

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:

- 1 SECTION 1. Section 1389.1 of the Health and Safety Code is
- 2 repealed.
- 3 SEC. 2. Section 1389.1 is added to the Health and Safety Code,
- 4 to read:
- 5 1389.1. (a) The director shall, by regulation, establish standard
- 6 information and health history questions that shall be used by all

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

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

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

17
18 “California law prohibits an HIV test from being required or
19 used by health care service plans as a condition of obtaining
20 coverage.”

21
22 (d) The health history questions established under this section
23 shall include a limitation on how far back in time from the date of
24 the application the applicant was diagnosed with, or treated for,
25 the health condition specified in the questions.

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

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

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

36 1389.9. (a) A health care service plan shall complete medical
37 underwriting prior to issuing an enrollee or subscriber health care
38 service plan contract.

39 (b) “Medical underwriting” means the completion of a
40 reasonable investigation of the applicant’s health history

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

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

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

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

15 (1) Reviews all of the following:

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

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

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

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

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

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

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

33 1389.10. (a) Within 10 business days of issuing a health care
34 service plan contract, the health care service plan shall send a copy
35 of the completed written application to the applicant with a copy
36 of the health care service plan contract issued by the health care
37 service plan, along with a notice that states all of the following:

38 (1) The applicant should review the completed application
39 carefully and notify the health care service plan within 30 days of
40 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

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

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

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

26 (c) (1) The plan shall complete its investigation no later than
27 90 days from the date of the notice sent to the enrollee or subscriber
28 pursuant to subdivision (b).

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

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

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

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

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

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

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

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

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

24 1389.14. (a) A health care service plan shall continue to
25 authorize and provide all medically necessary health care services
26 required to be covered under an enrollee's or subscriber's health
27 care service plan contract until the effective date of cancellation
28 or rescission.

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

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

38 1389.15. (a) Commencing January 1, 2011, there is hereby
39 established in the department the independent review process for

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

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

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

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

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

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

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

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

33 (C) A copy of all information provided to the enrollee or
34 subscriber by the plan concerning the health care service plan's
35 decision to cancel or rescind the enrollee's or subscriber's health
36 care service plan contract and a copy of any materials the enrollee
37 or subscriber, the enrollee's or subscriber's agent, or the enrollee's
38 or subscriber's provider submitted to the plan. The confidentiality
39 of any enrollee or subscriber medical information shall be
40 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.

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

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

9 1389.17. (a) On or before January 1, 2011, the department
10 shall contract or otherwise arrange with one or more independent
11 organizations in the state to conduct reviews for purposes of this
12 article. The independent review organizations shall be not-for-profit
13 and shall be independent of any health care service plan doing
14 business in this state. The director shall establish additional
15 requirements, including conflict-of-interest standards, consistent
16 with the purposes of this article, and an organization shall be
17 required to meet these requirements in order to qualify for
18 participation in the independent review process and to assist the
19 department in carrying out its responsibilities. The
20 conflict-of-interest standards established by the director shall also
21 be consistent with the conflict-of-interest provisions of Section
22 1374.32 to the extent applicable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 1389.18. (a) (1) Upon receipt of information and documents
4 related to a case, the arbitrator selected to conduct the review by
5 the independent review organization shall promptly review all
6 pertinent records of the enrollee or subscriber, provider reports,
7 and any other information submitted to the organization as
8 authorized by the department or requested from any of the parties
9 to the dispute by the reviewers.

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

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

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

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

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

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

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

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

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

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

19 1389.19. (a) A health care service plan shall not engage in any
20 conduct that has the effect of prolonging the independent review
21 process. Engaging in that conduct or the failure of the plan to
22 promptly implement an independent review process decision is a
23 violation of this chapter and, in addition to any other fines,
24 penalties, and other remedies available to the director under this
25 chapter, the plan shall be subject to an administrative penalty of
26 not less than five thousand dollars (\$5,000) for each day the
27 independent review process is prolonged or the decision is not
28 implemented. Administrative penalties shall be deposited in the
29 Managed Care Administrative Fines and Penalties Fund, and shall
30 not be used to lower health care service plans' assessments used
31 to fund the department.

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

39 SEC. 13. Section 1389.20 is added to the Health and Safety
40 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.*

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

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

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

16 10291.5. (a) The purpose of this section is to achieve both of
17 the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 (9) If it contains provision, other than as provided in Section
7 10369.3, reducing any original benefit more than 50 percent on
8 account of age of the insured.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 Any such withdrawal shall be in writing and shall specify
26 reasons. An insurer adversely affected by any such withdrawal
27 may, within a period of 30 days following mailing or delivery of
28 the writing containing the withdrawal, by written request, secure
29 a hearing to determine whether the withdrawal should be annulled,
30 modified, or confirmed. Unless, at any time, it is mutually agreed
31 to the contrary, a hearing shall be granted and commenced within
32 30 days following filing of the request and shall proceed with
33 reasonable dispatch to determination. Unless the commissioner in
34 writing in the withdrawal, or subsequent thereto, grants an
35 extension, any such withdrawal shall, in the absence of any such
36 request, be effective, prospectively and not retroactively, on the
37 91st day following the mailing or delivery of the withdrawal, and,
38 if request for the hearing is filed, on the 91st day following mailing
39 or delivery of written notice of the commissioner's determination.

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

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

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

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

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

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

32 10384.1. (a) The commissioner shall, by regulation, establish
33 standard information and health history questions that shall be
34 used by all health insurers for their individual health care coverage
35 application forms. The commissioner shall jointly develop the
36 regulation with the Director of the Department of Managed Health
37 Care. The regulation shall include a pool of approved questions
38 for use in health care service plan and health insurance application
39 forms for individual health plan contracts and individual health
40 insurance policies. The health care service plan and health

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

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

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

12
13 “California law prohibits an HIV test from being required or
14 used by health insurance companies as a condition of obtaining
15 health insurance coverage.”

16
17 (d) The health history questions established under this section
18 shall include a limitation on how far back in time from the date of
19 the application the applicant was diagnosed with, or treated for,
20 the health condition specified in the questions.

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

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

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

30 10384.12. (a) A health insurer shall complete medical
31 underwriting prior to using a health insurance policy.

32 (b) “Medical underwriting” means the completion of a
33 reasonable investigation of the applicant’s health history
34 information, which includes, but is not limited to, both of the
35 following:

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

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

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

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

8 (1) Reviews all of the following:

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

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

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

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

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

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

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

25 10384.14. (a) Within 10 business days of issuing a health
26 insurance policy, the health insurer shall send a copy of the
27 completed written application to the applicant with a copy of the
28 health insurance policy issued by the health insurer, along with a
29 notice that states all of the following:

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

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

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

38 (b) If new information is provided by the applicant within the
39 30-day period permitted by subdivision (a), medical underwriting,
40 as defined in Section 10384.12, applies to the new information.

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

3 10384.16. (a) Once an insurer has issued an individual health
4 insurance policy, the insurer shall not rescind or cancel the policy
5 unless all of the following apply:

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

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

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

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

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

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

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

28 10384.18. (a) If a health insurer obtains information after
29 issuing an individual health insurance policy that the subscriber
30 or enrollee may have intentionally omitted or intentionally
31 misrepresented material information during the application for
32 coverage process, the health insurer may investigate the potential
33 omissions or misrepresentations in order to determine whether the
34 insured's or policyholder's health insurance policy should be
35 rescinded or canceled.

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

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

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

15 (c) (1) The insurer shall complete its investigation no later than
16 90 days from the date of the notice sent to the insured or
17 policyholder pursuant to subdivision (b).

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

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

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

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

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

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

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

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

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

13 10384.2. (a) A health insurer shall continue to authorize and
14 provide all medically necessary health care services required to
15 be covered under an insured's or policyholder's health insurance
16 policy until the effective date of cancellation or rescission.

17 (b) The effective date of the health insurer's cancellation or the
18 date upon which the insurer may initiate a rescission shall be no
19 earlier than the date that the insured or policyholder receives
20 notification via regular and certified mail that the independent
21 review organization has made a determination upholding the health
22 insurer's decision to rescind or cancel pursuant to Section
23 10384.16.

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

26 10384.22. (a) Commencing January 1, 2011, there is hereby
27 established in the department the independent review process for
28 the review of health insurer decisions to cancel or rescind health
29 insurance policies pursuant to Section 10384.16.

30 (b) All health insurer decisions to cancel or rescind an insured's
31 or policyholder's health insurance policy pursuant to Section
32 10384.16 shall be reviewed, unless the insured opts out of the
33 independent review process.

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

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

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

1 health insurer shall prominently display in every plan member
2 handbook or relevant informational brochure, in every policy, on
3 evidence of coverage forms, and on copies of policy procedures
4 for resolving grievances, information concerning the right of an
5 insured or policyholder to an automatic independent review, unless
6 the insured or policyholder opts out, in cases where the health
7 insurer has decided to cancel or rescind the insured's or
8 policyholder's health insurance policy, pursuant to Section
9 10384.16.

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

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

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

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

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

30 (i) To complete medical underwriting pursuant to Section
31 10384.12.

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

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

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

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

5 10384.24. (a) The department shall expeditiously review
6 independent review requests and immediately notify the insured
7 or policyholder, in writing, as follows:

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

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

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

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

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

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

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

36 10384.26. (a) On or before January 1, 2011, the department
37 shall contract or otherwise arrange with one or more independent
38 organizations in the state to conduct reviews for purposes of this
39 article. The independent review organizations shall be not-for-profit
40 and shall be independent of any health insurer doing business in

1 this state. The commissioner shall establish additional
2 requirements, including conflict-of-interest standards, consistent
3 with the purposes of this article, and an organization shall be
4 required to meet these requirements in order to qualify for
5 participation in the independent review process and to assist the
6 department in carrying out its responsibilities. The
7 conflict-of-interest standards established by the commissioner shall
8 also be consistent with the conflict-of-interest provisions of Section
9 10169.2 to the extent applicable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 10384.28. (a) (1) Upon receipt of information and documents
28 related to a case, the arbitrator selected to conduct the review by
29 the independent review organization shall promptly review all
30 pertinent records of the insured or policyholder, provider reports,
31 and any other information submitted to the organization as
32 authorized by the department or requested from any of the parties
33 to the dispute by the reviewers.

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

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

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

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

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

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

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

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

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

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

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

3 10384.29. (a) A health insurer shall not engage in any conduct
4 that has the effect of prolonging the independent review process.
5 Engaging in that conduct or the failure of the insurer to promptly
6 implement an independent review process decision is a violation
7 of this chapter and, in addition to any other fines, penalties, and
8 other remedies available to the director under this chapter, the
9 insurer shall be subject to an administrative penalty of not less
10 than five thousand dollars (\$5,000) for each day the independent
11 review process is prolonged or the decision is not implemented.
12 Administrative penalties shall be deposited in the Major Risk
13 Medical Insurance Fund created pursuant to Section 12739, to be
14 used, upon appropriation by the Legislature, for the Major Risk
15 Medical Insurance Program for the purposes specified in Section
16 12739.1.

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

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

27 10384.3. (a) After considering the results of a competitive
28 bidding process and any other relevant information on program
29 costs, the commissioner shall establish a reasonable, per-case
30 reimbursement schedule to pay the costs of independent review
31 organization reviews, which may vary depending upon relevant
32 factors.

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

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

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

8 10384.32. (a) On and after January 1, 2010, every health
9 insurer shall annually report to the department the total number of
10 individual health insurance policies issued, and the total number
11 of individual health insurance policies where the insurer initiated
12 a cancellation or rescission or completed a cancellation or
13 rescission pursuant to the provisions of this article for the preceding
14 calendar year.

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

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

20 10396. The requirements of Sections 10384.1, 10384.12,
21 10384.14, 10384.16, 10384.17, 10384.18, 10384.2, 10384.22,
22 10384.24, 10384.26, 10384.28, 10384.29, 10384.3, and 10384.32
23 shall not apply to ~~health~~ *the following*:

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

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

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

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

1 This section shall not apply to policies subject to the provisions
2 of subdivision (d) of Section 10291.5, or to policies, contracts, or
3 agreements that were approved under an alternative filing and
4 approval procedure as provided for in subdivision (f) of Section
5 10506.4 or subdivision (c) of Section 10507.5.

6 SEC. 33. No reimbursement is required by this act pursuant to
7 Section 6 of Article XIII B of the California Constitution because
8 the only costs that may be incurred by a local agency or school
9 district will be incurred because this act creates a new crime or
10 infraction, eliminates a crime or infraction, or changes the penalty
11 for a crime or infraction, within the meaning of Section 17556 of
12 the Government Code, or changes the definition of a crime within
13 the meaning of Section 6 of Article XIII B of the California
14 Constitution.