declares all of the~~  
2 ~~following:~~  
3     ~~(1) More than 16 million Californians are enrolled in health~~  
4 ~~care service plans, and this number is likely to grow significantly~~  
5 ~~over the next decade.~~  
6     ~~(2) Although the Knox-Keene Health Care Service Plan Act~~  
7 ~~of 1975 contains many consumer protections, there is interest on~~  
8 ~~the part of consumers and providers to determine if additional~~  
9 ~~protections may be necessary.~~  
10    ~~(3) Health care service plans have many different structures~~  
11 ~~and payment mechanisms, and there is interest on the part of health~~  
12 ~~care service plans, providers, health professions educators, and~~  
13 ~~consumers as to whether and how these structures and payment~~  
14 ~~mechanisms affect quality and cost.~~  
15    ~~(b) The Governor shall convene a task force on health care~~  
16 ~~service plans, composed of 30 members, to research all of the~~  
17 ~~following by January 1, 1998:~~  
18    ~~(1) The picture of health care service plans, as it stands in~~  
19 ~~California today, including, but not limited to, the different types~~  
20 ~~of health care service plans, how they are regulated, how they are~~  
21 ~~structured, how they operate, the trends and changes in health care~~  
22 ~~delivery, and how these changes have affected the health care~~  
23 ~~economy, academic medical centers, and health professions~~  
24 ~~education.~~  
25    ~~(2) Whether the goals of managed care provided by health care~~  
26 ~~service plans are being satisfied, including the goals of controlling~~  
27 ~~costs and improving quality and access to care.~~  
28    ~~(3) A comparison of the effects of provider financial incentives~~  
29 ~~on the delivery of health care in health care service plans, other~~  
30 ~~managed care plans, and fee-for-service settings.~~  
31    ~~(4) The effect of managed care on the patient-physician~~  
32 ~~relationship, if any.~~  
33    ~~(5) The effect of other managed care plans on academic medical~~  
34 ~~centers and health professions education.~~  
35    ~~(c) The task force shall be composed of equal representation~~  
36 ~~from the following groups:~~  
37    ~~(1) Health care service plans, including at least one local~~  
38 ~~initiative under contract with the State Department of Health~~  
39 ~~Services as part of the two-plan model for Medi-Cal managed care,~~  
40 ~~and at least one disability insurer.~~

- 1 ~~(2) Employers who purchase health care.~~
- 2 ~~(3) Health care service plan enrollees.~~
- 3 ~~(4) Providers of health care.~~
- 4 ~~(5) Representatives from consumer groups.~~

5 ~~(d) The members of the task force shall be appointed as follows:~~

6 ~~(1) The Senate Committee on Rules shall appoint five members,~~  
7 ~~one from each of the categories set forth in subdivision (e).~~

8 ~~(2) The Speaker of the Assembly shall appoint five members,~~  
9 ~~one from each of the categories set forth in subdivision (e).~~

10 ~~(3) The Governor shall appoint 20 members, four from each~~  
11 ~~of the categories set forth in subdivision (e).~~

12 ~~(e) Notwithstanding any other provision of law, the members~~  
13 ~~of the task force shall receive no per diem or travel expense~~  
14 ~~reimbursement, or any other expense reimbursement.~~

15 SEC. 3. Section 1342.5 of the Health and Safety Code is  
16 amended to read:

17 1342.5. The director shall consult with the Insurance  
18 Commissioner prior to adopting any regulations applicable to  
19 health care service plans subject to this chapter ~~and nonprofit~~  
20 ~~hospital service plans subject to Chapter 11A (commencing with~~  
21 ~~Section 11491) of Part 2 of Division 2 of the Insurance Code and~~  
22 ~~other entities governed by the Insurance Code for the specific~~  
23 ~~purpose of ensuring, to the extent practical, that there is consistency~~  
24 ~~of regulations applicable to these plans and entities by the Insurance~~  
25 ~~Commissioner and the Director of the Department of Managed~~  
26 ~~Health Care.~~

27 SEC. 4. Section 1343 of the Health and Safety Code is amended  
28 to read:

29 1343. (a) This chapter shall apply to health care service plans  
30 and specialized health care service plan contracts as defined in  
31 subdivisions (f) and (o) of Section 1345.

32 (b) The director may by the adoption of rules or the issuance  
33 of orders deemed necessary and appropriate, either unconditionally  
34 or upon specified terms and conditions or for specified periods,  
35 exempt from this chapter any class of persons or plan contracts if  
36 the director finds the action to be in the public interest and not  
37 detrimental to the protection of subscribers, enrollees, or persons  
38 regulated under this chapter, and that the regulation of the persons  
39 or plan contracts is not essential to the purposes of this chapter.

1 (c) The director, upon request of the Director of Health Care  
2 Services, shall exempt from this chapter any county-operated pilot  
3 program contracting with the State Department of Health Care  
4 Services pursuant to Article 7 (commencing with Section 14490)  
5 of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions  
6 Code. The director may exempt non-county-operated pilot  
7 programs upon request of the ~~State~~ Director of Health Care  
8 Services. Those exemptions may be subject to conditions the  
9 Director of Health Care Services deems appropriate.

10 (d) Upon the request of the Director of Mental Health, the  
11 director may exempt from this chapter any mental health plan  
12 contractor or any capitated rate contract under Part 2.5  
13 (commencing with Section 5775) of Division 5 of the Welfare and  
14 Institutions Code. Those exemptions may be subject to conditions  
15 the Director of Mental Health deems appropriate.

16 (e) This chapter shall not apply to:

17 (1) A person organized and operating pursuant to a certificate  
18 issued by the Insurance Commissioner unless the entity is directly  
19 providing the health care service through those entity-owned or  
20 contracting health facilities and providers, in which case this  
21 chapter shall apply to the insurer's plan and to the insurer.

22 (2) A plan directly operated by a bona fide public or private  
23 institution of higher learning which directly provides health care  
24 services only to its students, faculty, staff, administration, and their  
25 respective dependents.

26 ~~(3) A nonprofit corporation formed under Chapter 11a~~  
27 ~~(commencing with Section 11491) of Part 2 of Division 2 of the~~  
28 ~~Insurance Code.~~

29 ~~(4)~~

30 (3) A person who does all of the following:

31 (A) Promises to provide care for life or for more than one year  
32 in return for a transfer of consideration from, or on behalf of, a  
33 person 60 years of age or older.

34 (B) Has obtained a written license pursuant to Chapter 2  
35 (commencing with Section 1250) or Chapter 3.2 (commencing  
36 with Section 1569).

37 (C) Has obtained a certificate of authority from the State  
38 Department of Social Services.

39 ~~(5)~~

1 (4) The Major Risk Medical Insurance Board when engaging  
 2 in activities under Chapter 8 (commencing with Section 10700)  
 3 of Part 2 of Division 2 of the Insurance Code, Part 6.3  
 4 (commencing with Section ~~12695~~ 12694) of Division 2 of the  
 5 Insurance Code, and Part 6.5 (commencing with Section 12700)  
 6 of Division 2 of the Insurance Code.

7 ~~(6)~~

8 (5) The California Small Group Reinsurance Fund.

9 SEC. 5. Section 1347.15 of the Health and Safety Code is  
 10 amended to read:

11 1347.15. (a) There is hereby established in the Department of  
 12 Managed Health Care the Financial Solvency Standards Board  
 13 composed of eight members. The members shall consist of the  
 14 director, or the director’s designee, and seven members appointed  
 15 by the director. The seven members appointed by the director may  
 16 be, but are not necessarily limited to, individuals with training and  
 17 experience in the following subject areas or fields: medical and  
 18 health care economics; accountancy, with experience in integrated  
 19 or affiliated health care delivery systems; excess loss insurance  
 20 underwriting in the medical, hospital, and health plan business;  
 21 actuarial studies in the area of health care delivery systems;  
 22 management and administration in integrated or affiliated health  
 23 care delivery systems; investment banking; and information  
 24 technology in integrated or affiliated health care delivery systems.  
 25 The members appointed by the director shall be appointed for a  
 26 term of three years, but may be removed or reappointed by the  
 27 director before the expiration of the term.

28 (b) The purpose of the board is to do all of the following:

29 (1) Advise the director on matters of financial solvency affecting  
 30 the delivery of health care services.

31 (2) Develop and recommend to the director financial solvency  
 32 requirements and standards relating to plan operations,  
 33 plan-affiliate operations and transactions, plan-provider contractual  
 34 relationships, and provider-affiliate operations and transactions.

35 (3) Periodically monitor and report on the implementation and  
 36 results of the financial solvency requirements and standards.

37 (c) Financial solvency requirements and standards recommended  
 38 to the director by the board may, after a period of review and  
 39 comment not to exceed 45 days, be noticed for adoption as  
 40 regulations as proposed or modified under the rulemaking

1 provisions of the Administrative Procedure Act (Chapter 3.5  
2 (commencing with Section 11340) of Part 1 of Division 3 of Title  
3 2 of the Government Code). During the director’s 45-day review  
4 and comment period, the director, in consultation with the board,  
5 may postpone the adoption of the requirements and standards  
6 pending further review and comment. Nothing in this subdivision  
7 prohibits the director from adopting regulations, including  
8 emergency regulations, under the rulemaking provisions of the  
9 Administrative Procedure Act.

10 (d) ~~Except as provided in subdivision (e), the~~ *The* board shall  
11 meet at least quarterly and at the call of the chair. In order to  
12 preserve the independence of the board, the director shall not serve  
13 as chair. The members of the board may establish their own rules  
14 and procedures. All members shall serve without compensation,  
15 but shall be reimbursed from department funds for expenses  
16 actually and necessarily incurred in the performance of their duties.

17 ~~(e) During the two years from the date of the first meeting of~~  
18 ~~the board, the board shall meet monthly in order to expeditiously~~  
19 ~~fulfill its purpose under paragraphs (1) and (2) of subdivision (b).~~

20 (f)

21 (e) For purposes of this section, “board” means the Financial  
22 Solvency Standards Board.

23 SEC. 6. Section 1352 of the Health and Safety Code is amended  
24 to read:

25 1352. (a) A licensed plan shall, within 30 days after any  
26 change in the information contained in its application, other than  
27 financial or statistical information, file an amendment thereto in  
28 the manner the director may by rule prescribe setting forth the  
29 changed information. However, the addition of any association,  
30 partnership, or corporation in a controlling, controlled, or affiliated  
31 status relative to the plan shall necessitate filing, within a 30-day  
32 period of an authorization for disclosure to the director of financial  
33 records of the person pursuant to Section 7473 of the Government  
34 Code.

35 (b) Prior to ~~any~~ *a* material modification of its plan or operations,  
36 a plan shall give notice thereof to the director, who shall, within  
37 20 business days or such additional time as the plan may specify,  
38 by order approve, disapprove, suspend, or postpone the  
39 effectiveness of ~~any such~~ *the* change, subject to Section 1354.

1 (c) A plan shall, within five days, give written notice to the  
 2 director in the form as by rule may be prescribed, of ~~any~~ a change  
 3 in the officers, directors, partners, controlling shareholders,  
 4 principal creditors, or persons occupying similar positions or  
 5 performing similar functions, of the plan and of ~~any~~ a management  
 6 company of the plan, and of ~~any~~ a parent company of the plan or  
 7 management company. The director may by rule define the  
 8 positions, duties, and relationships which are referred to in this  
 9 subdivision.

10 (d) The fee for filing a notice of ~~major~~ *material* modification  
 11 pursuant to subdivision (b) shall be the actual cost to the director  
 12 of processing the notice, including overhead, but shall not exceed  
 13 seven hundred fifty dollars (\$750).

14 SEC. 7. Section 106 of the Insurance Code is amended to read:

15 106. (a) Disability insurance includes insurance appertaining  
 16 to injury, disablement or death resulting to the insured from  
 17 accidents, and appertaining to disablements resulting to the insured  
 18 from sickness.

19 (b) In statutes that become effective on or after January 1, 2002,  
 20 the term “health insurance” for purposes of this code shall mean  
 21 an individual or group disability insurance policy that provides  
 22 coverage for hospital, medical, or surgical benefits. The term  
 23 “health insurance” shall not include any of the following kinds of  
 24 insurance:

25 (1) Accidental death and accidental death and dismemberment.

26 (2) Disability insurance, including hospital indemnity, accident  
 27 only, and specified disease insurance that pays benefits on a fixed  
 28 benefit, cash payment only basis.

29 (3) Credit disability, as defined in subdivision (2) of Section  
 30 779.2.

31 (4) Coverage issued as a supplement to liability insurance.

32 (5) Disability income, as defined in subdivision (i) of Section  
 33 799.01.

34 (6) Insurance under which benefits are payable with or without  
 35 regard to fault and that is statutorily required to be contained in  
 36 any liability insurance policy or equivalent self-insurance.

37 (7) Insurance arising out of a workers’ compensation or similar  
 38 law.

39 (8) Long-term care.

1 (c) *Effective January 1, 2008, the term “specialized health*  
2 *insurance policy” as used in this code shall mean a policy of health*  
3 *insurance for covered benefits in a single specialized area of health*  
4 *care.*

5 SEC. 8. Section 10113.95 of the Insurance Code is amended  
6 to read:

7 10113.95. (a) A health insurer that ~~markets and sells~~ *issues,*  
8 *renews, or amends* individual health insurance policies shall be  
9 subject to this section.

10 (b) An insurer subject to this section shall have written policies,  
11 procedures, or underwriting guidelines establishing the criteria  
12 and process whereby the insurer makes its decision to provide or  
13 to deny coverage to individuals applying for coverage and sets the  
14 rate for that coverage. These guidelines, policies, or procedures  
15 shall assure that the plan rating and underwriting criteria comply  
16 with Sections 10140 and 10291.5 and all other applicable  
17 provisions.

18 (c) On or before June 1, 2006, and annually thereafter, every  
19 insurer shall file with the commissioner a general description of  
20 the criteria, policies, procedures, or guidelines that the insurer uses  
21 for rating and underwriting decisions related to individual health  
22 insurance policies, which means automatic declinable health  
23 conditions, health conditions that may lead to a coverage decline,  
24 height and weight standards, health history, health care utilization,  
25 lifestyle, or behavior that might result in a decline for coverage or  
26 severely limit the health insurance products for which they would  
27 be eligible. An insurer may comply with this section by submitting  
28 to the department underwriting materials or resource guides  
29 provided to agents and brokers, provided that those materials  
30 include the information required to be submitted by this section.

31 (d) Commencing September 1, 2006, the commissioner shall  
32 post on the department’s Web site, in a manner accessible and  
33 understandable to consumers, general, noncompany specific  
34 information about rating and underwriting criteria and practices  
35 in the individual market and information about the Major Risk  
36 Medical Insurance Program. The commissioner shall develop the  
37 information for the Web site in consultation with the Department  
38 of Managed Health Care to enhance the consistency of information  
39 provided to consumers. Information about individual health  
40 insurance shall also include the following notification:

1 “Please examine your options carefully before declining group  
2 coverage or continuation coverage, such as COBRA, that may be  
3 available to you. You should be aware that companies selling  
4 individual health insurance typically require a review of your  
5 medical history that could result in a higher premium or you could  
6 be denied coverage entirely.”

7 (e) Nothing in this section shall authorize public disclosure of  
8 company-specific rating and underwriting criteria and practices  
9 submitted to the commissioner.

10 SEC. 9. Section 12693.365 of the Insurance Code is repealed.

11 ~~12693.365. Geographic managed care plans that have a contract  
12 with the Department of Health Services, that contract with the  
13 program, and that are licensed by the Department of Managed  
14 Health Care but do not have a commercial license from the  
15 Department of Managed Health Care, may contract with the board  
16 for a maximum of 12 months. During this 12-month period, those  
17 plans shall be required to be in good standing with the Department  
18 of Managed Health Care and shall demonstrate to the board that  
19 they are making a good faith effort to obtain a commercial license  
20 from the Department of Managed Health Care. In their application  
21 to the program, those plans shall provide assurance of their standing  
22 with the Department of Managed Health Care and shall outline  
23 their plans for obtaining commercial licensure.~~