ASSEMBLY BILL No. 4

Introduced by Assembly Member Wilk
(Coauthor: Assembly Member Conway)

May 16, 2013

An act to amend Sections 1389.1, 1389.2, 1389.4, 1389.5, and 1389.8 of, to add Section 1366.30 to, and to add Chapter 9 (commencing with Section 127670) to Part 2 of Division 107 of, the Health and Safety Code, and to amend Sections 10113.95, 10119.1, 10119.3, 10270.98, 10273.4, 10273.6, and 10291.5 of, to add Section 10128.60 to, and to repeal Section 10270.99 of, the Insurance Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 4, as introduced, Wilk. Health care.

(1) Existing law provides for the regulation of health insurers by the Insurance Commissioner. Existing law prohibits group health insurance policies and individual health insurance policies from canceling or refusing to renew plans and policies, except under specified circumstances, including, but not limited to, nonpayment of the required premiums if the appropriate party has been notified and given at least a 30-day grace period or other period of time as required by the federal Public Health Service Act. The health insurer is required to continue to provide coverage during the grace period.

This bill would require that individuals receiving coverage through the California Health Benefit Exchange and who are receiving a tax credit pursuant to the federal Patient Protection and Affordable Care Act (PPACA) would be subject to the required grace period and provisions of coverage during the grace period, if any, as provided by PPACA.

(2) Existing law authorizes group health insurance policies to provide, among other things, that the benefits payable are subject to reduction if the insured has any other coverage, other than individual policies or contracts, providing hospital, surgical, or medical benefits, resulting in the insured being eligible for more than 100% of the covered expenses. Except as permitted and except in the case of group practice prepayment plan contracts that do not provide for coordination of benefits, to the extent they provide for a reduction of benefits on account of other coverage with respect to emergency services that are not obtained from providers that contract with the plan, a group or individual health insurance policy or service contract issued by nonprofit hospital service plans, operating as provided, is not allowed to limit payment of benefits by reason of the existence of other insurance or service coverage.

This bill would delete the provisions prohibiting a group or individual health insurance policy or service contract issued by nonprofit hospital service plans, operating as provided, from limiting payment of benefits by reason of the existence of other insurance or service coverage. The bill would add individual health insurance policies to those policies authorized to reduce benefits where the insured has other coverage providing hospital, surgical, or medical benefits, resulting in the insured being eligible for more than 100% of the covered expenses. The bill would also make conforming changes.

(3) Existing law, the California Continuation Benefits Replacement Act (Cal-COBRA), provides for a continuation of health care coverage without evidence of insurability for up to 36 months after the date a qualified beneficiary's benefits would end due to a qualifying event, including the exhaustion of benefits under federal COBRA. Existing law also provides for certain underwriting practices regarding health care service plans and health insurance policies, including, but not limited to, an agent, broker, solicitor, solicitor firm, or representative who assists an applicant in submitting an application to a health care service plan or health insurer being required to attest in writing to the completeness and accuracy of the application to the best of his or her knowledge and that he or she explained to the applicant and was understood regarding the risk of providing inaccurate information.

This bill would make Cal-COBRA and certain underwriting requirements inoperative on January 1, 2014, and, if certain provisions of the federal Patient Protection and Affordable Care Act are repealed or amended, those provisions would become operative as of the date of the repeal or amendment.

(4) The federal Patient Protection and Affordable Care Act (PPACA) enacts various health care coverage market reforms that take effect January 1, 2014. Among other things, PPACA authorizes the federal Secretary of Health and Human Services to award states with demonstration grants to develop and test alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers and organizations. States interested in receiving a grant are required to develop an alternative to current tort litigation and submit an application to the secretary.

This bill would require the Secretary of California Health and Human Services to submit an application on behalf of the state to the federal Department of Health and Human Services to receive a grant for state demonstration programs to evaluate alternatives to current medical tort litigation, as authorized by PPACA. The bill would require the secretary to write the application to design a program to create health courts based upon a no-fault process to improve the injury resolution of liability. The bill would specify what items a patient would need to prove under the health court demonstration program.

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

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

SECTION 1. Section 1366.30 is added to the Health and Safety Code, immediately following Section 1366.29, to read:

1366.30. (a) This article shall become inoperative on January 1, 2014.

(b) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this article shall become operative as of the date of the repeal or amendment.

(c) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 2. Section 1389.1 of the Health and Safety Code is amended to read:

1389.1. (a) The director shall not approve any plan contract unless the director finds that the application conforms to both of the following requirements:

(1) All applications for coverage ~~which~~ *that* include health-related questions shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions related to an applicant's health shall be based on medical information that is reasonable and necessary for medical underwriting purposes. The application 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."

(b) Nothing in this section shall authorize the director to establish or require a single or standard application form for application questions.

(c) (1) This section shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative as of the date of the repeal or amendment.

(d) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 3. Section 1389.2 of the Health and Safety Code is amended to read:

1389.2. *(a)* At the request of the director, a health care service plan shall provide a written statement of the actuarial basis for any medical underwriting decision on any application form, or contract issued or delivered to, or denied a resident of this state.

(b) (1) This section shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal

Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative as of the date of the repeal or amendment.

(c) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 4. Section 1389.4 of the Health and Safety Code is amended to read:

1389.4. (a) A full service health care service plan that issues, renews, or amends individual health plan contracts shall be subject to this section.

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 1365.5 and 1389.1 and all other applicable provisions of state and federal law.

(c) On or before June 1, 2006, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual health plan contracts, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

(d) Commencing January 1, 2011, the director shall post on the department's Internet Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code) and the federal

temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code. The director shall develop the information for the Internet Web site in consultation with the Department of Insurance to enhance the consistency of information provided to consumers. Information about individual health coverage shall also include the following notification:

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

(e) Nothing in this section shall authorize public disclosure of company specific rating and underwriting criteria and practices submitted to the director.

(f) This section shall not apply to a closed block of business, as defined in Section 1367.15.

(g) (1) This section shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative as of the date of the repeal or amendment.

(h) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 5. Section 1389.5 of the Health and Safety Code is amended to read:

1389.5. (a) This section shall apply to a health care service plan that provides coverage under an individual plan contract that is issued, amended, delivered, or renewed on or after January 1, 2007.

(b) At least once each year, the health care service plan shall permit an individual who has been covered for at least 18 months under an individual plan contract to transfer, without medical underwriting, to any other individual plan contract offered by that

same health care service plan that provides equal or lesser benefits, as determined by the plan.

"Without medical underwriting" means that the health care service plan shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who transfers to another individual plan contract pursuant to this section.

(c) The plan shall establish, for the purposes of subdivision (b), a ranking of the individual plan contracts it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The plan shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The plan shall notify in writing all enrollees of the right to transfer to another individual plan contract pursuant to this section, at a minimum, when the plan changes the enrollee's premium rate. Posting this information on the plan's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform enrollees of the transfer rights provided under this section, including information on the process to obtain details about the individual plan contracts available to that enrollee and advising that the enrollee may be unable to return to his or her current individual plan contract if the enrollee transfers to another individual plan contract.

(e) The requirements of this section shall not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (c) of Section 1399.801, who is enrolled in an individual health benefit plan contract offered pursuant to Section 1366.35.

(2) An individual offered conversion coverage pursuant to Section 1373.6.

(3) Individual coverage under a specialized health care service plan contract.

(4) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Division 9 of Part 3 of the Welfare and Institutions Code.

(5) An individual enrolled in the Access for Infants and Mothers Program pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the Insurance Code.

(6) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code.

(f) It is the intent of the Legislature that individuals shall have more choice in their health coverage when health care service plans guarantee the right of an individual to transfer to another product based on the plan's own ranking system. The Legislature does not intend for the department to review or verify the plan's ranking for actuarial or other purposes.

(g) (1) This section shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative as of the date of the repeal or amendment.

(h) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 6. Section 1389.8 of the Health and Safety Code is amended to read:

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

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

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

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

(c) If, in an attestation required by subdivision (b), a declarant willfully states as true any material fact he or she knows to be

false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Managed Care Fund.

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

(e) (1) This section shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative as of the date of the repeal or amendment.

(f) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 7. Chapter 9 (commencing with Section 127670) is added to Part 2 of Division 107 of the Health and Safety Code, to read:

CHAPTER 9. HEALTH COURT DEMONSTRATION PROGRAM

127670. The Secretary of California Health and Human Services shall submit an application on behalf of the state to the United States Department of Health and Human Services to receive a grant for the State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation, as authorized by Section 10607 of the federal Patient Protection and Affordable Care Act (PPACA).

127672. (a) The secretary shall write the application described in Section 127670 to design a program to create health courts based upon a no-fault process to improve the resolution of liability for medical injury.

(b) In accordance with PPACA, the application shall demonstrate how the proposed alternative does all of the following:

(1) Makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes.

(2) Encourages the efficient resolution of disputes.
(3) Encourages the disclosure of health care errors.
(4) Enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events.
(5) Improves access to liability insurance.
(6) Fully informs patients about the differences in the alternative and current tort litigation.
(7) Provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative.
(8) Does not conflict with state law at the time of the application in a way that prohibits the adoption of the alternative to current tort litigation.
(9) Does not limit or curtail a patient's existing legal rights, ability to file a claim in or access the legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.
(10) Does not conflict with the Medical Injury Compensation Reform Act (MICRA), including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Section 667.7 of the Code of Civil Procedure.
(11) Does not require any party to participate in the program.
127674. (a) Under the health court demonstration program, a patient shall be required to prove only the following:
(1) He or she suffered an injury.
(2) The injury was caused by medical care.
(3) The injury meets specified severity criteria.
(b) A patient shall not be required to show a third party acted in a negligent fashion.
SEC. 8. Section 10113.95 of the Insurance Code is amended to read:
10113.95. (a) A health insurer that issues, renews, or amends individual health insurance policies shall be subject to this section.
(b) An insurer subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall ensure that the plan rating and underwriting criteria comply

with Sections 10140 and 10291.5 and all other applicable provisions.

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

(d) Commencing January 1, 2011, the commissioner shall post on the department's Internet Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)) and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5). The commissioner shall develop the information for the Internet Web site in consultation with the Department of Managed Health Care to enhance the consistency of information provided to consumers. Information about individual health insurance shall also include the following notification:

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

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

(f) This section shall not apply to a closed block of business, as defined in Section 10176.10.

(g) (1) This section shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative as of the date of the repeal or amendment.

(h) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 9. Section 10119.1 of the Insurance Code is amended to read:

10119.1. (a) This section shall apply to a health insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, that is issued, amended, renewed, or delivered on or after January 1, 2007.

(b) At least once each year, a health insurer shall permit an individual who has been covered for at least 18 months under an individual health benefit plan to transfer, without medical underwriting, to any other individual health benefit plan offered by that same health insurer that provides equal or lesser benefits as determined by the insurer.

"Without medical underwriting" means that the health insurer shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who transfers to another individual health benefit plan pursuant to this section.

(c) The insurer shall establish, for the purposes of subdivision (b), a ranking of the individual health benefit plans it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The insurer shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The insurer shall notify in writing all insureds of the right to transfer to another individual health benefit plan pursuant to this section, at a minimum, when the insurer changes the insured's premium rate. Posting this information on the insurer's Internet

Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform insureds of the transfer rights provided under this section including information on the process to obtain details about the individual health benefit plans available to that insured and advising that the insured may be unable to return to his or her current individual health benefit plan if the insured transfers to another individual health benefit plan.

(e) The requirements of this section shall not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (e) of Section 10900, who purchases individual coverage pursuant to Section 10785.

(2) An individual offered conversion coverage pursuant to Sections 12672 and 12682.1.

(3) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(4) An individual enrolled in the Access for Infants and Mothers Program, pursuant to Part 6.3 (commencing with Section 12695).

(5) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693).

(f) It is the intent of the Legislature that individuals shall have more choice in their health care coverage when health insurers guarantee the right of an individual to transfer to another product based on the insurer's own ranking system. The Legislature does not intend for the department to review or verify the insurer's ranking for actuarial or other purposes.

(g) (1) This section shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative as of the date of the repeal or amendment.

(h) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 10. Section 10119.3 of the Insurance Code is amended to read:

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

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

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

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

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

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

(e) (1) This section shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative as of the date of the repeal or amendment.

(f) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 11. Section 10128.60 is added to the Insurance Code, immediately following Section 10128.59, to read:

10128.60. (a) This article shall become inoperative on January 1, 2014.

(b) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this article shall become operative as of the date of the repeal or amendment.

(c) For the purposes of this section, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 12. Section 10270.98 of the Insurance Code is amended to read:

10270.98. Group *and individual* disability policies may provide, among other things, that the benefits payable thereunder are subject to reduction if the individual insured has any other coverage ~~(other than individual policies or contracts)~~ providing hospital, surgical, or medical benefits, whether on an indemnity basis or a provision of service basis, resulting in ~~such~~ *the* insured being eligible for more than 100 percent of the covered expenses.

~~Except as permitted by this section and by Section 10323, 10369.5, 10369.6, or 11515.5, and except in the case of group practice prepayment plan contracts which do not provide for coordination of benefits, to the extent they provide for a reduction of benefits on account of other coverage with respect to emergency services that are not obtained from providers that contract with the plan, no group or individual disability insurance policy or service contract issued by nonprofit hospital service plans operating under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 shall limit payment of benefits by reason of the existence of other insurance or service coverage.~~

The policy provisions authorized by this section shall contain a provision that payments of funds may be made directly between insurers and other providers of benefits. ~~Such~~ *Those* policy provisions shall also contain a provision that if benefits are provided in the form of services rather than cash payments the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. The reasonable

cash value of any contractual benefit provided to the insured in the form of service rather than cash payment by or through any hospital service organization or medical service organization or group-practice prepayment plan shall be deemed an expense incurred by the insured for ~~such~~ *that* service, whether or not actually incurred, and the liability of the insurer shall be the same as if the insured had not been entitled to ~~any such~~ *that* service ~~benefit, unless the policy contains a provision authorized by Section 10323, 10369.5 or 10369.6 in the case of an individual disability policy, or by this section, in the case of a group disability policy~~ *benefit*.

This section shall not be construed to require that benefits payable under group *and individual* disability policies be subject to reduction by the benefit amounts payable under Chapter 3 (commencing with Section 2800) of Part 2 of Division 1 of the Unemployment Insurance Code.

The provisions of this section, and all regulations adopted pursuant thereto pertaining to coordination of benefits with other group *and individual* disability benefits, shall apply to all employers, labor-management trustee plans, union welfare plans (including those established in conformity with 29 U.S.C. Sec. 186), employer organization ~~plans or~~ *plans,* employee benefit organization plans, *or* health care service plan contracts, pursuant to regulations adopted by the Director of the Department of Managed Health Care ~~which~~ *that* shall be uniform with those issued under this section for those plans that elect to coordinate benefits, group practice, individual practice, any other prepayment coverage for medical or dental care or treatment, and administrators, within the meaning of Section 1759 not otherwise subject to the provisions of this section whenever ~~such~~ *that* plan, contract, or practice provides or administers hospital, surgical, medical, or dental benefits to employees or agents who are also covered under one or more additional group disability policies ~~which~~ *that* are subject to this section or health care service plans.

SEC. 13. Section 10270.99 of the Insurance Code is repealed.

~~10270.99. The term "individual policies or contracts," as used in the first paragraph of Section 10270.98, does not include selected group disability policies or contracts, unless those policies or contracts are noncancelable or guaranteed renewable and solely~~

~~provide hospital confinement indemnity or specified disease coverage.~~

SEC. 14. Section 10273.4 of the Insurance Code is amended to read:

10273.4. All disability insurers writing, issuing, or administering group health benefit plans shall make all of these health benefit plans renewable with respect to the policyholder, contractholder, or employer except in case of the following:

(a) (1) Nonpayment of the required premiums by the policyholder, contractholder, or employer if the policyholder, contractholder, or employer has been duly notified and billed for the premium and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and any subsequent rules or regulations has elapsed.

(2) Pursuant to paragraph (1), the disability insurer shall continue to provide coverage as required by the policyholder's, certificate holder's, or other insured's policy during the period described in paragraph (1).

(3) Notwithstanding paragraphs (1) and (2), the required grace period and provisions of coverage during a grace period, if any, for individuals receiving coverage through the Exchange, and who are receiving a tax credit pursuant to PPACA, shall be subject to and shall be governed by the requirements of PPACA, and any related rules and regulations.

(b) The insurer demonstrates fraud or an intentional misrepresentation of material fact under the terms of the policy by the policyholder, contractholder, or employer.

(c) Violation of a material contract provision relating to employer or other group contribution or group participation rates by the contractholder or employer.

(d) The insurer ceases to provide or arrange for the provision of health care services for new group health benefit plans in this state, provided that the following conditions are satisfied:

(1) Notice of the decision to cease writing, issuing, or administering new or existing group health benefit plans in this state is provided to the commissioner and to either the policyholder,

contractholder, or employer at least 180 days prior to discontinuation of that coverage.

(2) Group health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any disability insurer that ceases to write, issue, or administer new group health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) Except as provided under subdivision (h) of Section 10705, or unless the commissioner had made a determination pursuant to Section 10712, a disability insurer that ceases to write, issue, or administer new group health benefit plans in this state after the effective date of this section shall be prohibited from writing, issuing, or administering new group health benefit plans to employers in this state for a period of five years from the date of notice to the commissioner.

(e) The disability insurer withdraws a group health benefit plan from the market; provided, that the plan notifies all affected contractholders, policyholders, or employers and the commissioner at least 90 days prior to the discontinuation of the health benefit plans, and that the insurer makes available to the contractholder, policyholder, or employer all health benefit plans that it makes available to new employer business without regard to the claims experience of health-related factors of insureds or individuals who may become eligible for the coverage.

(f) If the coverage is offered through a network plan, there is no longer any covered individual in connection with the plan who lives, resides, or works in the service area of the disability insurer.

(g) If coverage is made available in the individual market through a bona fide association, the membership of the individual in the association on the basis of which the coverage is provided, ceases, but only if that coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(h) For the purposes of this section, “health benefit plan” shall have the same meaning as in subdivision (a) of Section 10198.6 and Section 10198.61.

(i) For the purposes of this section, “eligible employee” shall have the same meaning as in Section 10700, except that it applies

to all health benefit plans issued to employer groups of two or more employees.

(j) For the purposes of this section, the following definitions shall apply:

(1) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(2) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

SEC. 15. Section 10273.6 of the Insurance Code is amended to read:

10273.6. All individual health benefit plans, except for short-term limited duration insurance, shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) (1) For nonpayment of the required premiums by the individual if the individual has been duly notified and billed for the premium and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and any subsequent rules or regulations has elapsed.

(2) Pursuant to paragraph (1), the disability insurer shall continue to provide coverage as required by the policyholder's, certificate holder's, or other insured's policy during the period described in paragraph (1).

(3) Notwithstanding paragraphs (1) and (2), the required grace period and provisions of coverage during a grace period, if any, for individuals receiving coverage through the Exchange, and who are receiving a tax credit pursuant to PPACA, shall be subject to and shall be governed by the requirements of PPACA, and any related rules and regulations.

(b) The insurer demonstrates fraud or intentional misrepresentation of material fact under the terms of the policy by the individual.

(c) Movement of the individual contractholder outside the service area but only if coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(d) If the disability insurer ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state; provided, however, that the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the individual policy or contractholder at least 180 days prior to discontinuation of that coverage.

(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a disability insurer that remains in force, any disability insurer that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) A disability insurer that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.

(e) If the disability insurer withdraws an individual health benefit plan from the market; provided, that the disability insurer notifies all affected individuals and the commissioner at least 90 days prior to the discontinuation of these plans, and that the disability insurer makes available to the individual all health benefit plans that it makes available to new individual businesses without regard to a health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(f) If coverage is made available in the individual market through a bona fide association, the membership of the individual in the association on the basis of which the coverage is provided, ceases, but only if that coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(g) For the purposes of this section, the following definitions shall apply:

(1) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the

federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(2) "Exchange" means the California Health Benefit Exchange created by Section 100500 of the Government Code.

SEC. 16. 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, in respect to disability insurance, fraud, unfair trade practices, and insurance economically unsound to the insured.

(2) Assure 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 ~~which~~ *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) If it contains *a* provision or provisions ~~which~~ *that* 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~~ *that* right shall not reduce or end the liability in 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.

The specified losses referred to in the preceding paragraph are:

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

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

(iii) Losses ~~which~~ *that* 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~~ *that* occur within 90 days from the termination of the policy or during a period of continuous

compensable loss or losses ~~which~~ *that* period commences prior to the end of ~~such~~ *that* 90 days.

(iv) Losses other than those specified in clause (i), (ii), or (iii) of this paragraph ~~which~~ *that* result from accident occurring or sickness contracted while the policy is in force and ~~which~~ *that* 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~~ *that* 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~~ *that* 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~~ *that* 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~~ *the* specified indemnity is substituted and ~~which,~~ *that,* assuming in all cases that the insured would continue to live, could possibly accrue within four years from the date of ~~such~~ *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.

(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,~~ *that* 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~~ *that* 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~~ *those* diseases.

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

(iii) In case of diseases of an unusually serious nature and protracted course of treatment, the common characteristics of all ~~such~~ *those* 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 shall not approve any disability policy covering hospital, medical, or surgical expenses unless the commissioner finds that the application conforms to both of the following requirements:

(1) All applications for disability insurance covering hospital, medical, or surgical expenses, except that which is guaranteed

issue, ~~which~~ *that* include questions relating to medical conditions, shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant.

(2) The application questions designed to ascertain the health condition or history of the applicant shall be based on medical information that is reasonable and necessary for medical underwriting purposes. The application shall include a prominently displayed notice that states:

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

(d) Nothing in this section authorizes the commissioner to establish or require a single or standard application form for application questions.

(e) 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~~ *a* rule or ~~regulation~~ *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~~

That 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.

(f) 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~~

That withdrawal shall be in writing and shall specify reasons. An insurer adversely affected by ~~any such~~ *that* 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~~ *that* withdrawal shall, in the absence of ~~any such~~ *that* 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.

(g) 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.

(h) Except as provided in subdivision (k), 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~~ *that* 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.

(i) 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.

(j) This section shall be effective on and after July 1, 1950, as to all policies thereafter submitted and on and after January 1, 1951, the commissioner may withdraw approval pursuant to subdivision (d) of any policy thereafter issued or delivered in this state irrespective of when its form may have been submitted or approved, and prior to those dates the provisions of law in effect on January 1, 1949, shall apply to those policies.

(k) ~~Any such~~ *A* 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.

(l) (1) Subdivisions (c) and (d) shall become inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), subdivisions (c) and (d) shall become operative as of the date of the repeal or amendment.

(3) For the purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

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