Assembly Bill No. 2540

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Passed the Assembly August 26, 2010

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Chief Clerk of the Assembly

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Passed the Senate August 24, 2010

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Secretary of the Senate

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This bill was received by the Governor this _____ day of _____, 2010, at _____ o'clock ____M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 790.03, 790.035, and 10400 of, and to add Section 12739.06 to, the Insurance Code, relating to health insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 2540, De La Torre. Health insurance: postclaims underwriting: unfair and deceptive practices.

Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health insurer from engaging in postclaims underwriting, as defined, and requires an insurer that willfully violates that provision to pay a $118 penalty to the state.

Existing law prohibits any person in the state from engaging in any trade practices that are defined as unfair methods of competition or unfair or deceptive acts or practices in the business of insurance and makes a person who engages in those practices liable to the state for a civil penalty not to exceed $5,000 or $10,000, as specified.

This bill would include engaging in health insurance postclaims underwriting as an unfair method of competition or unfair or deceptive act or practice in the business of insurance. The bill would specify the penalties that could be levied on a person who engages in postclaims underwriting, as specified, and would require that the amount by which a penalty exceeds $118 be deposited in the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature, for the California Major Risk Medical Insurance Program.

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

SECTION 1. Section 790.03 of the Insurance Code is amended to read:

790.03. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his or her insurance.

(b) Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading.

(c) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(d) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with intent to deceive.

(e) Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to

make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer.

(f) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

This subdivision shall be interpreted, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, to require differentials based upon the sex of the individual insured or annuitant in the rates or dividends or benefits, or any combination thereof. This requirement is satisfied if those differentials are substantially supported by valid pertinent data segregated by sex, including, but not necessarily limited to, mortality data segregated by sex.

However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of those differentials based on data segregated by sex, rates, or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (a) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars ($5,000) or a contract of individual life annuity; and (b) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars ($5,000) or less. “Compliance date” as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.1 and 10489.2 or successor sections.

Notwithstanding the provisions of this subdivision, sex-based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (1) any contract of life insurance or life annuity issued pursuant to arrangements that may be

considered terms, conditions, or privileges of employment as these terms are used in Title VII of the Civil Rights Act of 1964 (Public Law 88-352), as amended, and (2) tax sheltered annuities for employees of public schools or of tax-exempt organizations described in Section 501(c)(3) of the Internal Revenue Code.

(g) Making or disseminating, or causing to be made or disseminated, before the public in this state, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that a named insurer, or named insurers, are members of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This subdivision shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063).

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or

she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

(i) Canceling or refusing to renew a policy in violation of Section 676.10.

(j) Engaging in postclaims underwriting as defined by Section 10384.

SEC. 2. Section 790.035 of the Insurance Code is amended to read:

790.035. (a) A person who engages in an unfair method of competition or an unfair or deceptive act or practice defined in Section 790.03 is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars ($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act. However, when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purpose of this section.

(b) The penalty imposed by this section shall be imposed by and determined by the commissioner as provided by Section 790.05. The penalty imposed by this section is appealable by means of any remedy provided by Section 12940 or by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) With respect to a penalty imposed under this section against a person who engages in an unfair method of competition or unfair or deceptive act or practice as defined in subdivision (j) of Section 790.03, the amount by which the penalty exceeds one hundred eighteen dollars ($118) shall be deposited in the Major Risk Medical Insurance Fund created pursuant to Section 12739 to be used, upon appropriation by the Legislature, for the California Major Risk Medical Insurance Program for the purposes specified in Section 12739.1.

SEC. 3. Section 10400 of the Insurance Code is amended to read:

10400. (a) A person who willfully violates any provision of this chapter or order of the commissioner made in accordance therewith shall forfeit to the people of this state a sum not to exceed one hundred eighteen dollars ($118) for each violation, which sum may be recovered by civil action. The commissioner may also suspend or revoke the license of an insurer or agent for any such willful violation.

(b) An insurer that violates Section 10384 shall not be subject to the monetary penalty described in subdivision (a) where the insurer has been assessed a civil penalty for that violation under subdivision (j) of Section 790.03 and Section 790.035.

SEC. 4. Section 12739.06 is added to the Insurance Code, to read:

12739.06. Notwithstanding Section 12739, funds placed in the Major Risk Medical Insurance Fund pursuant to subdivision (c) of Section 790.035 shall not be continuously appropriated.

Approved _____, 2010

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Governor