AMENDED IN SENATE APRIL 18, 2012

AMENDED IN SENATE APRIL 10, 2012

SENATE BILL No. 1313

Introduced by Senator Lieu

February 23, 2012

An act to amend Section 1361 of, and to add Sections 1360.2, ~~1361.2,~~ 1361.4, 1363.06, 1367.004, and 1367.041 to, the Health and Safety Code, and to amend ~~Sections~~ *Section* 781 ~~and 790.03~~ of, and to add Sections 790.16, 1748.1, 10112.26, 10127.14, 10127.45, and 10133.10 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1313, as amended, Lieu. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan from publishing or distributing an advertisement unless a copy thereof has first been filed with the Director of the Department of Managed Health Care at least 30 days prior to that use and the director has not found the advertisement to be untrue, misleading, deceptive, or in violation of the Knox-Keene Act within those 30 days, except as specified. Under existing law, if an advertisement fails to comply with the Knox-Keene Act, the director has the authority to require a plan to publish a correction or retraction of an untrue, misleading, or deceptive statement contained in the advertisement and to prohibit the plan from publishing the advertisement or a material revision thereof without filing a copy with the director, as

specified. Existing law authorizes the director to exempt a plan or advertisement from these requirements.

This bill would, until January 1, 2020, prohibit a plan from publishing or distributing an advertisement unless a copy has first been filed with the director at least 60 days prior to that use and the director has not found the advertisement to be untrue, misleading, deceptive, or in violation of the Knox-Keene Act within those 60 days. The bill would authorize the director to extend this period of review by an additional 60 days. Under the bill, if an advertisement fails to comply with the Knox-Keene Act, the director would be mandated to require a plan to publish a correction or retraction of an untrue, misleading, or deceptive statement contained in the advertisement and to prohibit the plan from publishing the advertisement or a material revision thereof without filing a copy with the director, as specified. The bill would also prohibit the director from exempting certain types of materials from these requirements. The bill would also require health insurers and specified insurance agents to comply with similar advertising requirements.

Existing law prohibits a plan, solicitor, solicitor firm, or representative from using any advertising or solicitation, or making or permitting the use of any verbal statement, that is untrue or misleading or any form of evidence of coverage that is deceptive, as specified. Existing law prohibits an insurer, agent, or broker from causing to be issued a misrepresentation of the terms of the policy issued by the insurer, among other things, and makes a violation of that requirement a crime. Existing law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms. Among other things, commencing January 1, 2014, PPACA requires every individual to be covered under minimum essential coverage, as specified, and requires every health insurance issuer ~~issuing individual or group health insurance coverage to accept every employer and individual who applies for coverage~~ *offering coverage in the individual or small group markets to ensure that the coverage includes a specified essential health benefits package*.

This bill would ~~prohibit an~~ *make it an unfair business practice for an* insurer or agent ~~from using~~ *to use* any advertising or solicitation, or ~~making or permitting~~ *make or permit* the use of any verbal statement, that is untrue or misleading or any form of evidence of coverage that is deceptive, as specified~~, and would specify that a violation of this provision is an unfair business practice~~. The bill would prohibit a person from making any statement to a person that is known, or should have

been known, to be a misrepresentation regarding the requirements of PPACA. The bill would prohibit a specialized health care service plan from offering, issuing, selling, or renewing an individual or group plan contract that does not, at a minimum, cover basic health care services unless the individual or group has proof of enrollment in minimum essential coverage, as defined. The bill would also prohibit an entity that arranges for the provision of health care services from offering or selling a product to an individual or group unless the individual enrollee has proof of enrollment in minimum essential coverage. The bill would prohibit a health insurer, a specialized health insurer, or an insurer offering policies or certificates of specified disease or hospital confinement indemnity insurance from offering, issuing, selling, or renewing an individual or small group health insurance policy that does not, at a minimum, cover essential health benefits, as defined, unless the individual or group has proof of enrollment in minimum essential coverage, as defined. The bill would require a health care service plan or health insurer that offers, issues, or sells a plan contract or health insurance policy that provides coverage that does not constitute minimum essential coverage to include in all solicitations, marketing materials, and the evidence of coverage a clear and easily identified disclosure to that effect, as specified. The bill would enact other related provisions.

Existing law requires the Department of Managed Health Care and the Department of Insurance to adopt regulations establishing standards and requirements to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services, as specified. Existing law requires plans and insurers to translate specified vital documents into a language when a certain proportion of its enrollees or insureds indicate a preference for written materials in that language.

Under this bill, if a solicitor~~, solicitor firm, or representative of a health care service plan,~~ or an insurance agent advertises~~,~~ *or* markets~~, sells, solicits, or negotiates the purchase of a health care service plan contract or health insurance policy~~ *health care service plan contracts or health insurance policies* in a language other than English, the plan or insurer would be required to comply with those language assistance requirements. *The bill would require a solicitor, solicitor firm, or insurance agent to disclose to the plan or insurer the non-English languages in which the solicitor, solicitor firm, or insurance agent markets, advertises, negotiates, or solicits contracts or policies offered*

by the plan or insurer, as specified. The bill would require a health care service plan or health insurer that advertises or markets in a language in which vital documents do not have to be translated to translate certain documents into that language.

Because a violation of certain of the bill's requirements would be a crime, the bill 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 1360.2 is added to the Health and Safety Code, to read:

1360.2. (a) It is unlawful for any person, including a plan, subject to this chapter to make any statement to any other person that is known or should have been known to be a misrepresentation regarding the requirements of 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).

(b) For purposes of subdivision (a), a written or printed statement or item of information shall be deemed to be a misrepresentation whether or not it is literally true if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage, of possible significance to an enrollee, potential enrollee, or potential subscriber in a plan, and such is not the case.

SEC. 2. Section 1361 of the Health and Safety Code is amended to read:

1361. (a) Except as provided in subdivision (b), no plan shall publish or distribute, or allow to be published or distributed on its

behalf, any advertisement not subject to Section 1352.1 unless both of the following requirements are met:

(1) Effective on or after January 1, 2013, to December 31, 2019, inclusive, a true copy thereof has first been filed with the director at least 60 days prior to any such use, or any shorter period as the director by rule or order may allow. Between January 1, 2013, and December 31, 2019, inclusive, the director may, at his or her discretion, extend the period of review by up to 60 days. Commencing January 1, 2020, this copy shall be filed at least 30 days prior to any such use, or any shorter period as the director by rule or order may allow.

(2) The director by notice has not found the advertisement, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this chapter or the rules thereunder, and specified the deficiencies, within the period specified in paragraph (1), or any shorter time as the director by rule or order may allow.

(b) Except as provided in subdivision (c), a licensed plan that has been continuously licensed under this chapter for the preceding 18 months may publish or distribute, or allow to be published or distributed on its behalf, an advertisement not subject to Section 1352.1 without having filed the same for the director's prior approval if the plan and the material comply with each of the following conditions:

(1) The advertisement or a material provision thereof has not been previously disapproved by the director by written notice to the plan and the plan reasonably believes that the advertisement does not violate any requirement of this chapter or the rules thereunder.

(2) The plan files a true copy of each new or materially revised advertisement, used by it or by any person acting on behalf of the plan, with the director not later than 10 business days after publication or distribution of the advertisement or within such additional period as the director may allow by rule or order.

(c) If the director finds that any advertisement of a plan has materially failed to comply with this chapter or the rules thereunder, the director shall, by order, require the plan to publish in the same or similar medium, an approved correction or retraction of any untrue, misleading, or deceptive statement contained in the advertising, and shall prohibit the plan from publishing or distributing, or allowing to be published or distributed on its behalf,

the advertisement or any new materially revised advertisement without first having filed a copy thereof with the director 30 days prior to the publication or distribution thereof, or any shorter period specified in the order. An order issued under this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the advertisements submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this chapter and the rules thereunder.

(d) A licensed plan or other person regulated under this chapter may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the director.

(e) The director may classify plans and advertisements and exempt certain classes, wholly or in part, either unconditionally or upon specified terms and conditions or for specified periods, from the application of subdivisions (a) and (b), except for the following:

(1) Advertisements or marketing materials that include ~~claims~~ *endorsements or ratings* about quality of care.

(2) Advertisement or marketing materials about new health care products.

(3) Enrollment-related materials, including, but not limited to, disclosure forms, contract documents, and enrollment forms.

(4) Any other materials as provided by regulation.

~~SEC. 3. Section 1361.2 is added to the Health and Safety Code, to read:~~

~~1361.2. If a solicitor, solicitor firm, or representative of a health care service plan advertises, markets, sells, solicits, or negotiates the purchase of a health care service plan contract in a language other than English, the health care service plan shall meet the requirements of Sections 1367.04 and 1367.07, and, if applicable, Section 1367.041, and any rules or regulations adopted thereunder.~~

~~SEC. 4.~~

SEC. 3. Section 1361.4 is added to the Health and Safety Code, to read:

1361.4. A person licensed pursuant to Section 1351 whose license is revoked or suspended pursuant to the grounds set forth in this article, Article 3 (commencing with Section 1349), or Article 5 (commencing with Section 1367), and a person who engages in solicitation, as defined in subdivision (*l*) of Section 1345 who is

disciplined pursuant to Section 1388, shall be prohibited from doing any of the following:

(a) Becoming a navigator as determined by the California Health Benefit Exchange pursuant to subdivision (*l*) of Section 100502 of the Government Code in accordance with subdivision (i) of Section 1311 of 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).

(b) Becoming licensed as a life licensee agent as defined in Section 1622 of the Insurance Code.

(c) Becoming a designated individual or organization authorized to receive a fee under Section 12693.32 of the Insurance Code.

~~SEC. 5.~~

SEC. 4. Section 1363.06 is added to the Health and Safety Code, to read:

1363.06. The director shall adopt rules to implement Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15). In so doing, the director shall minimize duplication with disclosure requirements under California law.

~~SEC. 6.~~

SEC. 5. Section 1367.004 is added to the Health and Safety Code, to read:

1367.004. (a) (1) On and after January 1, 2014, a specialized health care service plan shall not offer, issue, sell, or renew for any group a plan contract that does not, at a minimum, cover basic health care services unless the group provides proof of coverage that constitutes minimum essential coverage, as defined in Section 5000A(f) of the Internal Revenue Code and any rules or regulations issued thereunder.

(2) On and after January 1, 2014, a specialized health care service plan shall not offer, issue, sell, or renew for any individual a plan contract that does not, at a minimum, cover basic health care services unless the individual enrollee has proof of enrollment in coverage that constitutes minimum essential coverage, as defined in Section 5000A(f) of the Internal Revenue Code and any rules or regulations issued thereunder.

(3) For products offered through the California Health Benefit Exchange, the Exchange may provide proof of coverage of essential health benefits for an individual or small group.

(b) On and after January 1, 2014, any entity that arranges for the provision of health care services shall not offer or sell a product or service to an individual or group unless the individual enrollee has proof of enrollment in coverage that constitutes minimum essential coverage as defined in Section 5000A(f) of the Internal Revenue Code and any rules or regulations issued thereunder.

(c) On and after January 1, 2014, a health care service plan, including a specialized health care service plan, that offers, issues, or sells a plan contract that provides coverage that does not constitute minimum essential coverage, as defined in Section 5000A(f) of the Internal Revenue Code and any rules or regulations issued thereunder, shall include in all solicitations, marketing materials, and the evidence of coverage a clear and easily identified disclosure that the contract does not meet the requirements of federal law with respect to minimum essential coverage and may expose an individual enrolled in the contract to significant federal tax penalties unless the individual also obtains coverage that provides minimum essential coverage as required by federal law.

~~SEC. 7.~~

SEC. 6. Section 1367.041 is added to the Health and Safety Code, to read:

1367.041. (a) A health care service plan that advertises or markets in a language other than English, which language does not meet the minimum enrollee thresholds established under Sections 1367.04 and 1367.07 or the regulations adopted thereunder, shall translate into that language the documents listed in clauses (i), (iii), and (v) of subparagraph (B) of paragraph (1) of subdivision (b) of Section 1367.04 and in subparagraphs (F) and (G) of paragraph (7) of subdivision (b) of Section 1300.67.04 of Title 28 of the California Code of Regulations.

(b) Once the enrollee population of the non-English-language population meets a threshold listed in subparagraph (A) of paragraph (1) of subdivision (b) of Section 1367.04, the plan shall translate all vital documents as required under Sections 1367.04 and 1367.07 and the regulations adopted thereunder.

(c) If a solicitor advertises or markets health care service plan contracts in a language other than English, the health care service plan for which the solicitor is advertising or marketing shall meet the requirements of Sections 1367.04 and 1367.07 and, if

applicable, Section 1367.041, and any rules or regulations adopted thereunder.

(d) A solicitor or solicitor firm shall disclose to the health care service plan for which the solicitor or solicitor firm markets, advertises, or solicits health care service plan coverage each of the non-English languages in which the solicitor or solicitor firm markets, advertises, or solicits that coverage.

~~SEC. 8.~~

SEC. 7. Section 781 of the Insurance Code is amended to read:

781. (a) A person shall not make any statement that is known, or should have been known, to be a misrepresentation (1) to any other person for the purpose of inducing, or tending to induce, the other person either to take out a policy of insurance, or to refuse to accept a policy issued upon an application therefor and instead take out any policy in another insurer, or (2) to a policyholder in any insurer for the purpose of inducing or tending to induce him or her to forfeit or surrender his or her insurance therein, or inducing or tending to induce a lapse in that insurance.

(b) A person shall not make any representation or comparison of insurers or policies to an insured that is misleading for the purpose of inducing or tending to induce him or her to forfeit, change, or surrender his or her insurance, or inducing or tending to induce a lapse in that insurance, whether on a temporary or permanent plan.

(c) (1) A person shall not make any statement to any other person that is known or should have been known to be a misrepresentation regarding the requirements of 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).

(2) For purposes of this subdivision, a written or printed statement or item of information shall be deemed to be a misrepresentation whether or not it is literally true if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage, of possible significance to an insured, potential insured, or potential policyholder, and such is not the case.

~~SEC. 9. 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) (1) 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.~~

~~(2) 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 limited to, mortality data segregated by sex.~~

~~(3) 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.~~

~~(4) Notwithstanding the provisions of this subdivision, sex-based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (A) any contract of life insurance or life annuity issued pursuant to arrangements which 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 (B) 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 which 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) Marketing, soliciting, or advertising policies of health insurance, as defined in subdivision (b) of Section 106, or categories of coverage described in subdivision (a) of Section 10604, in a language other than English if the health insurer does not meet the requirements set forth in Sections 10133.8 and 10133.9, and, if applicable, Section 10133.10.~~

~~SEC. 10.~~

SEC. 8. Section 790.16 is added to the Insurance Code, to read:

790.16. (a) ~~No~~ *It is an unfair method of competition and an unfair and deceptive act or practice in the business of insurance for an* insurer or agent, as defined in Section 1622, ~~shall~~ *to* use or permit the use of any advertising or solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of this section:

(1) A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is, or may be significant to an insured or policyholder, or potential insured or policyholder of a policy.

(2) A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or such item of information is communicated, such statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an insured, or potential insured or policyholder, of a policy, and such is not the case.

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge of policies, and evidence of coverage therefor to expect benefits,

service charges, or other advantages which the evidence of coverage does not provide or which the insurer issuing such coverage or evidence of coverage does not regularly make available to insureds or policyholders covered under such evidence of coverage.

(b) ~~No~~ *It is an unfair method of competition and an unfair and deceptive act or practice for an* insurer or agent ~~shall~~, *as defined in Section 1622, to* use or permit the use of any verbal statement that is untrue, misleading, or deceptive or make any representations about coverage offered by the insurer or its cost that does not conform to fact. All verbal statements are to be held to the same standards as those for printed matter provided in subdivision (a).

~~(c) A violation of this section shall constitute an unfair business practice.~~

~~SEC. 11.~~

SEC. 9. Section 1748.1 is added to the Insurance Code, to read:

1748.1. A person licensed pursuant to Section 1622 whose license is revoked or suspended pursuant to the grounds set forth in Article 6 (commencing with Section 1666) of Chapter 5 of Part 2 of Division 1, or an insurer whose certificate of authority is revoked or suspended, shall be prohibited from doing any of the following:

(a) Becoming a navigator as determined by the California Health Benefit Exchange pursuant to subdivision (*l*) of Section 100502 of the Government Code in accordance with subdivision (i) of Section 1311 of 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).

(b) Engaging in solicitation, as defined in Section 1345 of the Health and Safety Code, or being approved by the Department of Managed Health Care to become a solicitor or solicitor firm.

(c) Being approved for licensure by the Department of Managed Health Care, as set forth in Section 1351 of the Health and Safety Code.

(d) Becoming a designated individual or organization authorized to receive a fee under Section 12693.32.

~~SEC. 12.~~

SEC. 10. Section 10112.26 is added to the Insurance Code, to read:

10112.26. (a) (1) On and after January 1, 2014, a health insurer, as defined in subdivision (b) of Section 106, shall not offer, issue, sell, or renew for any individual or any small group a policy of health insurance that does not, at a minimum, cover essential health benefits, as defined by the state pursuant to regulations, rules, or guidance, adopted pursuant to 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), unless the individual insured has proof of enrollment in coverage that constitutes minimum essential coverage, as defined in Section 5000A(f) of the Internal Revenue Code and any rules or regulations issued thereunder.

(2) On and after January 1, 2014, a specialized health insurer and an insurer offering policies or certificates of specified disease or hospital confinement indemnity insurance shall not offer, issue, sell, or renew for any small group a policy of health insurance that does not, at a minimum, cover essential health benefits, as defined by the state pursuant to regulations, rules, or guidance, adopted pursuant to 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), unless the group provides proof of enrollment in coverage that constitutes minimum essential coverage, as defined in Section 5000A(f) of the Internal Revenue Code and any rules or regulations issued thereunder.

(3) On and after January 1, 2014, a specialized health insurer and an insurer offering policies or certificates of specified disease or hospital confinement indemnity insurance shall not offer, issue, sell, or renew for any individual a policy of health insurance that does not, at a minimum, cover essential health benefits, as defined by the state pursuant to regulations, rules, or guidance, adopted pursuant to 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), unless the individual insured has proof of enrollment in coverage that constitutes minimum essential coverage, as defined in Section 5000A(f) of the Internal Revenue Code and any rules or regulations issued thereunder.

(4) For products offered through the California Health Benefit Exchange, the Exchange may provide proof of coverage of essential health benefits for an individual or small group.

(b) On and after January 1, 2014, a health insurer, including a specialized health insurer, that offers, issues, or sells a policy of health insurance that provides coverage that does not constitute minimum essential coverage, as defined in Section 5000A(f) of the Internal Revenue Code and any rules or regulations issued thereunder, shall include in all solicitations, marketing materials, and the evidence of coverage a clear and easily identified disclosure that the policy does not meet the requirements of federal law with respect to minimum essential coverage and may expose an individual covered under the policy to significant federal tax penalties unless the individual also obtains coverage that provides minimum essential coverage as required by federal law.

~~SEC. 13.~~

SEC. 11. Section 10127.14 is added to the Insurance Code, to read:

10127.14. The commissioner shall adopt rules to implement Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15). In so doing, the commissioner shall minimize duplication with disclosure requirements under California law.

~~SEC. 14.~~

SEC. 12. Section 10127.45 is added to the Insurance Code, to read:

10127.45. (a) Except as provided in subdivision (b), no insurer offering policies of health insurance, as defined in subdivision (b) of Section 106, or categories of coverage described in subdivision (a) of Section 10604, shall publish or distribute, or allow to be published or distributed on its behalf, any advertisement until both of the following occur:

(1) A true copy thereof has first been filed with the commissioner, at least 60 days prior to any such use beginning January 1, 2013, to December 31, 2019, inclusive, or any shorter period as the commissioner by rule or order may allow. Between January 1, 2013, and December 31, 2019, inclusive, the commissioner may, at his or her discretion, extend the period of review by up to 60 days. Commencing January 1, 2020, this copy shall be filed at least 30 days prior to any such use, or any shorter period, as the commissioner by rule or order may allow.

(2) The commissioner by notice has not found the advertisement, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this code or the rules thereunder, and specified the deficiencies, within the period specified in paragraph (1), or any shorter time as the commissioner by rule or order may allow.

(b) Except as provided in subdivision (c), an insurer or agent that has been continuously licensed under this code for the preceding 18 months may publish or distribute, or allow to be published or distributed on its behalf, an advertisement without having filed the advertisement for the commissioner's prior approval, if the insurer or agent and the material comply with each of the following conditions:

(1) The advertisement or a material provision thereof has not been previously disapproved by the commissioner by written notice to the insurer or agent and the insurer or agent reasonably believes that the advertisement does not violate any requirement of this code or the rules thereunder.

(2) The insurer or agent files a true copy of each new or materially revised advertisement, used by it or by any person acting on behalf of the insurer or agent, with the commissioner not later than 10 business days after publication or distribution of the advertisement or within such additional period as the commissioner may allow by rule or order.

(c) If the commissioner finds that any advertisement of an insurer or agent has materially failed to comply with this code or the rules thereunder, the commissioner shall, by order, require the insurer or agent to publish in the same or similar medium, an approved correction or retraction of any untrue, misleading, or deceptive statement contained in the advertising, and shall prohibit the insurer or agent from publishing or distributing, or allowing to be published or distributed on its behalf the advertisement or any new materially revised advertisement without first having filed a copy thereof with the commissioner 30 days prior to the publication or distribution thereof, or any shorter period specified in the order. An order issued under this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the advertisements submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this code and the rules thereunder.

(d) An insurer or agent or other person regulated under this code may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the commissioner.

(e) The commissioner may classify certain types of insurance and advertisements and exempt certain classes, wholly or in part, either unconditionally or upon specified terms and conditions or for specified periods, from the application of subdivisions (a) and (b), except for the following:

(1) Advertisements or marketing materials that include ~~claims~~ *endorsements or ratings* about quality of care.

(2) Advertisement or marketing materials about new health care products.

(3) Enrollment-related materials, including, but not limited to, disclosure forms, contract documents, and enrollment forms.

(4) Any products described in subdivision (a) of Section 10112.26.

~~(4)~~

(5) Any other materials as provided by regulation.

(f) Two copies of a proposed advertisement, marketing document, or educational material shall be filed. To minimize the expense of changes in advertising copy, the advertisement may be submitted in draft form for preliminary review subject to the later filing of a proof or final copy, and the later filing of a proof or final copy may be waived when the draft copy is presented in a manner reasonably representing the final appearance of the advertisement. The text of audio-visual advertising shall indicate any directions for presentation, including voice qualities and the juxtaposition of the visual materials with the text. The commissioner shall allow insurers and agents to file these materials electronically.

(g) The commissioner shall not issue letters of nondisapproval of advertising. If the person submitting the advertisement requests an order shortening the 30-day or 90-day waiting period specified in paragraph (1) of subdivision (a), that order shall be issued when an appropriate showing of the need therefor is made.

~~SEC. 15.~~

SEC. 13. Section 10133.10 is added to the Insurance Code, to read:

10133.10. (a) An insurer that markets, advertises, or produces educational materials for health insurance policies in a language

other than English, which language does not meet the minimum insured thresholds established under Sections 10133.8 and 10133.9 or the regulations adopted thereunder, shall translate into that language the documents listed in clauses (i), (iii), and (v) of subparagraph (B) of paragraph (3) of subdivision (b) of Section 10133.8 and in paragraphs (6) and (7) of subdivision (k) of Section 2538.2 of Title 10 of the California Code of Regulations.

(b) Once the insured population of the non-English-language population meets a threshold listed in subparagraph (A) of paragraph (3) of subdivision (b) of Section 10133.8, the insurer shall translate all vital documents as required under Sections 10133.8 and 10133.9 and the regulations adopted thereunder.

~~(b) A health insurer shall disclose to the commissioner each of the languages in which the insurer does any of the following:~~

~~(1) Markets, advertises, or produces educational materials for health insurance policies.~~

~~(2) Furnishes, provides, or distributes to life licensee agents, licensed under Section 1622, marketing, advertising, or educational materials.~~

(c) If an agent advertises or markets health insurance policies in a language other than English, the insurer for which that individual is an agent shall meet the requirements of Sections 10133.8 and 10133.9 and, if applicable, Section 10133.10, and any rules or regulations promulgated thereunder. ~~An~~

(d) An agent licensed to sell health insurance policies pursuant to Section 1622 shall ~~annually~~ disclose to the ~~commissioner~~ *insurer or insurers for which the agent markets, sells, advertises, or negotiates health insurance policies* each of the languages in which ~~he or she~~ *the agent* markets, sells, advertises, or negotiates health insurance policies.

~~SEC. 16.~~

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

the meaning of Section 6 of Article XIII B of the California Constitution.

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