ASSEMBLY BILL No. 108

Introduced by Assembly Member Hayashi

January 12, 2009

An act to amend Section 1389.1 of, and to add Sections 1389.12 and 1389.21 to, the Health and Safety Code, and to amend Section 10291.5 of, and to add Sections 10384.15 and 10384.17 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 108, as introduced, Hayashi. 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. Existing law prohibits the nonrenewal of individual health benefit plans by a health insurer except in specified circumstances.

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. The bill would also prohibit a health care service plan or health insurer from

rescinding an individual health care service plan contract or individual health insurance policy for any reason after 18 months following the issuance of the plan contract or policy.

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

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

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

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

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

SECTION 1. Section 1389.1 of the Health and Safety Code is amended to read:

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

~~(1)~~

(a) All ~~applications~~ *application forms* for coverage ~~which~~ include ~~health-related~~ *the standard information and health history* questions ~~shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant~~ *required by Section 1389.12*.

~~(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~~

(b) The application ~~shall include~~ *form includes* a prominently displayed notice that ~~shall read~~ *reads*:

"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.~~

SEC. 2. Section 1389.12 is added to the Health and Safety Code, to read:

1389.12. (a) On or before January 1, 2010, the director shall, by regulation, establish standard information and health history questions that shall be used by all health care service plans for their individual health care coverage application forms. The director shall jointly develop the regulation with the Insurance Commissioner. The regulation shall include a set of approved questions for use in health care service plan and health insurance application forms for individual health plan contracts and individual health insurance policies. The application forms for individual health plan contracts and individual health insurance policies may only contain questions from the set of approved questions established pursuant to this subdivision.

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

(c) On or after July 1, 2010, all individual health care service plan application forms shall utilize only the pool of approved questions and the standardized information established pursuant to this section.

SEC. 3. Section 1389.21 is added to the Health and Safety Code, to read:

1389.21. Once a plan has issued an individual health care service plan contract, the health care service plan may not rescind the health care service plan contract for any reason after 18 months following the issuance of the plan contract.

SEC. 4. 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~~ *Ensure* that the language of all insurance policies can be readily understood and interpreted.

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

(1) If the commissioner finds that it contains any provision, or has any label, description of its contents, title, heading, backing,

or other indication of its provisions ~~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 provision or provisions which would have the effect, upon any termination of the policy, of reducing or ending the liability as the insurer would have, but for the termination, for loss of time resulting from accident occurring while the policy is in force or for loss of time commencing while the policy is in force and resulting from sickness contracted while the policy is in force

or for other losses resulting from accident occurring or sickness contracted while the policy is in force, and also contains provision or provisions reserving to the insurer the right to cancel or refuse to renew the policy, unless it also contains other provision or provisions the effect of which is that termination of the policy as the result of the exercise by the insurer of any such right shall not reduce or end the liability 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 commences while the policy is in force and results from sickness contracted while the policy is in force.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) The policy is entitled and each provision granting the benefits is separately captioned in clearly understandable words so as to accurately describe the classification of diseases covered

and expressly point out, when that is the case, that not all diseases of the classification are covered.

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

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

(c) The commissioner shall not approve any disability policy covering hospital, medical, or surgical expenses unless the commissioner finds that the application *form* conforms to both of the following requirements:

(1) All ~~applications~~ *application forms* for disability insurance covering hospital, medical, or surgical expenses, except that which is guaranteed issue, ~~which~~ include *the standard information and health history* questions ~~relating to medical conditions, shall contain clear and unambiguous questions designed to ascertain the health condition or history of the applicant~~ *required by Section 10384.15*.

(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~~ *form includes* 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)~~

(d) The commissioner may, from time to time as conditions warrant, after notice and hearing, promulgate such reasonable rules and regulations, and amendments and additions thereto, as are necessary or convenient, to establish, in advance of the submission of policies, the standard or standards conforming to subdivision

(b), by which he or she shall disapprove or withdraw approval of any disability policy.

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

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

~~(f)~~

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

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

~~(g)~~

(f) 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)~~

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

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

~~(i)~~

(h) 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)~~

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

SEC. 5. Section 10384.15 is added to the Insurance Code, to read:

10384.15. (a) On or before January 1, 2010, the commissioner shall, by regulation, establish standard information and health history questions that shall be used by all health insurers for their

individual health care coverage application forms. The commissioner shall jointly develop the regulation with the Director of the Department of Managed Health Care. The regulation shall include a set of approved questions for use in health care service plan and health insurance application forms for individual health plan contracts and individual health insurance policies. The application forms for individual health plan contracts and individual health insurance policies may only contain questions from the set of approved questions established pursuant to this subdivision.

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

(c) On or after July 1, 2010, all individual health insurance application forms shall utilize only the pool of approved questions and the standardized information established pursuant to this section.

SEC. 6. Section 10384.17 is added to the Insurance Code, to read:

10384.17. Once an insurer has issued an individual health insurance policy, the insurer shall not rescind the policy for any reason after 18 months following the issuance of the policy.

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

SEC. 8. (a) The amendments made to Section 1389.1 of the Health and Safety Code by this act shall become operative on July 1, 2010.

(b) The amendments made to Section 10291.5 of the Insurance Code by this act shall become operative on July 1, 2010.

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