

Assembly Bill No. 2569

Passed the Assembly August 31, 2008

Chief Clerk of the Assembly

Passed the Senate August 29, 2008

Secretary of the Senate

This bill was received by the Governor this _____ day
of _____, 2008, at _____ o'clock ____M.

Private Secretary of the Governor

CHAPTER _____

An act to add Sections 1389.7 and 1389.8 to the Health and Safety Code, and to add Sections 10119.2 and 10119.3 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2569, De Leon. Health care coverage: rescission.

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 and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a plan or insurer from rescinding, canceling, or limiting a health plan contract or health insurance policy due to the plan's or insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information on or with an application before issuing a contract or policy. Existing law requires a health care service plan and individual benefit plans issued, amended, renewed, or delivered on or after January 1, 2007, to permit an individual who has been covered for at least 18 months to transfer, without medical underwriting, as defined, to any other individual plan contract or individual health benefit plan, as defined, that provides equal or lesser benefits, as specified.

This bill would specifically require a health care service plan or health insurer that offers, issues, or renews individual plan contracts or individual health benefit plans to offer to any individual who was covered under an individual plan contract or individual health benefit plan that was rescinded, other than the individual whose information led to the rescission, a new individual plan contract or individual health benefit plan, without a lapse in coverage or medical underwriting, as defined, that provides equal benefits. The bill would also authorize a health care service plan or health insurer to permit these individuals to remain covered under that individual plan contract or individual health benefit plan, with a specified revised premium rate. The bill would also require an agent, broker, or solicitor assisting an applicant with an application to make a

specified attestation on the written application and the bill would specify that a declarant willfully making a false attestation may be subject to a civil penalty up to \$10,000.

Because a willful violation of the bill's provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 1389.7 is added to the Health and Safety Code, to read:

1389.7. (a) Every health care service plan that offers, issues, or renews individual plan contracts shall offer to any individual, who was covered under an individual plan contract that was rescinded, a new individual plan contract, without medical underwriting, that provides equal benefits. A health care service plan may also permit an individual, who was covered under an individual plan contract that was rescinded, to remain covered under that individual plan contract, with a revised premium rate that reflects the number of persons remaining on the plan contract.

(b) "Without medical underwriting" means that the health care service plan shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who is issued a new individual plan contract or remains covered under an individual plan contract pursuant to this section.

(c) If a new individual plan contract is issued, the plan may revise the premium rate to reflect only the number of persons covered on the new individual plan contract.

(d) Notwithstanding subdivision (a) and (b), if an individual was subject to a preexisting condition provision or a waiting or an affiliation period under the individual plan contract that was rescinded, the health care service plan may apply the same preexisting condition provision or waiting or affiliation period in

the new individual plan contract. The time period in the new individual plan contract for the preexisting condition provision or waiting or affiliation period shall not be longer than the one in the individual plan contract that was rescinded and the health care service plan shall credit any time that the individual was covered under the rescinded individual plan contract.

(e) The plan shall notify in writing all enrollees of the right to coverage under an individual plan contract pursuant to this section, at a minimum, when the plan rescinds the individual plan contract. The notice shall adequately inform enrollees of the right to coverage provided under this section.

(f) The plan shall provide 60 days for enrollees to accept the offered new individual plan contract and this contract shall be effective as of the effective date of the original plan contract and there shall be no lapse in coverage.

(g) This section shall not apply to any individual whose information in the application for coverage and related communications led to the rescission.

SEC. 2. Section 1389.8 is added to the Health and Safety Code, to read:

1389.8. (a) Notwithstanding any other provision of law, an agent, broker, solicitor, solicitor firm, or representative who assists an applicant in submitting an application to a health care service plan has the duty to assist the applicant in providing answers to health questions accurately and completely.

(b) An agent, broker, solicitor, solicitor firm, or representative who assists an applicant in submitting an application to a health care service plan shall attest on the written application to both of the following:

(1) That to the best of his or her knowledge, the information on the application is complete and accurate.

(2) That he or she explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

(c) If, in an attestation required by subdivision (b), a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars (\$10,000). Any public prosecutor

may bring a civil action to impose that civil penalty. These penalties shall be paid to the Managed Care Fund.

(d) A health care service plan application shall include a statement advising declarants of the civil penalty authorized under this section.

SEC. 3. Section 10119.2 is added to the Insurance Code, to read:

10119.2. (a) Every health insurer that offers, issues, or renews health insurance under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, shall offer to any individual, who was covered under an individual health benefit plan that was rescinded, a new individual health benefit plan without medical underwriting that provides equal benefits. A health insurer may also permit an individual, who was covered under an individual health benefit plan that was rescinded, to remain covered under that individual health benefit plan, with a revised premium rate that reflects the number of persons remaining on the health benefit plan.

(b) “Without medical underwriting” means that the health insurer shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who is issued a new individual health benefit plan or remains covered under an individual health benefit plan pursuant to this section.

(c) If a new individual health benefit plan is issued, the insurer may revise the premium rate to reflect only the number of persons covered under the new individual health benefit plan.

(d) Notwithstanding subdivision (a) and (b), if an individual was subject to a preexisting condition provision or a waiting or affiliation period under the individual health benefit plan that was rescinded, the health insurer may apply the same preexisting condition provision or waiting or affiliation period in the new individual health benefit plan. The time period in the new individual health benefit plan for the preexisting condition provision or waiting or affiliation period shall not be longer than the one in the individual health benefit plan that was rescinded and the health insurer shall credit any time that the individual was covered under the rescinded individual health benefit plan.

(e) The insurer shall notify in writing all insureds of the right to coverage under an individual health benefit plan pursuant to

this section, at a minimum, when the insurer rescinds the individual health benefit plan. The notice shall adequately inform insureds of the right to coverage provided under this section.

(f) The insurer shall provide 60 days for insureds to accept the offered new individual health benefit plan and this plan shall be effective as of the effective date of the original individual health benefit plan and there shall be no lapse in coverage.

(g) This section shall not apply to any individual whose information in the application for coverage and related communications led to the rescission.

SEC. 4. Section 10119.3 is added to the Insurance Code, to read:

10119.3. (a) Notwithstanding any other provision of law, an agent or broker who assists an applicant in submitting an application to a health insurer has the duty to assist the applicant in providing answers to health questions accurately and completely.

(b) An agent or broker who assists an applicant in submitting an application to a health insurer shall attest on the written application to both of the following:

(1) That to the best of his or her knowledge, the information on the application is complete and accurate.

(2) That he or she explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

(c) If, in an attestation required by subdivision (b), a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars (\$10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

(d) A health insurance application shall include a statement advising declarants of the civil penalty authorized under this section.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty

for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 2008

Governor