

CALIFORNIA PASSES INSURANCE REGULATION BILLS

Before adjourning their 2007-08 legislative session on August 31, California lawmakers in both houses passed legislation (A.B. 1945) aimed at reining in post-claim rescission of coverage by insurers and managed care plans.

The introduction and passage of this legislation came shortly after a 2007 California Court of Appeal decision (*Hailey v. California Physicians' Service*, Cal., No. S160586, *review denied* 3/26/08; 60 HCDR, 3/28/08) that held that managed care plans could not rescind coverage based on an applicant's material misrepresentation or omission of their medical history unless it can be shown that the misrepresentation or omission was willful or, alternatively, that the plan had made reasonable efforts to ensure the application was accurate and complete as part of the precontract underwriting process.

According to a Bureau of National Affairs (BNA) report, the bill, if signed by Governor Arnold Schwarzenegger, would "codify key holdings of the 2007 California Court of Appeal decision and expand on that ruling."

The bill (A.B. 1945):

- Goes beyond *Hailey* by applying both of these conditions for rescission to insurance-based individual coverage regulated by the California Department of Insurance, such as preferred provider organizations, as well as health maintenance organizations that fall within the scope of the ruling.
- Exceeds the scope of *Hailey* by specifically defining medical underwriting requirements for both managed care plans as well as insurance-based products.
- Defines medical underwriting to mean "the completion of a reasonable investigation of the applicant's health history information," including ensuring that the information submitted on the application "is complete and accurate and resolving all reasonable questions arising from the application form or materials submitted with the application form or any information obtained ... as part of its verification of the accuracy and completeness of the application form."
- Requires managed care plans and insurers to adopt and implement written medical underwriting policies and procedures reflecting all information collected during the underwriting process and file them with regulators on or before Jan. 1, 2010.
- Requires managed care plans and insurers to use only applications approved by regulators after that date. At that time, plans and insurers would be restricted to using only health history questions from a pool of questions approved by regulators. The questions must contain "clear and unambiguous information" designed to ascertain applicants' health history and based on "medical information that is reasonable and necessary for medical underwriting purposes."
- Establishes procedural requirements that must be followed before health plans and insurers can rescind coverage.

- Requires health plans and insurers to notify policyholders and subscribers in writing upon initiating an investigation for potential rescission or cancellation of coverage and of the fact that the investigation could result in rescission or cancellation.
 - Health plans and insurers would have 90 days from the date of the notice to complete the inquiry after which they would be required to notify consumers of the findings.
 - In cases where intentional misrepresentation or intentional omission of material information is discovered warranting rescission or cancellation of coverage, plans and insurers must notify policyholders and subscribers of their intent to seek approval from regulators to do so.
 - In the meantime health plans and insurers would be required to continue to authorize and provide all medically necessary health care services until the effective date of cancellation or rescission.

Lawmakers also approved a related measure, A.B. 2569, that would require coverage be kept in force for dependents of individuals whose policies have been rescinded. It also would require those who help applicants complete health history questionnaires to attest to the accuracy of the information provided and face civil penalties of up to \$10,000 for knowingly attesting to false information.

Regulators would have until Jan. 1, 2010, to establish independent review programs using outside independent review organizations and arbitrators to "expeditiously" review rescission and cancellation requests.

The bill is sponsored by the California Medical Association and opposed by health plans and insurers.

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