AMENDED IN SENATE AUGUST 17, 2009

AMENDED IN SENATE JULY 23, 2009

AMENDED IN ASSEMBLY JUNE 2, 2009

AMENDED IN ASSEMBLY APRIL 20, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 2

Introduced by Assembly Member De La Torre

December 1, 2008

An act to add Sections 1389.9, 1389.10, 1389.11, 1389.13, 1389.14, 1389.15, 1389.16, 1389.17, 1389.18, 1389.19, 1389.20, 1389.22, and 1389.24 to, and to repeal and add Section 1389.1 of, the Health and Safety Code, and to amend Sections 10270.95, 10291.5, and 12957 of, and to add Sections 10384.1, 10384.12, 10384.14, 10384.16, 10384.18, 10384.2, 10384.22, 10384.24, 10384.26, 10384.28, 10384.29, 10384.3, 10384.32, and 10396 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2, as amended, De La Torre. Individual health care coverage.

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 its provisions a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits the Director of the Department of Managed Health Care and the Insurance Commissioner from approving a plan contract or health insurance policy without a finding that the application conforms

to specified requirements. Existing law prohibits the cancellation or nonrenewal of an enrollment or subscription by a health care service plan except in specified circumstances, including for nonpayment, fraud or deception in the use of services or facilities, or for good cause as agreed upon in the contract. Existing law prohibits the nonrenewal of individual health benefit plans by a health insurer except in specified circumstances, including for nonpayment or for fraud or intentional misrepresentation of material fact.

Existing law subjects health care service plans to various fines and administrative penalties for failing to comply with specified provisions of the act and requires that certain fines and administrative penalties be deposited in the Managed Care Administrative Fines and Penalties Fund. Under existing law, the Managed Risk Medical Insurance Board manages the California Major Risk Medical Insurance Program (MRMIP) to provide major risk medical insurance coverage to eligible persons who have been rejected for health care coverage by at least one private health plan. Existing law creates the Major Risk Medical Insurance Fund, and continuously appropriates the fund to the board for purposes of the program.

This bill would require the director and the commissioner to jointly, by regulation, establish standard information and health history questions to be used by health care service plans and health insurers for their individual health care coverage application forms, as specified, and, on and after January 1, 2011, would require all individual health care service plan and health insurance applications to be reviewed and approved by the director or the commissioner, respectively, before use by a health care service plan or health insurer.

This bill would require all plans and insurers to complete medical underwriting prior to issuing a health care service plan contract or health insurance policy, and to meet certain requirements with regard to medical underwriting, including a requirement that the plan or insurer review each application for accuracy and completeness, review specified claims information, make prescription drug database inquiries, and identify and inquire of the applicant about any omissions, ambiguities, or inconsistencies. The bill would prohibit a plan or insurer from canceling or rescinding an individual health care service plan contract or individual health insurance policy unless specified conditions are met with regard to whether an applicant intentionally misrepresented or intentionally omitted material information in the plan or policy application, as specified, and would provide for cancellation or

nonrenewal for nonpayment. The bill would also require a plan or insurer to annually report to the department the total number of individual health care service plan contracts or individual health insurance policies issued, canceled, or rescinded pursuant to these provisions during the preceding calendar year. The bill would require a health care service plan or health insurer to provide specified notices to subscribers and enrollees and insureds and policyholders. The bill would, commencing January 1, 2011, establish in the Department of Managed Health Care and the Department of Insurance an independent review process for the review of health care service plans' and health insurers' decisions to cancel or rescind individual health care service plan contracts and health insurance policies, and would impose administrative penalties upon a plan or insurer that engages in any conduct that has the effect of prolonging an independent review process or that fails to implement an independent review process decision. The bill would require that penalties collected from plans be deposited into the Managed Care Administrative Fines and Penalties Fund, and that penalties collected from insurers be deposited into the Major Risk Medical Insurance Fund for purposes of MRMIP, subject to appropriation by the Legislature. The bill would *exempt certain types of plans and policies from the bill's requirements and would* enact related provisions.

Because this bill would impose additional requirements on health care service plans, the willful violation of which would be a crime, it 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.

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

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

SECTION 1. Section 1389.1 of the Health and Safety Code is repealed.

SEC. 2. Section 1389.1 is added to the Health and Safety Code, to read:

1389.1. (a) The director shall, by regulation, establish standard information and health history questions that shall be used by all

health care service plans for their individual health care coverage application forms. The director shall jointly develop the regulation with the Insurance Commissioner. The regulation shall include a pool of approved questions for use in health care service plan and health insurance application forms for individual health plan contracts and individual health insurance policies. The health care service plan and health insurance application forms for individual health plan contracts and health insurance policies may only contain questions approved by the director and commissioner.

(b) The standard information and health history questions developed by the director shall contain clear and unambiguous information and questions designed to ascertain the health history of the applicant and shall be based on the medical information that is reasonable and necessary for medical underwriting purposes.

(c) The application form shall include a prominently displayed notice that shall read:

"California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage."

(d) The health history questions established under this section shall include a limitation on how far back in time from the date of the application the applicant was diagnosed with, or treated for, the health condition specified in the questions.

(e) No later than six months after the adoption of the regulation under subdivision (a), all individual health care service plan application forms shall utilize only the pool of approved questions and the standardized information established pursuant to that subdivision.

(f) On and after January 1, 2011, all individual health care service plan applications shall be reviewed and approved by the director before they may be used by a health care service plan.

SEC. 3. Section 1389.9 is added to the Health and Safety Code, to read:

1389.9. (a) A health care service plan shall complete medical underwriting prior to issuing an enrollee or subscriber health care service plan contract.

(b) "Medical underwriting" means the completion of a reasonable investigation of the applicant's health history

information, which includes, but is not limited to, both of the following:

(1) Ensuring that the information submitted on the application form and the material submitted with the application form are complete and accurate.

(2) Resolving all reasonable questions arising from the application form or materials submitted with the application form or any information obtained by the health care service plan as part of its verification of the accuracy and completeness of the application form.

(c) A health care service plan shall adopt and implement written medical underwriting policies and procedures to ensure that the health care service plan does all of the following with respect to an application for health care coverage:

(1) Reviews all of the following:

(A) Information on the application and any materials submitted with the application form for accuracy and completeness.

(B) Claims information about the applicant that is within the health care service plan's own claims information.

(C) At least one commercially available prescription drug database for information about the applicant.

(2) Identifies and makes inquiries, including contacting the applicant about any questions raised by omissions, ambiguities, or inconsistencies based upon the information collected pursuant to paragraph (1).

(d) The plan shall document all information collected during the underwriting review process.

(e) On or before January 1, 2011, a health care service plan shall file its medical underwriting policies and procedures with the department pursuant to Section 1352.

SEC. 4. Section 1389.10 is added to the Health and Safety Code, to read:

1389.10. (a) Within 10 business days of issuing a health care service plan contract, the health care service plan shall send a copy of the completed written application to the applicant with a copy of the health care service plan contract issued by the health care service plan, along with a notice that states all of the following:

(1) The applicant should review the completed application carefully and notify the health care service plan within 30 days of any inaccuracy in the application.

(2) Any intentional material misrepresentation or intentional material omission in the information submitted in the application may result in the cancellation or rescission of the plan contract.

(3) The applicant should retain a copy of the completed written application for the applicant's records.

(b) If new information is provided by the applicant within the 30-day period permitted by subdivision (a), medical underwriting, as defined in Section 1389.9, applies to the new information.

SEC. 5. Section 1389.11 is added to the Health and Safety Code, to read:

1389.11. (a) Once a plan has issued an individual health care service plan contract, the health care service plan shall not rescind or cancel the health care service plan contract unless all of the following apply:

(1) There was a material misrepresentation or material omission in the information submitted by the applicant in the written application to the health care service plan prior to the issuance of the health care service plan contract that would have prevented the contract from being entered into.

(2) The health care service plan completed medical underwriting pursuant to Section 1389.9 before issuing the plan contract.

(3) The health care service plan demonstrates that the applicant intentionally misrepresented or intentionally omitted material information on the application prior to the issuance of the plan contract with the purpose of misrepresenting his or her health history in order to obtain health care coverage.

(4) The application form was approved by the department pursuant to Section 1389.1.

(5) The health care service plan sent a copy of the completed written application to the applicant with a copy of the health care service plan contract issued by the health care service plan, along with the written notice required by Section 1389.10.

(b) Notwithstanding subdivision (a), an enrollment or subscription may be canceled or not renewed for failure to pay the charge for that coverage as set forth in paragraph (1) of subdivision (a) of Section 1365.

SEC. 6. Section 1389.13 is added to the Health and Safety Code, to read:

1389.13. (a) If a health care service plan obtains information after issuing an individual health care service plan contract that

the subscriber or enrollee may have intentionally omitted or intentionally misrepresented material information during the application for coverage process, the health care service plan may investigate the potential omissions or misrepresentations in order to determine whether the subscriber's or enrollee's health care service plan contract should be rescinded or canceled.

(b) (1) Upon initiating a postcontract issuance investigation for potential rescission or cancellation of health care coverage, the plan shall provide a written notice to the enrollee or subscriber via regular and certified mail that it has initiated an investigation of intentional material misrepresentation or intentional material omission on the part of the enrollee or subscriber and that the investigation could lead to the rescission or cancellation of the enrollee's or subscriber's health care service plan contract. The notice shall be provided by the health care service plan within five days of the initiation of the investigation.

(2) The written notice required under paragraph (1) shall include full disclosure of the allegedly intentional material omission or misrepresentation and a clear and concise explanation of why the information has resulted in the health care service plan's initiation of an investigation to determine whether rescission or cancellation is warranted. The notice shall invite the enrollee or subscriber to provide any evidence or information within 45 business days to negate the plan's reasons for initiating the postissuance investigation.

(c) (1) The plan shall complete its investigation no later than 90 days from the date of the notice sent to the enrollee or subscriber pursuant to subdivision (b).

(2) Upon completion of its postissuance investigation, the plan shall provide written notice via regular and certified mail to the subscriber or enrollee that it has concluded its investigation and has made one of the following determinations:

(A) The plan has determined that the enrollee or subscriber did not intentionally misrepresent or intentionally omit material information during the application process and that the subscriber's or enrollee's health care coverage will not be canceled or rescinded.

(B) The plan intends to seek approval from the director to cancel or rescind the enrollee's or subscriber's health care service plan contract for intentional misrepresentation or intentional omission of material information during the application for coverage process.

(3) The written notice required under subparagraph (B) of paragraph (2) shall do all of the following:

(A) Include full disclosure of the nature and substance of any information that led to the plan's determination that the enrollee or subscriber intentionally misrepresented or intentionally omitted material information on the application form.

(B) Provide the enrollee or subscriber with information indicating that the health plan's determination shall not become final until it is reviewed and approved by the department's independent review process.

(C) Provide the enrollee or subscriber with information regarding the department's independent review process and the right of the enrollee or subscriber to opt out of that review process within 45 days of the date upon which an independent review organization receives a request for independent review.

(D) Provide a statement that the health care service plan's proposed decision to cancel or rescind the health care service plan contract shall not become effective unless the department's independent review organization upholds the health care service plan's decision or unless the enrollee or subscriber has opted out of the independent review.

SEC. 7. Section 1389.14 is added to the Health and Safety Code, to read:

1389.14. (a) A health care service plan shall continue to authorize and provide all medically necessary health care services required to be covered under an enrollee's or subscriber's health care service plan contract until the effective date of cancellation or rescission.

(b) The effective date of the health care service plan's cancellation or the date upon which the plan may initiate a rescission shall be no earlier than the date that the enrollee or subscriber receives notification via regular and certified mail that the independent review organization has made a determination upholding the health care service plan's decision to rescind or cancel pursuant to Section 1389.11.

SEC. 8. Section 1389.15 is added to the Health and Safety Code, to read:

1389.15. (a) Commencing January 1, 2011, there is hereby established in the department the independent review process for

the review of health care service plan decisions to cancel or rescind health care service plan contracts pursuant to Section 1389.11.

(b) All health care service plan decisions to cancel or rescind an enrollee's or subscriber's health care service plan contract pursuant to Section 1389.11 shall be reviewed, unless the enrollee or subscriber opts out of the independent review process.

(c) For purposes of this article, an enrollee or subscriber may designate an agent to act on his or her behalf.

(d) The independent review process authorized by this article is in addition to any other procedures or remedies that may be available.

(e) No later than January 1, 2011, in addition to the notice required pursuant to subdivision (b) of Section 1389.13, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, and on copies of plan procedures for resolving grievances, information concerning the right of an enrollee or subscriber to an automatic independent review, unless the enrollee or subscriber opts out, in cases where the health care service plan has decided to cancel or rescind the enrollee's or subscriber's health care service plan contract pursuant to Section 1389.11.

(f) (1) Upon the health care service plan's receipt of notice from the department, the plan shall provide to the independent review organization designated by the department a copy of all of the following documents within seven business days:

(A) A copy of all of the enrollee's or subscriber's medical records in the possession of the plan or its contracting providers relevant to the plan's decision to cancel or rescind the enrollee's or subscriber's health care service plan contract.

(B) A copy of the enrollee's or subscriber's application for coverage with the health care service plan.

(C) A copy of all information provided to the enrollee or subscriber by the plan concerning the health care service plan's decision to cancel or rescind the enrollee's or subscriber's health care service plan contract and a copy of any materials the enrollee or subscriber, the enrollee's or subscriber's agent, or the enrollee's or subscriber's provider submitted to the plan. The confidentiality of any enrollee or subscriber medical information shall be maintained pursuant to applicable state and federal laws.

(D) A copy of any other relevant documents or information used by the plan for the following:

(i) To complete medical underwriting pursuant to Section 1389.9.

(ii) In determining that the enrollee's or subscriber's health care service plan contract should be canceled or rescinded and any statements by the plan explaining the reasons for the decision to cancel or rescind the enrollee's or subscriber's health care service plan contract.

(2) The plan shall concurrently provide a copy of documents required by this subdivision to the enrollee or subscriber. The department and the independent review organization shall maintain the confidentiality of any information found by the director to be the proprietary information of the plan.

SEC. 9. Section 1389.16 is added to the Health and Safety Code, to read:

1389.16. (a) The department shall expeditiously review independent review requests and immediately notify the enrollee or subscriber, in writing, as follows:

(1) That the health care service plan has requested an independent review that has been approved, in whole or in part, or, if not approved, the reasons for disapproval.

(2) That the health care service plan's proposed decision to cancel or rescind the enrollee's or subscriber's health care service plan contract will not become effective unless the independent review organization upholds the health care service plan's decision.

(3) That the enrollee or subscriber has 45 days from the date of the organization's receipt of the request for an independent review to submit any information that may be relevant to the independent review.

(4) That an independent review does not limit the enrollee's or subscriber's rights to pursue any other remedies available under the law.

(b) The health care service plan shall promptly issue a notification to the enrollee or subscriber, after submitting all of the required material to the independent review organization, that includes an annotated list of documents submitted and offer the enrollee or subscriber the opportunity to request copies of those documents from the plan.

(c) An independent review organization shall conduct the review in accordance with Section 1389.18 and any regulations or orders of the director adopted pursuant to that section and the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 10. Section 1389.17 is added to the Health and Safety Code, to read:

1389.17. (a) On or before January 1, 2011, the department shall contract or otherwise arrange with one or more independent organizations in the state to conduct reviews for purposes of this article. The independent review organizations shall be not-for-profit and shall be independent of any health care service plan doing business in this state. The director shall establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, and an organization shall be required to meet these requirements in order to qualify for participation in the independent review process and to assist the department in carrying out its responsibilities. The conflict-of-interest standards established by the director shall also be consistent with the conflict-of-interest provisions of Section 1374.32 to the extent applicable.

(b) The department shall include in its contract or other arrangements with an independent review organization the following requirements, with which the independent review organization shall comply:

(1) Provide the department with a description of the system the independent review organization uses to identify and recruit arbitrators and expert consultants to review health care service plan decisions to cancel or rescind health care service plan contracts and the number of arbitrators and expert consultants.

(2) A description of how the independent review organization ensures compliance with the conflict-of-interest provisions established by the director pursuant to this section.

(3) Demonstrate that it has a quality assurance mechanism in place that does all of the following:

(A) Ensures that the arbitrators retained are appropriately licensed as attorneys and in good standing with the State Bar of California.

(B) Ensures that the reviews provided by the arbitrator are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting an arbitrator for individual cases achieves a fair and impartial panel of arbitrators who are qualified to render recommendations regarding the health care service plan's decision to cancel or rescind a health care service plan contract.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the arbitrator retained to perform the reviews and of the experts retained to provide expert opinions through conflict-of-interest policies and prohibitions consistent with the standards established by the director, and ensures adequate screening for conflicts of interest.

(4) Ensures that arbitrators selected by independent review organizations to review health care service plan decisions to cancel or rescind a health care service plan contract meet the following minimum requirements:

(A) Notwithstanding any other provision of law, the arbitrator holds an unrestricted license to practice law in California.

(B) The arbitrator has no history of disciplinary action or sanctions taken by the State Bar of California.

(C) The arbitrator does not represent health care service plans or insurers.

(c) "Expert consultant" means an underwriter, actuary, physician and surgeon, or other professional whose background, experience, and knowledge are relevant to determining whether the health care service plan completed medical underwriting or to determining the issues raised in the review of the health care service plan's decision to cancel or rescind the enrollee's or subscriber's health care service plan contract.

(d) The department shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the director, filed with it by an independent review organization seeking to contract under this article. The department may charge a nominal fee to the interested person for photocopying the requested information.

SEC. 11. Section 1389.18 is added to the Health and Safety Code, to read:

1389.18. (a) (1) Upon receipt of information and documents related to a case, the arbitrator selected to conduct the review by the independent review organization shall promptly review all pertinent records of the enrollee or subscriber, provider reports, and any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers.

(2) If an arbitrator requests information from any of the parties, a copy of the request and the response shall be provided to all of the parties.

(3) The arbitrator may request an opinion of an expert consultant with respect to specific questions raised in the review of whether the health care service plan completed medical underwriting or the health care service plan's decision to cancel or rescind an enrollee's or subscriber's health care service plan contract where the use of an expert is warranted. However, the expert consultant may not render an opinion as to whether the enrollee or subscriber intentionally misrepresented or intentionally omitted information during the health care service plan application process.

(b) (1) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 60 days of the receipt of the application for review and supporting documentation.

(2) The enrollee or subscriber or the enrollee's or subscriber's agent shall have 45 days from the date of the organization's receipt of the request for an independent review to submit any information that may be relevant to the independent review. If the organization does not receive any information from the enrollee or subscriber or the enrollee's or subscriber's agent at the end of the 45 days, the organization shall issue a written analysis and determination based on the information it has received by that date.

(3) Subject to the approval of the department, the deadline for the analysis and determination of the review may be extended by the director for up to three days in extraordinary circumstances or for good cause.

(c) The arbitrator's analysis and determination shall state the reasons for the determination, the relevant documents in the record, and the relevant findings supporting the determination.

(d) The independent review organization shall provide the director, the plan, the enrollee or subscriber, and the enrollee's or subscriber's provider with the name of the arbitrator reviewing the case, the analysis and determination of the arbitrator, and a description of the qualifications of the arbitrator.

(e) The director shall immediately adopt the determination of the independent review organization and shall promptly issue a written decision to the parties that shall be binding on the plan.

(f) After removing the names of the parties, including, but not limited to, the enrollee or subscriber, all medical providers, the plan, and any of the insurer's employees or contractors, director decisions adopting a determination of an independent review organization shall be made available by the department to the public upon request, at the department's cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.

SEC. 12. Section 1389.19 is added to the Health and Safety Code, to read:

1389.19. (a) A health care service plan shall not engage in any conduct that has the effect of prolonging the independent review process. Engaging in that conduct or the failure of the plan to promptly implement an independent review process decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the plan shall be subject to an administrative penalty of not less than five thousand dollars ($5,000) for each day the independent review process is prolonged or the decision is not implemented. Administrative penalties shall be deposited in the Managed Care Administrative Fines and Penalties Fund, and shall not be used to lower health care service plans' assessments used to fund the department.

(b) The director shall perform an annual audit of independent review cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the department, particularly if a plan repeatedly fails to act promptly and reasonably with respect to decisions to cancel, rescind, limit, or deny benefits under or raise premiums on a subscriber's or enrollee's health care service plan contract.

SEC. 13. Section 1389.20 is added to the Health and Safety Code, to read:

1389.20. (a) After considering the results of a competitive bidding process and any other relevant information on program costs, the director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent review organization reviews, which may vary depending upon relevant factors.

(b) The costs of the independent review system for enrollees and subscribers shall be borne by the affected health care service plans pursuant to an assessment fee system established by the director. Plans that do not cancel or rescind individual health care service plan contracts pursuant to Section 1389.11 shall not be considered by the director as "affected health care service plans" under this section. In determining the amount to be assessed, the director shall consider all appropriations available for the support of this chapter and existing fees paid to the department. The director may adjust fees upward or downward, on a schedule set by the department, to address shortages or overpayments, and to reflect utilization of the independent review process.

SEC. 14. Section 1389.22 is added to the Health and Safety Code, to read:

1389.22. (a) On and after January 1, 2010, every health care service plan shall annually report to the department the total number of individual health care service plan contracts issued, and the total number of individual health care service plan contracts where the plan initiated a cancellation or rescission or completed a cancellation or rescission pursuant to the provisions of this article for the preceding calendar year.

(b) On or before March 31, 2010, and annually thereafter, the department shall publish on its Internet Web site the information filed pursuant to this section.

SEC. 15. Section 1389.24 is added to the Health and Safety Code, to read:

1389.24. *(a)* The requirements of this article shall not apply to health care service plan contracts for coverage issued under the Medi-Cal program, the Access for Infants and Mothers Program, the Healthy Families Program, or the federal Medicare Program.

(b) The requirements of this article shall not apply to specialized health care service plan contracts that provide coverage for dental services.

SEC. 16. Section 10270.95 of the Insurance Code is amended to read:

10270.95. Without affecting the applicability or degree of applicability of other sections of this chapter, it is hereby specified that the provisions of Sections 10321, 10325, 10401, of subdivisions (a), (c), (e), (h), and (i) of Section 10320, of subdivision (a) of Section 10290, of paragraphs (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), and (12) of subdivision (b) and subdivisions (c), (d), (e), (f), (g), and (i) of Section 10291.5 and of Section 10291.6, shall not apply to group disability insurance. The provisions of Section 10401 shall not apply to family expense disability insurance; provided, there is no discrimination between families of the same class.

SEC. 17. Section 10291.5 of the Insurance Code is amended to read:

10291.5. (a) The purpose of this section is to achieve both of the following:

(1) Prevent, with respect to disability insurance, fraud, unfair trade practices, and insurance economically unsound to the insured.

(2) Ensure that the language of all insurance policies can be readily understood and interpreted.

(b) The commissioner shall not approve any disability policy for insurance or delivery in this state in any of the following circumstances:

(1) If the commissioner finds that it contains any provision, or has any label, description of its contents, title, heading, backing, or other indication of its provisions that is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

(2) If it contains any provision for payment at a rate, or in an amount (other than the product of rate times the periods for which payments are promised) for loss caused by particular event or events (as distinguished from character of physical injury or illness of the insured) more than triple the lowest rate, or amount, promised in the policy for the same loss caused by any other event or events (loss caused by sickness, loss caused by accident, and different degrees of disability each being considered, for the purpose of this paragraph, a different loss); or if it contains any provision for payment for any confining loss of time at a rate more than six times the least rate payable for any partial loss of time or

more than twice the least rate payable for any nonconfining total loss of time; or if it contains any provision for payment for any nonconfining total loss of time at a rate more than three times the least rate payable for any partial loss of time.

(3) If it contains any provision for payment for disability caused by particular event or events (as distinguished from character of physical injury or illness of the insured) payable for a term more than twice the least term of payment provided by the policy for the same degree of disability caused by any other event or events; or if it contains any benefit for total nonconfining disability payable for lifetime or for more than 12 months and any benefit for partial disability, unless the benefit for partial disability is payable for at least three months; or if it contains any benefit for total confining disability payable for lifetime or for more than 12 months, unless it also contains benefit for total nonconfining disability caused by the same event or events payable for at least three months, and, if it also contains any benefit for partial disability, unless the benefit for partial disability is payable for at least three months. The provisions of this paragraph shall apply separately to accident benefits and to sickness benefits.

(4) (A) If it contains provision or provisions which would have the effect, upon any termination of the policy, of reducing or ending the liability as the insurer would have, but for the termination, for loss of time resulting from accident occurring while the policy is in force or for loss of time commencing while the policy is in force and resulting from sickness contracted while the policy is in force or for other losses resulting from accident occurring or sickness contracted while the policy is in force, and also contains provision or provisions reserving to the insurer the right to cancel or refuse to renew the policy, unless it also contains other provision or provisions the effect of which is that termination of the policy as the result of the exercise by the insurer of any such right shall not reduce or end the liability with respect to the hereinafter specified losses as the insurer would have had under the policy, including its other limitations, conditions, reductions, and restrictions, had the policy not been so terminated.

(B) The specified losses referred to in subparagraph (A) are:

(i) Loss of time which commences while the policy is in force and results from sickness contracted while the policy is in force.

(ii) Loss of time which commences within 20 days following and results from accident occurring while the policy is in force.

(iii) Losses which result from accident occurring or sickness contracted while the policy is in force and arise out of the care or treatment of illness or injury and which occur within 90 days from the termination of the policy or during a period of continuous compensable loss or losses which period commences prior to the end of such 90 days.

(iv) Losses other than those specified in clause (i), (ii), or (iii) of this paragraph which result from accident occurring or sickness contracted while the policy is in force and which losses occur within 90 days following the accident or the contraction of the sickness.

(5) If by any caption, label, title, or description of contents the policy states, implies, or infers without reasonable qualification that it provides loss of time indemnity for lifetime, or for any period of more than two years, if the loss of time indemnity is made payable only when house confined or only under special contingencies not applicable to other total loss of time indemnity.

(6) If it contains any benefit for total confining disability payable only upon condition that the confinement be of an abnormally restricted nature unless the caption of the part containing any such benefit is accurately descriptive of the nature of the confinement required and unless, if the policy has a description of contents, label, or title, at least one of them contain reference to the nature of the confinement required.

(7) (A) If, irrespective of the premium charged therefor, any benefit of the policy is, or the benefits of the policy as a whole are, not sufficient to be of real economic value to the insured.

(B) In determining whether benefits are of real economic value to the insured, the commissioner shall not differentiate between insureds of the same or similar economic or occupational classes and shall give due consideration to all of the following:

(i) The right of insurers to exercise sound underwriting judgment in the selection and amounts of risks.

(ii) Amount of benefit, length of time of benefit, nature or extent of benefit, or any combination of those factors.

(iii) The relative value in purchasing power of the benefit or benefits.

(iv) Differences in insurance issued on an industrial or other special basis.

(C) To be of real economic value, it shall not be necessary that any benefit or benefits cover the full amount of any loss which might be suffered by reason of the occurrence of any hazard or event insured against.

(8) If it substitutes a specified indemnity upon the occurrence of accidental death for any benefit of the policy, other than a specified indemnity for dismemberment, which would accrue prior to the time of that death or if it contains any provision which has the effect, other than at the election of the insured exercisable within not less than 20 days in the case of benefits specifically limited to the loss by removal of one or more fingers or one or more toes or within not less than 90 days in all other cases, of doing any of the following:

(A) Of substituting, upon the occurrence of the loss of both hands, both feet, one hand and one foot, the sight of both eyes or the sight of one eye and the loss of one hand or one foot, some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or greater than the total of the benefit or benefits for which such specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of such dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(B) Of substituting, upon the occurrence of any other dismemberment some specified indemnity for any or all benefits under the policy unless the indemnity so specified is equal to or greater than one-fourth of the total of the benefit or benefits for which the specified indemnity is substituted and which, assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of the dismemberment under all other provisions of the policy applicable to the particular event or events (as distinguished from character of physical injury or illness) causing the dismemberment.

(C) Of substituting a specified indemnity upon the occurrence of any dismemberment for any benefit of the policy which would accrue prior to the time of dismemberment.

As used in this section, loss of a hand shall be severance at or above the wrist joint, loss of a foot shall be severance at or above the ankle joint, loss of an eye shall be the irrecoverable loss of the entire sight thereof, loss of a finger shall mean at least one entire phalanx thereof and loss of a toe the entire toe.

(9) If it contains provision, other than as provided in Section 10369.3, reducing any original benefit more than 50 percent on account of age of the insured.

(10) If the insuring clause or clauses contain no reference to the exceptions, limitations, and reductions (if any) or no specific reference to, or brief statement of, each abnormally restrictive exception, limitation, or reduction.

(11) If it contains benefit or benefits for loss or losses from specified diseases only unless:

(A) All of the diseases so specified in each provision granting the benefits fall within some general classification based upon the following:

(i) The part or system of the human body principally subject to all such diseases.

(ii) The similarity in nature or cause of such diseases.

(iii) In case of diseases of an unusually serious nature and protracted course of treatment, the common characteristics of all such diseases with respect to severity of affliction and cost of treatment.

(B) The policy is entitled and each provision granting the benefits is separately captioned in clearly understandable words so as to accurately describe the classification of diseases covered and expressly point out, when that is the case, that not all diseases of the classification are covered.

(12) If it does not contain provision for a grace period of at least the number of days specified below for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force provided, that the grace period to be included in the policy shall be not less than seven days for policies providing for weekly payment of premium, not less than 10 days for policies providing for monthly payment of premium and not less than 31 days for all other policies.

(13) If it fails to conform in any respect with any law of this state.

(c) The commissioner may, from time to time as conditions warrant, after notice and hearing, promulgate such reasonable rules and regulations, and amendments and additions thereto, as are necessary or convenient, to establish, in advance of the submission of policies, the standard or standards conforming to subdivision (b), by which he or she shall disapprove or withdraw approval of any disability policy.

In promulgating any such rule or regulation the commissioner shall give consideration to the criteria herein established and to the desirability of approving for use in policies in this state uniform provisions, nationwide or otherwise, and is hereby granted the authority to consult with insurance authorities of any other state and their representatives individually or by way of convention or committee, to seek agreement upon those provisions.

Any such rule or regulation shall be promulgated in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) The commissioner may withdraw approval of filing of any policy or other document or matter required to be approved by the commissioner, or filed with him or her, by this chapter when the commissioner would be authorized to disapprove or refuse filing of the same if originally submitted at the time of the action of withdrawal.

Any such withdrawal shall be in writing and shall specify reasons. An insurer adversely affected by any such withdrawal may, within a period of 30 days following mailing or delivery of the writing containing the withdrawal, by written request, secure a hearing to determine whether the withdrawal should be annulled, modified, or confirmed. Unless, at any time, it is mutually agreed to the contrary, a hearing shall be granted and commenced within 30 days following filing of the request and shall proceed with reasonable dispatch to determination. Unless the commissioner in writing in the withdrawal, or subsequent thereto, grants an extension, any such withdrawal shall, in the absence of any such request, be effective, prospectively and not retroactively, on the 91st day following the mailing or delivery of the withdrawal, and, if request for the hearing is filed, on the 91st day following mailing or delivery of written notice of the commissioner’s determination.

(e) No proceeding under this section is subject to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(f) Except as provided in subdivision (h), any action taken by the commissioner under this section is subject to review by the courts of this state and proceedings on review shall be in accordance with the Code of Civil Procedure.

Notwithstanding any other provision of law to the contrary, petition for any such review may be filed at any time before the effective date of the action taken by the commissioner. No action of the commissioner shall become effective before the expiration of 20 days after written notice and a copy thereof are mailed or delivered to the person adversely affected, and any action so submitted for review shall not become effective for a further period of 15 days after the filing of the petition in court. The court may stay the effectiveness thereof for a longer period.

(g) This section shall be liberally construed to effectuate the purpose and intentions herein stated; but shall not be construed to grant the commissioner power to fix or regulate rates for disability insurance or prescribe a standard form of disability policy, except that the commissioner shall prescribe a standard supplementary disclosure form for presentation with all disability insurance policies, pursuant to Section 10603.

(h) Any such policy issued by an insurer to an insured on a form approved by the commissioner, and in accordance with the conditions, if any, contained in the approval, at a time when that approval is outstanding shall, as between the insurer and the insured, or any person claiming under the policy, be conclusively presumed to comply with, and conform to, this section.

SEC. 18. Section 10384.1 is added to the Insurance Code, to read:

10384.1. (a) The commissioner shall, by regulation, establish standard information and health history questions that shall be used by all health insurers for their individual health care coverage application forms. The commissioner shall jointly develop the regulation with the Director of the Department of Managed Health Care. The regulation shall include a pool of approved questions for use in health care service plan and health insurance application forms for individual health plan contracts and individual health insurance policies. The health care service plan and health

insurance application forms for individual health plan contracts and health insurance policies may only contain questions approved by the commissioner and director.

(b) The standard information and health history questions developed by the commissioner shall contain clear and unambiguous information and questions designed to ascertain the health history of the applicant and shall be based on the medical information that is reasonable and necessary for medical underwriting purposes.

(c) The application form shall include a prominently displayed notice that shall read:

"California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage."

(d) The health history questions established under this section shall include a limitation on how far back in time from the date of the application the applicant was diagnosed with, or treated for, the health condition specified in the questions.

(e) No later than six months after the adoption of the regulation under subdivision (a), all individual health insurance application forms shall utilize only the pool of approved questions and the standardized information established pursuant to that subdivision.

(f) On and after January 1, 2011, all individual health insurance applications shall be reviewed and approved by the commissioner before they may be used by a health insurer.

SEC. 19. Section 10384.12 is added to the Insurance Code, to read:

10384.12. (a) A health insurer shall complete medical underwriting prior to using a health insurance policy.

(b) "Medical underwriting" means the completion of a reasonable investigation of the applicant's health history information, which includes, but is not limited to, both of the following:

(1) Ensuring that the information submitted on the application form and the material submitted with the application form are complete and accurate.

(2) Resolving all reasonable questions arising from the application form or materials submitted with the application form

or any information obtained by the health insurer as part of its verification of the accuracy and completeness of the application form.

(c) A health insurer shall adopt and implement written medical underwriting policies and procedures to ensure that the health insurer does all of the following with respect to an application for health insurance:

(1) Reviews all of the following:

(A) Information on the application and any materials submitted with the application form for accuracy and completeness.

(B) Claims information about the applicant that is within the health insurer's own claims information.

(C) At least one commercially available prescription drug database for information about the applicant.

(2) Identifies and makes inquiries, including contacting the applicant about any questions raised by omissions, ambiguities, or inconsistencies based upon the information collected pursuant to paragraph (1).

(d) The health insurer shall document all information collected during the underwriting review process.

(e) On or before January 1, 2011, a health insurer shall file its medical underwriting policies and procedures with the department.

SEC. 20. Section 10384.14 is added to the Insurance Code, to read:

10384.14. (a) Within 10 business days of issuing a health insurance policy, the health insurer shall send a copy of the completed written application to the applicant with a copy of the health insurance policy issued by the health insurer, along with a notice that states all of the following:

(1) The applicant should review the completed application carefully and notify the health insurer within 30 days of any inaccuracy in the application.

(2) Any intentional material misrepresentation or intentional material omission in the information submitted in the application may result in the cancellation or rescission of the policy.

(3) The applicant should retain a copy of the completed written application for the applicant's records.

(b) If new information is provided by the applicant within the 30-day period permitted by subdivision (a), medical underwriting, as defined in Section 10384.12, applies to the new information.

SEC. 21. Section 10384.16 is added to the Insurance Code, to read:

10384.16. (a) Once an insurer has issued an individual health insurance policy, the insurer shall not rescind or cancel the policy unless all of the following apply:

(1) There was a material misrepresentation or material omission in the information submitted by the applicant in the written application prior to the issuance of the health insurance policy that would have prevented the contract from being entered into.

(2) The health insurer completed medical underwriting pursuant to Section 10384.12 before issuing the policy.

(3) The health insurer demonstrates that the applicant intentionally misrepresented or intentionally omitted material information on the application to the health insurer prior to the issuance of the policy with the purpose of misrepresenting his or her health history in order to obtain health care coverage.

(4) The application form was approved by the department pursuant to Section 10384.1.

(5) The health insurer sent a copy of the completed written application to the applicant with a copy of the health insurance policy issued by the health insurer, along with the written notice required by Section 10384.14.

(b) Notwithstanding subdivision (a), an individual policy may be canceled or not renewed for failure to pay the charge for that coverage as set forth in subdivision (a) of Section 10273.6.

SEC. 22. Section 10384.18 is added to the Insurance Code, to read:

10384.18. (a) If a health insurer obtains information after issuing an individual health insurance policy that the subscriber or enrollee may have intentionally omitted or intentionally misrepresented material information during the application for coverage process, the health insurer may investigate the potential omissions or misrepresentations in order to determine whether the insured's or policyholder's health insurance policy should be rescinded or canceled.

(b) (1) Upon initiating a postcontract issuance investigation for potential rescission or cancellation of health care coverage, the insurer shall provide a written notice to the insured or policyholder via regular and certified mail that it has initiated an investigation of intentionally material misrepresentation or intentionally material

omission on the part of the insured or policyholder and that the investigation could lead to the rescission or cancellation of the insured's or policyholder's health insurance policy. The notice shall be provided by the health insurer within five days of the initiation of the investigation.

(2) The written notice required under paragraph (1) shall include full disclosure of the allegedly intentional material omission or misrepresentation and a clear and concise explanation of why the information has resulted in the health insurer's initiation of an investigation to determine whether rescission or cancellation is warranted. The notice shall invite the insured or policyholder to provide any evidence or information within 45 business days to negate the insurer's reasons for initiating the postissuance investigation.

(c) (1) The insurer shall complete its investigation no later than 90 days from the date of the notice sent to the insured or policyholder pursuant to subdivision (b).

(2) Upon completion of its postissuance investigation, the insurer shall provide written notice via regular and certified mail to the insured or policyholder that it has concluded its investigation and has made one of the following determinations:

(A) The insurer has determined that the insured or policyholder did not intentionally misrepresent or intentionally omit material information during the application process and that the insured's or policyholder's health care coverage will not be canceled or rescinded.

(B) The insurer intends to seek approval from the commissioner to cancel or rescind the insured's or policyholder's health insurance policy for intentional misrepresentation or intentional omission of material information during the application for coverage process.

(3) The written notice required under subparagraph (B) of paragraph (2) shall do all of the following:

(A) Include full disclosure of the nature and substance of any information that led to the insurer's determination that the insured or policyholder intentionally misrepresented or intentionally omitted material information on the application form.

(B) Provide the insured or policyholder with information indicating that the health insurer's determination shall not become final until it is reviewed and approved by the department's independent review process.

(C) The insurer shall provide the insured or policyholder with information regarding the department's independent review process and the right of the insured or policyholder to opt out of that review process within 45 days of the date upon which an independent review organization reviews a request for an independent review.

(D) Provide a statement that the health insurer's proposed decision to cancel or rescind the health insurance policy shall not become effective unless the department's independent review organization upholds the health insurer's decision or unless the insured has opted out of the independent review.

SEC. 23. Section 10384.2 is added to the Insurance Code, to read:

10384.2. (a) A health insurer shall continue to authorize and provide all medically necessary health care services required to be covered under an insured's or policyholder's health insurance policy until the effective date of cancellation or rescission.

(b) The effective date of the health insurer's cancellation or the date upon which the insurer may initiate a rescission shall be no earlier than the date that the insured or policyholder receives notification via regular and certified mail that the independent review organization has made a determination upholding the health insurer's decision to rescind or cancel pursuant to Section 10384.16.

SEC. 24. Section 10384.22 is added to the Insurance Code, to read:

10384.22. (a) Commencing January 1, 2011, there is hereby established in the department the independent review process for the review of health insurer decisions to cancel or rescind health insurance policies pursuant to Section 10384.16.

(b) All health insurer decisions to cancel or rescind an insured's or policyholder's health insurance policy pursuant to Section 10384.16 shall be reviewed, unless the insured opts out of the independent review process.

(c) For purposes of this article, an insured or policyholder may designate an agent to act on his or her behalf.

(d) The independent review process authorized by this article is in addition to any other procedures or remedies that may be available.

(e) No later than January 1, 2011, in addition to the notice required pursuant to subdivision (b) of Section 10384.18, every

health insurer shall prominently display in every plan member handbook or relevant informational brochure, in every policy, on evidence of coverage forms, and on copies of policy procedures for resolving grievances, information concerning the right of an insured or policyholder to an automatic independent review, unless the insured or policyholder opts out, in cases where the health insurer has decided to cancel or rescind the insured's or policyholder's health insurance policy, pursuant to Section 10384.16.

(f) (1) Upon the health insurer's receipt of notice from the department, the insurer shall provide to the independent review organization designated by the department a copy of all of the following documents within seven business days:

(A) A copy of all of the insured's or policyholder's medical records in the possession of the insurer or its contracting providers relevant to the insurer's decision to cancel or rescind the insured's or policyholder's health insurance policy.

(B) A copy of the insured's or policyholder's application for coverage with the health insurer.

(C) A copy of all information provided to the insured or policyholder by the insurer concerning the health insurer's decision to cancel or rescind the insured's or policyholder's health insurance policy and a copy of any materials the insured or policyholder, the insured's or policyholder's agent, or the insured's or policyholder's provider submitted to the plan. The confidentiality of any insured or policyholder medical information shall be maintained pursuant to applicable state and federal laws.

(D) A copy of any other relevant documents or information used by the insurer for the following:

(i) To complete medical underwriting pursuant to Section 10384.12.

(ii) In determining that the insured's or policyholder's health insurance policy should be canceled or rescinded and any statements by the insurer explaining the reasons for the decision to cancel or rescind the insured's or policyholder's health insurance policy.

(2) The insurer shall concurrently provide a copy of documents required by this subdivision to the insured or policyholder. The department and the independent review organization shall maintain

the confidentiality of any information found by the commissioner to be the proprietary information of the insurer.

SEC. 25. Section 10384.24 is added to the Insurance Code, to read:

10384.24. (a) The department shall expeditiously review independent review requests and immediately notify the insured or policyholder, in writing, as follows:

(1) That the health insurer has requested an independent review that has been approved, in whole or in part, or, if not approved, the reasons for disapproval.

(2) That the health insurer's proposed decision to cancel or rescind the insured's or policyholder's health insurance policy will not become effective unless the independent review organization upholds the health insurer's decision.

(3) That the insured or policyholder has 45 days from the date of the organization's receipt of the request for an independent review to submit any information that may be relevant to the independent review.

(4) That an independent review does not limit the insured's or policyholder's rights to pursue any other remedies available under the law.

(b) The health insurer shall promptly issue a notification to the insured or policyholder, after submitting all of the required material to the independent review organization, that includes an annotated list of documents submitted and offer the insured or policyholder the opportunity to request copies of those documents from the insurer.

(c) An independent review organization shall conduct the review in accordance with Section 10384.28 and any regulations or orders of the commissioner adopted pursuant to that section and the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 26. Section 10384.26 is added to the Insurance Code, to read:

10384.26. (a) On or before January 1, 2011, the department shall contract or otherwise arrange with one or more independent organizations in the state to conduct reviews for purposes of this article. The independent review organizations shall be not-for-profit and shall be independent of any health insurer doing business in

this state. The commissioner shall establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, and an organization shall be required to meet these requirements in order to qualify for participation in the independent review process and to assist the department in carrying out its responsibilities. The conflict-of-interest standards established by the commissioner shall also be consistent with the conflict-of-interest provisions of Section 10169.2 to the extent applicable.

(b) The department shall include in its contract or other arrangements with an independent review organization the following requirements, with which the independent review organization shall comply:

(1) Provide the department with a description of the system the independent review organization uses to identify and recruit arbitrators and expert consultants to review health insurer decisions to cancel or rescind health insurance policies and the number of arbitrators and expert consultants.

(2) A description of how the independent review organization ensures compliance with the conflict-of-interest provisions established by the commissioner pursuant to this section.

(3) Demonstrate that it has a quality assurance mechanism in place that does all of the following:

(A) Ensures that the arbitrators retained are appropriately licensed as attorneys and in good standing with the State Bar of California.

(B) Ensures that the reviews provided by the arbitrator are timely, clear, and credible, and that reviews are monitored for quality on an ongoing basis.

(C) Ensures that the method of selecting an arbitrator for individual cases achieves a fair and impartial panel of arbitrators who are qualified to render recommendations regarding the health insurer’s decision to cancel or rescind a health insurance policy.

(D) Ensures the confidentiality of medical records and the review materials, consistent with the requirements of this section and applicable state and federal law.

(E) Ensures the independence of the arbitrator retained to perform the reviews and of the experts retained to provide expert opinions through conflict-of-interest policies and prohibitions

consistent with the standards established by the commissioner, and ensures adequate screening for conflicts of interest.

(4) Ensures that arbitrators selected by independent review organizations to review health insurer decisions to cancel or rescind a health insurance policy meet the following minimum requirements:

(A) Notwithstanding any other provision of law, the arbitrator holds an unrestricted license to practice law in California.

(B) The arbitrator has no history of disciplinary action or sanctions taken by the State Bar of California.

(C) The arbitrator does not represent insurers or health care service plans.

(c) "Expert consultant" means an underwriter, actuary, physician and surgeon, or other professional whose background, experience, and knowledge are relevant to determining whether the health insurer completed medical underwriting or to determining the issues raised in the review of the health insurer's decision to cancel or rescind the insured's or policyholder's health insurance policy.

(d) The department shall provide, upon the request of any interested person, a copy of all nonproprietary information, as determined by the commissioner, filed with it by an independent review organization seeking to contract under this article. The commissioner may charge a nominal fee to the interested person for photocopying the requested information.

SEC. 27. Section 10384.28 is added to the Insurance Code, to read:

10384.28. (a) (1) Upon receipt of information and documents related to a case, the arbitrator selected to conduct the review by the independent review organization shall promptly review all pertinent records of the insured or policyholder, provider reports, and any other information submitted to the organization as authorized by the department or requested from any of the parties to the dispute by the reviewers.

(2) If an arbitrator requests information from any of the parties, a copy of the request and the response shall be provided to all of the parties.

(3) The arbitrator may request an opinion of an expert consultant with respect to specific questions raised in the review of whether the health insurer completed medical underwriting or the health insurer's decision to cancel or rescind an insured's or

policyholder's health insurance policy where the use of an expert is warranted. However, the expert consultant may not render an opinion as to whether the insured or policyholder intentionally misrepresented or intentionally omitted information during the health insurance application process.

(b) (1) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 60 days of the receipt of the application for review and supporting documentation.

(2) The insured or policyholder or the insured's or policyholder's agent shall have 45 days from the date of the organization's receipt of the request for an independent review to submit any information that may be relevant to the independent review. If the organization does not receive any information from the insured or policyholder or the insured's or policyholder's agent at the end of the 45 days, the organization shall issue a written analysis and determination based on the information it has received by that date.

(3) Subject to the approval of the department, the deadline for the analysis and determination of the review may be extended by the commissioner for up to three days in extraordinary circumstances or for good cause.

(c) The arbitrator's analysis and determination shall state the reasons for the determination, the relevant documents in the record, and the relevant findings supporting the determination.

(d) The independent review organization shall provide the commissioner, the insurer, the insured or policyholder, and the insured's or policyholder's provider with the name of the arbitrator reviewing the case, the analysis and determination of the arbitrator, and a description of the qualifications of the arbitrator.

(e) The commissioner shall immediately adopt the determination of the independent review organization and shall promptly issue a written decision to the parties that shall be binding on the insurer.

(f) After removing the names of the parties, including, but not limited to, the insured or policyholder, all medical providers, the insurer, and any of the insurer's employees or contractors, commissioner decisions adopting a determination of an independent review organization shall be made available by the department to the public upon request, at the department's cost and after considering applicable laws governing disclosure of public records, confidentiality, and personal privacy.

SEC. 28. Section 10384.29 is added to the Insurance Code, to read:

10384.29. (a) A health insurer shall not engage in any conduct that has the effect of prolonging the independent review process. Engaging in that conduct or the failure of the insurer to promptly implement an independent review process decision is a violation of this chapter and, in addition to any other fines, penalties, and other remedies available to the director under this chapter, the insurer shall be subject to an administrative penalty of not less than five thousand dollars ($5,000) for each day the independent review process is prolonged or the decision is not implemented. Administrative penalties shall be deposited in the Major Risk Medical Insurance Fund created pursuant to Section 12739, to be used, upon appropriation by the Legislature, for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1.

(b) The commissioner shall perform an annual audit of independent review cases for the dual purposes of education and the opportunity to determine if any investigative or enforcement actions should be undertaken by the department, particularly if an insurer repeatedly fails to act promptly and reasonably with respect to decisions to cancel, rescind, limit, or deny benefits under or raise premiums on an insured's or policyholder's health insurance policy.

SEC. 29. Section 10384.3 is added to the Insurance Code, to read:

10384.3. (a) After considering the results of a competitive bidding process and any other relevant information on program costs, the commissioner shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent review organization reviews, which may vary depending upon relevant factors.

(b) The costs of the independent review system for insureds and policyholders shall be borne by the affected health insurers pursuant to an assessment fee system established by the commissioner. Insurers that do not cancel or rescind individual health insurance policies pursuant to Section 10384.16 shall not be considered by the commissioner as "affected health insurers" under this section. In determining the amount to be assessed, the commissioner shall consider all appropriations available for the

support of this chapter and existing fees paid to the department. The commissioner may adjust fees upward or downward, on a schedule set by the department, to address shortages or overpayments, and to reflect utilization of the independent review process.

SEC. 30. Section 10384.32 is added to the Insurance Code, to read:

10384.32. (a) On and after January 1, 2010, every health insurer shall annually report to the department the total number of individual health insurance policies issued, and the total number of individual health insurance policies where the insurer initiated a cancellation or rescission or completed a cancellation or rescission pursuant to the provisions of this article for the preceding calendar year.

(b) On or before March 31, 2010, and annually thereafter, the department shall publish on its Internet Web site the information filed pursuant to this section.

SEC. 31. Section 10396 is added to the Insurance Code, to read:

10396. The requirements of Sections 10384.1, 10384.12, 10384.14, 10384.16, 10384.17, 10384.18, 10384.2, 10384.22, 10384.24, 10384.26, 10384.28, 10384.29, 10384.3, and 10384.32 shall not apply to ~~health~~ *the following:*

(a) Health insurance policies for coverage issued under the Medi-Cal program, the Access for Infants and Mothers Program, the Healthy Families Program, or the federal Medicare Program.

(b) Specialized health insurance policies that provide dental-only coverage.

SEC. 32. Section 12957 of the Insurance Code is amended to read:

12957. The commissioner shall not withdraw approval of a policy theretofore approved by him or her except upon those grounds as, in his or her opinion, would authorize disapproval upon original submission thereof. Any withdrawal of approval shall be in writing and shall specify the ground thereof. If the insurer demands a hearing on a withdrawal, the hearing shall be granted and commenced within 30 days of filing of a written demand therefor with the commissioner. Unless the hearing is so commenced, the notice of withdrawal shall become ineffective upon the 31st day from and after the date of filing of the demand.

This section shall not apply to policies subject to the provisions of subdivision (d) of Section 10291.5, or to policies, contracts, or agreements that were approved under an alternative filing and approval procedure as provided for in subdivision (f) of Section 10506.4 or subdivision (c) of Section 10507.5.

SEC. 33. 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.

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