

AMENDED IN SENATE AUGUST 30, 2008

AMENDED IN SENATE AUGUST 22, 2008

AMENDED IN SENATE AUGUST 21, 2008

AMENDED IN SENATE AUGUST 18, 2008

AMENDED IN SENATE JULY 2, 2008

AMENDED IN ASSEMBLY APRIL 2, 2008

AMENDED IN ASSEMBLY MARCH 28, 2008

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL

No. 1945

Introduced by Assembly Member De La Torre

February 13, 2008

An act to add Sections 1389.9, 1389.10, 1389.11, 1389.13, 1389.14, 1389.15, 1389.16, 1389.17, 1389.18, 1389.19, 1389.20, 1389.22, and 1389.24 to, and to repeal and add Section 1389.1 of, the Health and Safety Code, and to amend Sections 10270.95, 10291.5, and 12957 of, and to add Sections 10384.1, 10384.12, 10384.14, 10384.16, 10384.18, 10384.2, 10384.22, 10384.24, 10384.26, 10384.28, 10384.29, 10384.3, 10384.32, and 10396 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

AB 1945, as amended, De La Torre. Individual health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful

violation of its provisions a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits the Director of the Department of Managed Health Care and the Insurance Commissioner from approving a plan contract or health insurance policy without a finding that the application conforms to specified requirements.

This bill would require the director and the commissioner to jointly, by regulation, establish standard information and health history questions to be used by health care service plans and health insurers for their individual health care coverage application forms, as specified, and, on and after January 1, 2010, would require all health care service plan and health insurance applications to be reviewed and approved by the director or the commissioner, respectively, before use by a health care service plan or health insurer.

The bill would require all plans and insurers to complete medical underwriting prior to issuing a health care service plan contract or health insurance policy, and to meet certain requirements with regard to medical underwriting. The bill would prohibit a plan or insurer from canceling or rescinding an individual health care service plan contract or individual health insurance policy unless specified conditions are met and would require a plan or insurer to annually report to the department the total number of individual health care service plan contracts or individual health insurance policies issued, canceled, or rescinded pursuant to these provisions during the preceding calendar year. The bill would require a health care service plan or health insurer to provide specified notices to subscribers and enrollees and insureds and policyholders. The bill would, commencing January 1, 2010, establish in the Department of Managed Health Care and the Department of Insurance an independent review process for the review of health plans' and health insurers' decisions to cancel or rescind health care service plan contracts and health insurance policies. The bill would enact related provisions.

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

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

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

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

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

1 SECTION 1. Section 1389.1 of the Health and Safety Code is
2 repealed.
3 SEC. 2. Section 1389.1 is added to the Health and Safety Code,
4 to read:
5 1389.1. (a) The director shall, by regulation, establish standard
6 information and health history questions that shall be used by all
7 health care service plans for their individual health care coverage
8 application forms. The director shall jointly develop the regulation
9 with the Insurance Commissioner. The regulation shall include a
10 pool of approved questions for use in health care service plan and
11 health insurance application forms for individual health plan
12 contracts and individual health insurance policies. The application
13 forms for individual health plan contracts and individual health
14 insurance policies may only contain questions from the pool of
15 approved questions established pursuant to this subdivision.
16 (b) The standard information and health history questions
17 developed by the director shall contain clear and unambiguous
18 information and questions designed to ascertain the health history
19 of the applicant and shall be based on the medical information that
20 is reasonable and necessary for medical underwriting purposes.
21 (c) The application form shall include a prominently displayed
22 notice that shall read:
23 “California law prohibits an HIV test from being required or
24 used by health care service plans as a condition of obtaining
25 coverage.”
26 (d) The health history questions established under this section
27 shall include a limitation on how far back in time from the date of
28 the application the applicant was diagnosed or treated for the health
29 condition specified in the question.
30 (e) All individual health care service plan application forms
31 shall utilize only the pool of approved questions and the
32 standardized information established pursuant to subdivision (a)
33 no later than six months after the adoption of regulation under that
34 subdivision.

(f) On and after January 1, 2010, all individual health care service plan applications shall be reviewed and approved by the director before they may be used by a health care service plan.

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

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

(b) "Medical underwriting" means the completion of a reasonable investigation of the applicant's health history information, which includes, but is not limited to, both of the following:

(1) Ensuring that the information submitted on the application form and the material submitted with the application form is complete and accurate.

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

(c) A health care service plan shall adopt and implement written medical underwriting policies and procedures.

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

(e) On or before January 1, 2010, a health care service plan shall file its medical underwriting policies and procedures with the department pursuant to Section 1352.

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

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

(1) The applicant should review the completed application carefully and notify the health care service plan within 30 days of any inaccuracy in the application.

(2) Any intentional material misrepresentation or intentional material omission in the information submitted in the application may result in the cancellation or rescission of the plan contract.

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

3 (b) If new information is provided by the applicant within the
4 30-day period permitted by subdivision (a), medical underwriting,
5 as defined in Section 1389.9, applies to the new information.

6 SEC. 5. Section 1389.11 is added to the Health and Safety
7 Code, to read:

8 1389.11. Once a plan has issued an individual health care
9 service plan contract, the health care service plan shall not rescind
10 or cancel the health care service plan contract unless all of the
11 following apply:

12 (a) There was a material misrepresentation or material omission
13 in the information submitted by the applicant in the written
14 application to the health care service plan prior to the issuance of
15 the health care service plan contract that would have prevented
16 the contract from being entered into.

17 (b) The health care service plan completed medical underwriting
18 pursuant to Section 1389.9 before issuing the plan contract.

19 (c) The health care service plan demonstrates that the applicant
20 intentionally misrepresented or intentionally omitted material
21 information on the application prior to the issuance of the plan
22 contract with the purpose of misrepresenting his or her health
23 history in order to obtain health care coverage.

24 (d) The application form was approved by the department
25 pursuant to Section 1389.1.

26 (e) The health care service plan sent a copy of the completed
27 written application to the applicant with a copy of the health care
28 service plan contract issued by the health care service plan, along
29 with the written notice required by Section 1389.10.

30 SEC. 6. Section 1389.13 is added to the Health and Safety
31 Code, to read:

32 1389.13. (a) If a health care service plan obtains information
33 after issuing an individual health care service plan contract that
34 the subscriber or enrollee may have intentionally omitted or
35 intentionally misrepresented material information during the
36 application for coverage process, the health care service plan may
37 investigate the potential omissions or misrepresentations in order
38 to determine whether the subscriber's or enrollee's health care
39 service plan contract should be rescinded or canceled.

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

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

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

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

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

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

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

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

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

5 (C) Provide the enrollee or subscriber with information regarding
6 the department's independent review process and the right of the
7 enrollee or subscriber to opt-out of that review process within 45
8 days of the date upon which an independent review organization
9 receives a request for independent review.

10 (D) Provide a statement that the health care service plan's
11 proposed decision to cancel or rescind the health care service plan
12 contract shall not become effective unless the department's
13 independent review organization upholds the health care service
14 plan's decision, unless the enrollee has opted out of the independent
15 review.

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

18 1389.14. (a) A health care service plan shall continue to
19 authorize and provide all medically necessary health care services
20 required to be covered under an enrollee's or subscriber's health
21 care service plan contract until the effective date of cancellation
22 or rescission.

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

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

32 1389.15. (a) Commencing January 1, 2010, there is hereby
33 established in the department the independent review process for
34 the review of health care service plan decisions to cancel or rescind
35 health care service plan contracts pursuant to Section 1389.11.

36 (b) All health care service plan decisions to cancel or rescind
37 the enrollee's or subscriber's health care service plan contract
38 pursuant to Section 1389.11 shall be reviewed, unless the enrollee
39 opts-out of the independent review process.

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

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

6 (e) No later than January 1, 2010, in addition to the notice
7 required pursuant to subdivision (b) of Section 1389.13, every
8 health care service plan shall prominently display in every plan
9 member handbook or relevant informational brochure, in every
10 plan contract, on enrollee evidence of coverage forms, on copies
11 of plan procedures for resolving grievances, information concerning
12 the right of an enrollee or subscriber to an automatic unless you
13 opt-out independent review in cases where the health care service
14 plan has decided to cancel or rescind the enrollee's or subscriber's
15 health care service plan contract, pursuant to Section 1389.11.

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

20 (A) A copy of all of the enrollee's or subscriber's medical
21 records in the possession of the plan or its contracting providers
22 relevant to the plan's decision to cancel or rescind the enrollee's
23 or subscriber's health care service plan contract.

24 (B) The enrollee's or subscriber's application for coverage with
25 the health care service plan.

26 (C) A copy of all information provided to the enrollee or
27 subscriber by the plan concerning the health care service plan's
28 decision to cancel or rescind the enrollee or subscriber's health
29 care service plan contract and a copy of any materials the enrollee
30 or subscriber, the enrollee's or subscriber's agent, or the enrollee's
31 or subscriber's provider submitted to the plan. The confidentiality
32 of any enrollee or subscriber medical information shall be
33 maintained pursuant to applicable state and federal laws.

34 (D) A copy of any other relevant documents or information used
35 by the plan for the following:

36 (i) To complete medical underwriting pursuant to Section
37 1389.9.

38 (ii) In determining the enrollee's or subscriber's health care
39 service plan contract should be canceled or rescinded and any
40 statements by the plan explaining the reasons for the decision to

1 cancel or rescind the enrollee's or subscriber's health care service
2 plan contract.

3 (2) The plan shall concurrently provide a copy of documents
4 required by this subdivision to the enrollee or subscriber. The
5 department and the independent review organization shall maintain
6 the confidentiality of any information found by the director to be
7 the proprietary information of the plan.

8 SEC. 9. Section 1389.16 is added to the Health and Safety
9 Code, to read:

10 1389.16. (a) The department shall expeditiously review
11 independent review requests and immediately notify the enrollee
12 or subscriber, in writing, as follows:

13 (1) That the health care service plan has requested an
14 independent review that has been approved, in whole or in part,
15 or, if not approved, the reasons for disapproval.

16 (2) That the health care service plan's proposed decision to
17 cancel or rescind the enrollee's or subscriber's health care service
18 plan contract will not become effective unless the independent
19 review organization upholds the health care service plan's decision.

20 (3) That the enrollee or subscriber has 45 days from the date of
21 the organization's receipt of the request for an independent review
22 to submit any information that may be relevant to the independent
23 review.

24 (4) That an independent review does not limit the enrollee's or
25 subscriber's rights to pursue any other remedies available under
26 the law.

27 (b) The health care service plan shall promptly issue a
28 notification to the enrollee or subscriber, after submitting all of
29 the required material to the independent review organization, that
30 includes an annotated list of documents submitted and offer the
31 enrollee or subscriber the opportunity to request copies of those
32 documents from the plan.

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

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

1389.17. (a) On or before January 1, 2010, the department shall contract or otherwise arrange with one or more independent organizations in the state to conduct reviews for purposes of this article. The independent review organizations shall be not-for-profit and shall be independent of any health care service plan doing business in this state. The director shall establish additional requirements, including conflict-of-interest standards, consistent with the purposes of this article, and an organization shall be required to meet these requirements in order to qualify for participation in the independent review process and to assist the department in carrying out its responsibilities. The conflict-of-interest standards established by the director shall also be consistent with the conflict-of-interest provisions of Section 1374.32 to the extent applicable.

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

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

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

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

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

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

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

1 (D) Ensures the confidentiality of medical records and the
2 review materials, consistent with the requirements of this section
3 and applicable state and federal law.

4 (E) Ensures the independence of the arbitrator retained to
5 perform the reviews and of the experts retained to provide expert
6 opinions through conflict-of-interest policies and prohibitions
7 consistent with the standards established by the director, and
8 ensures adequate screening for conflicts of interest.

9 (4) Ensures that arbitrators selected by independent review
10 organizations to review health care service plan decisions to cancel
11 or rescind a health care service plan contract meet the following
12 minimum requirements:

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

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

17 (C) The arbitrator does not represent health care service plans
18 or insurers.

19 (c) “Expert consultant” means an underwriter, actuary, physician
20 and surgeon, or other professional whose background, experience,
21 and knowledge is relevant to determining whether the health care
22 service plan completed medical underwriting or to determining
23 the issues raised in the review of the health care service plan’s
24 decision to cancel or rescind the enrollee’s or subscriber’s health
25 care service plan contract.

26 (d) The department shall provide, upon the request of any
27 interested person, a copy of all nonproprietary information, as
28 determined by the director, filed with it by an independent review
29 organization seeking to contract under this article. The department
30 may charge a nominal fee to the interested person for photocopying
31 the requested information.

32 ~~(e) An approval for rescission or cancellation by the independent~~
33 ~~review organization shall be used solely for regulatory purposes~~
34 ~~and shall not be admissible in any judicial proceeding.~~

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

37 1389.18. (a) (1) Upon receipt of information and documents
38 related to a case, the arbitrator selected to conduct the review by
39 the independent review organization shall promptly review all
40 pertinent records of the enrollee, provider reports, as well as any

1 other information submitted to the organization as authorized by
2 the department or requested from any of the parties to the dispute
3 by the reviewers.

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

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

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

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

28 (3) Subject to the approval of the department, the deadline for
29 the analysis and determination of the review may be extended by
30 the director for up to three days in extraordinary circumstances or
31 for good cause.

32 (c) The arbitrator's analysis and determination shall state the
33 reasons for the determination, the relevant documents in the record,
34 and the relevant findings supporting the determination.

35 (d) The independent review organization shall provide the
36 director, the plan, the enrollee or subscriber, and the enrollee's or
37 subscriber's provider with the name of the arbitrator reviewing
38 the case, the analysis and determination of the arbitrator, and a
39 description of the qualifications of the arbitrator.

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

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

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

14 1389.19. (a) A health care service plan shall not engage in any
15 conduct that has the effect of prolonging the independent review
16 process. Engaging in that conduct or the failure of the plan to
17 promptly implement an independent review process decision is a
18 violation of this chapter and, in addition to any other fines,
19 penalties, and other remedies available to the director under this
20 chapter, the plan shall be subject to an administrative penalty of
21 not less than five thousand dollars (\$5,000) for each day the
22 independent review process is prolonged or the decision is not
23 implemented. Administrative penalties shall be deposited in the
24 Managed Care Fund, and shall not be used to lower health care
25 service plans' assessments used to fund the department.

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

33 SEC. 13. Section 1389.20 is added to the Health and Safety
34 Code, to read:

35 1389.20. (a) After considering the results of a competitive
36 bidding process and any other relevant information on program
37 costs, the director shall establish a reasonable, per-case
38 reimbursement schedule to pay the costs of independent review
39 organization reviews, which may vary depending upon relevant
40 factors.

(b) The costs of the independent review system for enrollees and subscribers shall be borne by the affected health care service plans pursuant to an assessment fee system established by the director. Plans that do not cancel or rescind individual health care service plan contracts pursuant to Section 1389.11 shall not be considered by the director as “affected health care service plans” under this section. In determining the amount to be assessed, the director shall consider all appropriations available for the support of this chapter and existing fees paid to the department. The director may adjust fees upward or downward, on a schedule set by the department, to address shortages or overpayments, and to reflect utilization of the independent review process.

SEC. 14. Section 1389.22 is added to the Health and Safety Code, to read:

1389.22. (a) On and after January 1, 2009, every health care service plan shall annually report to the department the total number of individual health care service plan contracts issued, and the total number of individual health care service plan contracts where the plan initiated a cancellation or rescission or completed a cancellation or rescission pursuant to the provisions of this article for the preceding calendar year.

(b) On or before March 31, 2009, and annually thereafter, the department shall publish on its Internet Web site the information filed pursuant to this section.

SEC. 14.5. Section 1389.24 is added to the Health and Safety Code, to read:

1389.24. The requirements of this article shall not apply to health care service plan contracts for coverage issued under the Medi-Cal program, the Access for Infants and Mothers Program, the Healthy Families Program or the federal Medicare Program.

SEC. 15. Section 10270.95 of the Insurance Code is amended to read:

10270.95. Without affecting the applicability or degree of applicability of other sections of this chapter, it is hereby specified that the provisions of Sections 10321, 10325, 10401, of subdivisions (a), (c), (e), (h) and (i) of Section 10320, of subdivision (a) of Section 10290, of paragraphs (2), (3), (4), (5), (6), (7), (8), (9), (10), (11) and (12) of subdivision (b) and subdivisions (c), (d), (e), (f), (g), and (i) of Section 10291.5 and of Section 10291.6, shall not apply to group disability insurance.

1 The provisions of Section 10401 shall not apply to family expense
2 disability insurance; provided, there is no discrimination between
3 families of the same class.

4 SEC. 16. Section 10291.5 of the Insurance Code is amended
5 to read:

6 10291.5. (a) The purpose of this section is to achieve both of
7 the following:

8 (1) Prevent, in respect to disability insurance, fraud, unfair trade
9 practices, and insurance economically unsound to the insured.

10 (2) Assure that the language of all insurance policies can be
11 readily understood and interpreted.

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

15 (1) If the commissioner finds that it contains any provision, or
16 has any label, description of its contents, title, heading, backing,
17 or other indication of its provisions which is unintelligible,
18 uncertain, ambiguous, or abstruse, or likely to mislead a person to
19 whom the policy is offered, delivered or issued.

20 (2) If it contains any provision for payment at a rate, or in an
21 amount (other than the product of rate times the periods for which
22 payments are promised) for loss caused by particular event or
23 events (as distinguished from character of physical injury or illness
24 of the insured) more than triple the lowest rate, or amount,
25 promised in the policy for the same loss caused by any other event
26 or events (loss caused by sickness, loss caused by accident, and
27 different degrees of disability each being considered, for the
28 purpose of this paragraph, a different loss); or if it contains any
29 provision for payment for any confining loss of time at a rate more
30 than six times the least rate payable for any partial loss of time or
31 more than twice the least rate payable for any nonconfining total
32 loss of time; or if it contains any provision for payment for any
33 nonconfining total loss of time at a rate more than three times the
34 least rate payable for any partial loss of time.

35 (3) If it contains any provision for payment for disability caused
36 by particular event or events (as distinguished from character of
37 physical injury or illness of the insured) payable for a term more
38 than twice the least term of payment provided by the policy for
39 the same degree of disability caused by any other event or events;
40 or if it contains any benefit for total nonconfining disability payable

1 for lifetime or for more than 12 months and any benefit for partial
2 disability, unless the benefit for partial disability is payable for at
3 least three months; or if it contains any benefit for total confining
4 disability payable for lifetime or for more than 12 months, unless
5 it also contains benefit for total nonconfining disability caused by
6 the same event or events payable for at least three months, and, if
7 it also contains any benefit for partial disability, unless the benefit
8 for partial disability is payable for at least three months. The
9 provisions of this paragraph shall apply separately to accident
10 benefits and to sickness benefits.

11 (4) (A) If it contains provision or provisions which would have
12 the effect, upon any termination of the policy, of reducing or ending
13 the liability as the insurer would have, but for the termination, for
14 loss of time resulting from accident occurring while the policy is
15 in force or for loss of time commencing while the policy is in force
16 and resulting from sickness contracted while the policy is in force
17 or for other losses resulting from accident occurring or sickness
18 contracted while the policy is in force, and also contains provision
19 or provisions reserving to the insurer the right to cancel or refuse
20 to renew the policy, unless it also contains other provision or
21 provisions the effect of which is that termination of the policy as
22 the result of the exercise by the insurer of any such right shall not
23 reduce or end the liability in respect to the hereinafter specified
24 losses as the insurer would have had under the policy, including
25 its other limitations, conditions, reductions, and restrictions, had
26 the policy not been so terminated.

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

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

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

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

38 (iv) Losses other than those specified in clause (i), (ii), or (iii)
39 of this paragraph which result from accident occurring or sickness
40 contracted while the policy is in force and which losses occur

1 within 90 days following the accident or the contraction of the
2 sickness.

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

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

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

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

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

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

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

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

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

35 (8) If it substitutes a specified indemnity upon the occurrence
36 of accidental death for any benefit of the policy, other than a
37 specified indemnity for dismemberment, which would accrue prior
38 to the time of that death or if it contains any provision which has
39 the effect, other than at the election of the insured exercisable
40 within not less than 20 days in the case of benefits specifically

1 limited to the loss by removal of one or more fingers or one or
2 more toes or within not less than 90 days in all other cases, of
3 doing any of the following:

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

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

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

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

34 (9) If it contains provision, other than as provided in Section
35 10369.3, reducing any original benefit more than 50 percent on
36 account of age of the insured.

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

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

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

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

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

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

13 (B) The policy is entitled and each provision granting the
14 benefits is separately captioned in clearly understandable words
15 so as to accurately describe the classification of diseases covered
16 and expressly point out, when that is the case, that not all diseases
17 of the classification are covered.

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

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

28 (c) The commissioner may, from time to time as conditions
29 warrant, after notice and hearing, promulgate such reasonable rules
30 and regulations, and amendments and additions thereto, as are
31 necessary or convenient, to establish, in advance of the submission
32 of policies, the standard or standards conforming to subdivision
33 (b), by which he or she shall disapprove or withdraw approval of
34 any disability policy.

35 In promulgating any such rule or regulation the commissioner
36 shall give consideration to the criteria herein established and to
37 the desirability of approving for use in policies in this state uniform
38 provisions, nationwide or otherwise, and is hereby granted the
39 authority to consult with insurance authorities of any other state

1 and their representatives individually or by way of convention or
2 committee, to seek agreement upon those provisions.

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

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

13 Any such withdrawal shall be in writing and shall specify
14 reasons. An insurer adversely affected by any such withdrawal
15 may, within a period of 30 days following mailing or delivery of
16 the writing containing the withdrawal, by written request secure
17 a hearing to determine whether the withdrawal should be annulled,
18 modified, or confirmed. Unless, at any time, it is mutually agreed
19 to the contrary, a hearing shall be granted and commenced within
20 30 days following filing of the request and shall proceed with
21 reasonable dispatch to determination. Unless the commissioner in
22 writing in the withdrawal, or subsequent thereto, grants an
23 extension, any such withdrawal shall, in the absence of any such
24 request, be effective, prospectively and not retroactively, on the
25 91st day following the mailing or delivery of the withdrawal, and,
26 if request for the hearing is filed, on the 91st day following mailing
27 or delivery of written notice of the commissioner's determination.

28 (e) No proceeding under this section is subject to Chapter 5
29 (commencing with Section 11500) of Part 1 of Division 3 of Title
30 2 of the Government Code.

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

35 Notwithstanding any other provision of law to the contrary,
36 petition for any such review may be filed at any time before the
37 effective date of the action taken by the commissioner. No action
38 of the commissioner shall become effective before the expiration
39 of 20 days after written notice and a copy thereof are mailed or
40 delivered to the person adversely affected, and any action so

1 submitted for review shall not become effective for a further period
2 of 15 days after the filing of the petition in court. The court may
3 stay the effectiveness thereof for a longer period.

4 (g) This section shall be liberally construed to effectuate the
5 purpose and intentions herein stated; but shall not be construed to
6 grant the commissioner power to fix or regulate rates for disability
7 insurance or prescribe a standard form of disability policy, except
8 that the commissioner shall prescribe a standard supplementary
9 disclosure form for presentation with all disability insurance
10 policies, pursuant to Section 10603.

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

17 SEC. 17. Section 10384.1 is added to the Insurance Code, to
18 read:

19 10384.1. (a) The commissioner shall, by regulation, establish
20 standard information and health history questions that shall be
21 used by all health insurers for their individual health care coverage
22 application forms. The commissioner shall jointly develop the
23 regulation with the Director of the Department of Managed Health
24 Care. The regulation shall include a pool of approved questions
25 for use in health care service plan and health insurance application
26 forms for individual health plan contracts and individual health
27 insurance policies. The application forms for individual health
28 plan contracts and individual health insurance policies may only
29 contain questions from the pool of approved questions established
30 pursuant to this subdivision.

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

37 (c) The application form shall include a prominently displayed
38 notice that shall read:

1 “California law prohibits an HIV test from being required or
2 used by health insurance companies as a condition of obtaining
3 health insurance coverage.”

4 (d) The health history questions established under this section
5 shall include a limitation on how far back in time from the date of
6 the application the applicant was diagnosed or treated for the health
7 condition specified in the question.

8 (e) All individual health insurance application forms shall utilize
9 only the pool of approved questions and the standardized
10 information established pursuant to subdivision (a) no later than
11 six months after the adoption of regulation under that subdivision.

12 (f) On and after January 1, 2010, all individual health insurance
13 applications shall be reviewed and approved by the commissioner
14 before they may be used by a health insurer.

15 SEC. 18. Section 10384.12 is added to the Insurance Code, to
16 read:

17 10384.12. (a) A health insurer shall complete medical
18 underwriting prior to using a health insurance policy.

19 (b) “Medical underwriting” means the completion of a
20 reasonable investigation of the applicant’s health history
21 information, which includes, but is not limited to, both of the
22 following:

23 (1) Ensuring that the information submitted on the application
24 form and the material submitted with the application form is
25 complete and accurate.

26 (2) Resolving all reasonable questions arising from the
27 application form or materials submitted with the application form
28 or any information obtained by the health insurer as part of its
29 verification of the accuracy and completeness of the application
30 form.

31 (c) A health insurer shall adopt and implement written medical
32 underwriting policies and procedures.

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

35 (e) On or before January 1, 2010, a health insurer shall file its
36 medical underwriting policies and procedures with the department.

37 SEC. 19. Section 10384.14 is added to the Insurance Code, to
38 read:

39 10384.14. (a) Within 10 business days of issuing a health
40 insurance policy, the health insurer shall send a copy of the

1 completed written application to the applicant with a copy of the
2 health insurance policy issued by the health insurer, along with a
3 notice that states all of the following:

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

7 (2) Any intentional material misrepresentation or intentional
8 material omission in the information submitted in the application
9 may result in the cancellation or rescission of the policy.

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

12 (b) If new information is provided by the applicant within the
13 30-day period permitted by subdivision (a), medical underwriting,
14 as defined in Section 10384.12, applies to the new information.

15 SEC. 20. Section 10384.16 is added to the Insurance Code, to
16 read:

17 10384.16. Once an insurer has issued an individual health
18 insurance policy, the insurer shall not rescind or cancel the policy
19 unless all of the following apply:

20 (a) There was a material misrepresentation or material omission
21 in the information submitted by the applicant in the written
22 application prior to the issuance of the health insurance policy that
23 would have prevented the contract from being entered into.

24 (b) The health insurer completed medical underwriting pursuant
25 to Section 10384.12 before issuing the policy.

26 (c) The health insurer demonstrates that the applicant
27 intentionally misrepresented or intentionally omitted material
28 information on the application to the health insurer prior to the
29 issuance of the policy with the purpose of misrepresenting his or
30 her health history in order to obtain health care coverage.

31 (d) The application form was approved by the department
32 pursuant to Section 10384.1.

33 (e) The health insurer sent a copy of the completed written
34 application to the applicant with a copy of the health insurance
35 policy issued by the health insurer, along with the written notice
36 required by Section 10384.14.

37 SEC. 21. Section 10384.18 is added to the Insurance Code, to
38 read:

39 10384.18. (a) If a health insurer obtains information after
40 issuing an individual health insurance policy that the subscriber

1 or enrollee may have intentionally omitted or intentionally
2 misrepresented material information during the application for
3 coverage process, the health insurer may investigate the potential
4 omissions or misrepresentations in order to determine whether the
5 insured's or policyholder's health insurance policy should be
6 rescinded or canceled.

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

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

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

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

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

38 (B) The insurer intends to seek approval from the commissioner
39 to cancel or rescind the insured's or policyholder's health insurance

1 policy for intentional misrepresentation or intentional omission of
2 material information during the application for coverage process.

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

5 (A) Include full disclosure of the nature and substance of any
6 information that led to the insurer's determination that the insured
7 or policyholder intentionally misrepresented or intentionally
8 omitted material information on the application form.

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

13 (C) The insurer shall provide the insured or policyholder with
14 information regarding the department's independent review process
15 and the right of the insured or policyholder to opt-out of that review
16 process within 45 days of the date upon which an independent
17 review organization reviews a request for an independent review.

18 (D) Provide a statement that the health insurer's proposed
19 decision to cancel or rescind the health insurance policy shall not
20 become effective unless the department's independent review
21 organization upholds the health insurer's decision, unless the
22 insured has opted out of the independent review.

23 SEC. 22. Section 10384.2 is added to the Insurance Code, to
24 read:

25 10384.2. (a) A health insurer shall continue to authorize and
26 provide all medically necessary health care services required to
27 be covered under an insured's or policyholder's health insurance
28 policy until the effective date of cancellation or rescission.

29 (b) The effective date of the health insurer's cancellation or the
30 date upon which the insurer may initiate a rescission shall be no
31 earlier than the date the insured or policyholder receives
32 notification via regular and certified mail that the independent
33 review organization has made a determination upholding the health
34 insurer's decision to rescind or cancel pursuant to Section
35 10384.16.

36 SEC. 23. Section 10384.22 is added to the Insurance Code, to
37 read:

38 10384.22. (a) Commencing January 1, 2010, there is hereby
39 established in the department the independent review process for

1 the review of health insurer decisions to cancel or rescind health
2 insurance policies pursuant to Section 10384.16.

3 (b) All health insurer decisions to cancel or rescind the insured's
4 or policyholder's health insurance policy pursuant to Section
5 10384.16 shall be reviewed, unless the insured opts-out of the
6 independent review process.

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

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

12 (e) No later than January 1, 2010, in addition to the notice
13 required pursuant to subdivision (b) of Section 10384.18, every
14 health insurer shall prominently display in every plan member
15 handbook or relevant informational brochure, in every policy, on
16 evidence of coverage forms, on copies of policy procedures for
17 resolving grievances, information concerning the right of an insured
18 or policyholder to an automatic unless you opt-out independent
19 review in cases where the health insurer has decided to cancel or
20 rescind the insured's or policyholder's health insurance policy,
21 pursuant to Section 10384.16.

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

26 (A) A copy of all of the insured's or policyholder's medical
27 records in the possession of the insurer or its contracting providers
28 relevant to the insurer's decision to cancel or rescind the insured's
29 or policyholder's health insurance policy.

30 (B) The insured's or policyholder's application for coverage
31 with the health insurer.

32 (C) A copy of all information provided to the insured or
33 policyholder by the insurer concerning the health insurer's decision
34 to cancel or rescind the insured's or policyholder's health insurance
35 policy and a copy of any materials the insured or policyholder, the
36 insured's or policyholder's agent, or the insured's or policyholder's
37 provider submitted to the plan. The confidentiality of any insured
38 or policyholder medical information shall be maintained pursuant
39 to applicable state and federal laws.

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

3 (i) To complete medical underwriting pursuant to Section
4 10384.12.

5 (ii) In determining the insured's or policyholder's health
6 insurance policy should be canceled or rescinded and any
7 statements by the insurer explaining the reasons for the decision
8 to cancel or rescind the insured's or policyholder's health insurance
9 policy.

10 (2) The insurer shall concurrently provide a copy of documents
11 required by this subdivision to the insured or policyholder. The
12 department and the independent review organization shall maintain
13 the confidentiality of any information found by the commissioner
14 to be the proprietary information of the insurer.

15 SEC. 24. Section 10384.24 is added to the Insurance Code, to
16 read:

17 10384.24. (a) The department shall expeditiously review
18 independent review requests and immediately notify the insured
19 or policyholder, in writing, as follows:

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

23 (2) That the health insurer's proposed decision to cancel or
24 rescind the insured's or policyholder's health insurance policy will
25 not become effective unless the independent review organization
26 upholds the health insurer's decision.

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

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

34 (b) The health insurer shall promptly issue a notification to the
35 insured or policyholder, after submitting all of the required material
36 to the independent review organization, that includes an annotated
37 list of documents submitted and offer the insured or policyholder
38 the opportunity to request copies of those documents from the
39 insurer.

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

7 SEC. 25. Section 10384.26 is added to the Insurance Code, to
8 read:

9 10384.26. (a) On or before January 1, 2010, the department
10 shall contract or otherwise arrange with one or more independent
11 organizations in the state to conduct reviews for purposes of this
12 article. The independent review organizations shall be not-for-profit
13 and shall be independent of any health insurer doing business in
14 this state. The commissioner shall establish additional
15 requirements, including conflict-of-interest standards, consistent
16 with the purposes of this article, and an organization shall be
17 required to meet these requirements in order to qualify for
18 participation in the independent review process and to assist the
19 department in carrying out its responsibilities. The
20 conflict-of-interest standards established by the commissioner shall
21 also be consistent with the conflict-of-interest provisions of Section
22 10169.2 to the extent applicable.

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

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

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

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

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

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

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

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

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

16 (4) Ensures that arbitrators selected by independent review
17 organizations to review health insurer decisions to cancel or rescind
18 a health insurance policy meet the following minimum
19 requirements:

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

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

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

26 (c) "Expert consultant" means an underwriter, actuary, physician
27 and surgeon, or other professional whose background, experience,
28 and knowledge is relevant to determining whether the health insurer
29 completed medical underwriting or to determining the issues raised
30 in the review of the health insurer's decision to cancel or rescind
31 the insured's or policyholder's health insurance policy.

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

38 ~~(e) An approval for rescission or cancellation by the independent~~
39 ~~review organization shall be used solely for regulatory purposes,~~
40 ~~and shall not be admissible in any judicial proceeding.~~

1 SEC. 26. Section 10384.28 is added to the Insurance Code, to
2 read:

3 10384.28. (a) (1) Upon receipt of information and documents
4 related to a case, the arbitrator selected to conduct the review by
5 the independent review organization shall promptly review all
6 pertinent records of the insured, provider reports, and any other
7 information submitted to the organization as authorized by the
8 department or requested from any of the parties to the dispute by
9 the reviewers.

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

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

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

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

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

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

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

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

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

17 SEC. 27. Section 10384.29 is added to the Insurance Code, to
18 read:

19 10384.29. (a) A health insurer shall not engage in any conduct
20 that has the effect of prolonging the independent review process.
21 Engaging in that conduct or the failure of the insurer to promptly
22 implement an independent review process decision is a violation
23 of this chapter and, in addition to any other fines, penalties, and
24 other remedies available to the director under this chapter, the
25 insurer shall be subject to an administrative penalty of not less
26 than five thousand dollars (\$5,000) for each day the independent
27 review process is prolonged or the decision is not implemented.
28 Administrative penalties shall be deposited in the General Fund.

29 (b) The commissioner shall perform an annual audit of
30 independent review cases for the dual purposes of education and
31 the opportunity to determine if any investigative or enforcement
32 actions should be undertaken by the department, particularly if an
33 insurer repeatedly fails to act promptly and reasonably to with
34 respect to decisions to cancel, rescind, limit, or deny benefits under
35 or raise premiums on a insured's or policyholder's health insurance
36 policy.

37 SEC. 28. Section 10384.3 is added to the Insurance Code, to
38 read:

39 10384.3. (a) After considering the results of a competitive
40 bidding process and any other relevant information on program

1 costs, the commissioner shall establish a reasonable, per-case
2 reimbursement schedule to pay the costs of independent review
3 organization reviews, which may vary depending upon relevant
4 factors.

5 (b) The costs of the independent review system for insureds and
6 policyholders shall be borne by the affected health insurers
7 pursuant to an assessment fee system established by the
8 commissioner. Insurers that do not cancel or rescind individual
9 health insurance policies pursuant to Section 10384.16 shall not
10 be considered by the commissioner as “affected health insurers”
11 under this section. In determining the amount to be assessed, the
12 commissioner shall consider all appropriations available for the
13 support of this chapter and existing fees paid to the department.
14 The commissioner may adjust fees upward or downward, on a
15 schedule set by the department, to address shortages or
16 overpayments, and to reflect utilization of the independent review
17 process.

18 SEC. 29. Section 10384.32 is added to the Insurance Code, to
19 read:

20 10384.32. (a) On and after January 1, 2009, every health
21 insurer shall annually report to the department the total number of
22 individual health insurance policies issued, and the total number
23 of individual health insurance policies where the insurer initiated
24 a cancellation or rescission or completed a cancellation or
25 rescission pursuant to the provisions of this article for the preceding
26 calendar year.

27 (b) On or before March 31, 2009, and annually thereafter, the
28 department shall publish on its Internet Web site the information
29 filed pursuant to this section.

30 SEC. 29.5. Section 10396 is added to the Insurance Code, to
31 read:

32 10396. The requirements of Sections 10384.1, 10384.12,
33 10384.14, 10384.16, 10384.18, 10384.2, 10384.22, 10394.24,
34 10384.26, 10384.28, 10384.29, 10384.3, and 10384.32 shall not
35 apply to health insurance policies for coverage issued under the
36 Medi-Cal program, the Access for Infants and Mothers Program,
37 the Healthy Families Program or the federal Medicare Program.

38 SEC. 30. Section 12957 of the Insurance Code is amended to
39 read:

1 12957. The commissioner shall not withdraw approval of a
2 policy theretofore approved by him except upon those grounds as,
3 in his opinion, would authorize disapproval upon original
4 submission thereof. Any withdrawal of approval shall be in writing
5 and shall specify the ground thereof. If the insurer demands a
6 hearing on a withdrawal, the hearing shall be granted and
7 commenced within thirty days of filing of a written demand
8 therefor with the commissioner. Unless the hearing is so
9 commenced, the notice of withdrawal shall become ineffective
10 upon the thirty-first day from and after the date of filing of the
11 demand.

12 This section shall not apply to policies subject to the provisions
13 of subdivision (d) of Section 10291.5, or to policies, contracts, or
14 agreements that were approved under an alternative filing and
15 approval procedure as provided for in subdivision (f) of Section
16 10506.4 or subdivision (c) of Section 10507.5.

17 SEC. 31. No reimbursement is required by this act pursuant to
18 Section 6 of Article XIII B of the California Constitution because
19 the only costs that may be incurred by a local agency or school
20 district will be incurred because this act creates a new crime or
21 infraction, eliminates a crime or infraction, or changes the penalty
22 for a crime or infraction, within the meaning of Section 17556 of
23 the Government Code, or changes the definition of a crime within
24 the meaning of Section 6 of Article XIII B of the California
25 Constitution.