STATE OF CALIFORNIA Dave Jones, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
Legal Division
45 Fremont Street, 24th Floor
San Francisco CA 94105

Notice of Issuance of Amended Guidance 2470:2

November 21, 2011

Based on comments from operational staff of health insurers regarding implementation of Guidance 2470:2, issued July 1, 2011, the Department of Insurance issues amended Guidance 2470:2, attached.

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Guidance 2470: 2

Final release date: July 1, 2011
Amended: November 21, 2011

Pursuant to Assembly Bill 2470 (Chapter 658, Statutes 2010), the California Department of Insurance issues the following guidance regarding compliance.

New Article 10. Guidance on Commissioner’s Review of Complaints of Unlawful Cancellation, Rescission or Nonrenewal of Health Insurance Policies

Adopt Section 2274.50. Notice of the Right to Request Review by the Commissioner.

(a) Each insurer who cancels, rescinds or non-renews, or sends a notice of intent to cancel, rescind or non-renew, a policy of health insurance shall provide to the ~~affected or potentially affected~~ policyholder~~s~~, certificate holder~~s~~ or other insured~~s~~ a notice of the right to request a review by the commissioner. The notice of the right to request a review by the commissioner shall be part of, accompany, or be sent simultaneously with any notice of intent to cancel, rescind or non-renew, including but not limited to the notice required by subdivision (b) of Section 2274.53, the notice required by subdivision (h) of Section 2274.78 when the insurer's determination is to cancel the policy, and the notice required by subdivision (b) of Insurance Code section 10384.17. In the event the insurer does not send a notice of intent to cancel, rescind or non-renew, the notice of the right to request a review by the commissioner shall be part of, accompany, or be sent simultaneously with any notice of cancellation, nonrenewal or rescission the insurer sends to the policyholder, certificate holder or other insured. The form of notice specified in subdivision (b) of this Section 2274.50 shall satisfy the notice requirement stated in this subdivision (a), provided the notice is printed in bold, 12-point or larger type. The insurer shall send the notice via first-class mail to the policyholder's, certificate holder's or other insured's most recent address known to the insurer.

(b) NOTICE OF RIGHT TO REVIEW BY THE CALIFORNIA INSURANCE COMMISSIONER

You may request a review by the California Insurance Commissioner if you believe your health insurance policy or coverage has been or will be wrongly canceled, rescinded or not renewed. To do so, you must, as soon as possible, submit your request for review in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California, 90013 or through the website: http://www.insurance.ca.gov. You may contact the California Insurance Commissioner’s Consumer Communications Bureau at 1-800-927-HELP (4357) or TDD 1-800-482-4833 for information about how to request a review in writing. Please provide the Department with

your health insurance policy number, copies of any letters you have received from us or a copy of your health insurance card.

You have 30 days from the date we sent this notice to you to request a review by the commissioner in order to ensure that we are required to provide you health insurance coverage while your request for review is being evaluated. To ensure that your coverage is continued without interruption, however, you must request a review by the commissioner before your coverage ends. Even if more than 30 days have passed since we sent this notice, we must continue your coverage while your request is being evaluated, as long as you request the review by the commissioner at a time when your coverage is still in effect.

Regardless of whether or not we are required to provide you health insurance coverage while your request for review is being evaluated, the commissioner will order us to reinstate your coverage, retroactive to the time of cancellation, rescission or nonrenewal, if the commissioner determines that your request for review is a proper complaint and, ultimately, that the cancellation, rescission or nonrenewal was unlawful.

WARNING: You must continue to pay your insurance premiums on time in order to maintain coverage, and if your coverage is reinstated retroactively you will be responsible for paying insurance premiums corresponding to any gap in coverage between the time your coverage was terminated and the time it was continued or reinstated.

Adopt Section 2274.51. The Request for Review.

A request for review by the commissioner is any communication received from a policyholder, certificate holder or other insured by the Department of Insurance (the "Department") regarding an actual or impending nonrenewal, cancellation or rescission of health insurance coverage in connection with which communication the policyholder, certificate holder or other insured asserts that the termination of coverage was or would be wrongful. The date of the request for review is the date the Department first receives the communication in writing, which for purposes of this Section 2274.51 shall include communications received via email. The preceding sentence notwithstanding, in the event the Department first receives the communication orally, the date of the request for review shall be the date of that oral communication, provided that the Department receives written confirmation of the request for review, which may include confirmation by email, from the policyholder, certificate holder or other insured, no later than thirty days after the date of the oral communication. However, in the event that the policyholder, certificate holder or other insured mistakenly directs his or her request for review by the commissioner to the Department of Managed Health Care (DMHC), the date of the request for review shall be the date upon which, according to DMHC, the request for review was received by DMHC, provided that the Department receives written confirmation of the request for review, which may include confirmation by email, from the policyholder, certificate holder or other insured.

Adopt Section 2274.52. The Proper Complaint.

(a) Subject to the additional requirements applicable to the complaint that are set forth in subdivisions (c) and (d) of this Section 2274.52, a request for review received by the commissioner from a policy holder, certificate holder or other insured constitutes a proper complaint for purposes of subdivision (b) of Insurance Code section 10273.7 if the complainant asserts, with or without prompting by the Department, all of the following:

(1) The insurance product in question constitutes health insurance that is within the jurisdiction of the Department of Insurance;

(2) The complainant has not voluntarily terminated the policy or coverage; and

(3) The complainant has been notified in writing, or has otherwise learned, that its policy, certificate or coverage has been or will be canceled, rescinded or nonrenewed by the insurer.

(b) After receiving a request for review, the Department shall contact the insurer in question, notify it of the policyholder's, certificate holder's or other insured's request for review, including the date thereof, and request from the insurer any information that may help the Department to determine whether the insurance coverage in question constitutes health insurance that is within the jurisdiction of the Department of Insurance. The preceding sentence shall not be binding on the Department, however, if the Department has not received:

(1) The name of the policyholder, certificate holder or other insured,

(2) The applicable policy number, certificate number or claim number, and

(3) The name of the insurer.

(c) In the event the Department establishes that the insurance coverage in question is not within its jurisdiction, the request for review shall not constitute a proper complaint.

(d) As soon as practicable after the date the Department receives a request for review, but no later than 30 days after the date the Department contacts the insurer pursuant to subdivision (b) of this Section 2274.52, it shall send notice to the insurer in question identifying the policyholder, certificate holder or other insured that has made the request for review. The 30-day deadline stated in the immediately preceding sentence shall not apply, however, if the insurer fails to make reasonable efforts to promptly provide the Department with the information requested by the Department pursuant to subdivision (b). The notice shall indicate either that the commissioner has determined that a proper complaint exists or that not all of the requirements applicable to the complaint that are set forth in this Section 2274.52 were satisfied. The request for review shall not constitute a proper complaint if the Department has not received:

(1) The name of the policyholder, certificate holder or other insured,

(2) The applicable policy number, certificate number or claim number, and

(3) The name of the insurer.

(e) Review by the commissioner pursuant to Insurance Code section 10273.7 shall be in addition to, and not in lieu of, any internal or external review process the insurer is required to offer or perform pursuant to any other provision of law or pursuant to the terms of any order of the commissioner binding on the insurer.

Adopt Section 2274.53. Grace Period.

For purposes of Insurance Code sections 10273.4, 10273.6 and 10713:

(a) The minimum 30-day grace period shall end no sooner than the thirtieth day following the last day of coverage for which the insurer has received payment.

(b) In order for a policyholder, certificate holder or other insured to have been "duly notified," the insurer must have sent to the policyholder, certificate holder or insured a ~~separate~~ notice of nonrenewal due to nonpayment, separately from the initial premium billing statement~~in addition to any other bills or notices~~, no later than the first day after the last day of coverage for which the insurer has received payment.

(c) The notice of nonrenewal due to nonpayment required by subdivision (b) above must provide instructions for making the premium payment necessary in order to maintain coverage in force.

(d) In the event the necessary premium payment is delivered to the insurer on or before the last day of the minimum 30-day grace period, the insurer shall continue coverage beyond the grace period without interruption pursuant to the terms of the policy or certificate.

(e) This Section 2274.53 shall not be construed to require that the insurer send the notice of nonrenewal due to nonpayment required by subdivision (b) of this section to:

(1) Employee certificate holders under a group policy; or

(2) Dependents of the policyholder, or insureds other than the policyholder, under an individual policy.

Adopt Section 2274.54. Reinstatement and Continuation of Coverage.

(a) For purposes of this article and Insurance Code section 10273.7, whenever an insurer is required to continue to provide coverage, to reinstate coverage or to reinstate a policyholder, certificate holder or other insured, the insurer must process and pay claims, and provide any required prior authorization of covered services, with respect to that coverage, policyholder, certificate holder or other insured, all in accordance with the terms of the policy or certificate as in the ordinary course of business.

(b) The insurer shall provide coverage to the policyholder, certificate holder or other insured pursuant to subdivision (d) of Insurance Code section 10273.7 if, on the date of the request for review by the commissioner, any of the following are true:

(1) The policyholder's, certificate holder's or other insured's coverage is in effect;

(2) No more than 30 days have passed since the date the insurer sent to the policyholder, certificate holder or other insured the notice set forth in subdivision (b) of Section 2274.50; or

(3) The insurer has not sent to the policyholder, certificate holder or other insured the notice set forth in subdivision (b) of Section 2274.50.

(c) The insurer shall provide coverage to its policyholder, certificate holder or other insured pursuant to subdivision (b) of this Section 2274.54 as of the date of the request for review. The insurer must comply with the preceding sentence at the time the insurer receives notice pursuant to subdivision (b) of Section 2274.52 that the policyholder, certificate holder or other insured has requested a review by the commissioner. The insurer shall continue to provide coverage until such time as the commissioner determines that:

(1) Not all of the requirements applicable to the complaint that are set forth in Section 2274.52 were satisfied; or

(2) The rescission, cancellation or failure to renew was lawful.

(c) Subdivision (b) of this Section 2274.54 shall not apply if the insurer cancels the policy or coverage for nonpayment of premiums.

Adopt Section 2274.55. Submittal of Information by Insurers for Use in Determination by the Commissioner that a Cancellation, Rescission or Failure to Renew Is or Is not Contrary to Existing Law.

(a) After the commissioner determines that a proper complaint exists pursuant to Section 2274.52 and prior to any determination by the commissioner that a cancellation, rescission or failure to renew is or is not contrary to existing law, the insurer shall submit any written information required by this article to the commissioner at the following address:

Legal Division, Health Enforcement Bureau
California Department of Insurance
45 Fremont Street, 22nd Floor
San Francisco CA 94105

(b) The insurer shall specify a responsible person whom Department staff may contact with questions or requests for further information. After the insurer has sent the information required by this article to the address specified in subdivision (a) of this Section 2274.55, Department staff may, under conditions consented to by the insurer's designated responsible

person, agree to receive further information from the insurer by specified alternate means of delivery. Nothing in this section shall be interpreted to bar informal communication during the time period referenced in subdivision (a) of this section between Department staff and the insurer's responsible person, including by telephone, provided Department staff agrees beforehand to such informal communication.

(c) No later than 15 days after receiving from the Department a notice of a proper complaint pursuant to subdivision (f) of Section 2274.52, the insurer shall either:

(1) Request a hearing pursuant to subdivision (b) of Insurance Code section 10273.7 by submitting to the Department its evidence that the insurer's rescission, cancellation or failure to renew was lawful, including but not limited to any and all of the information called for by Section 2274.56, Section 2274.57 or Section 2274.59 that is applicable; or

(2) Reinstate the policyholder, certificate holder or other insured.

(d) Upon a showing of good cause Department staff evaluating a request for a hearing pursuant to subdivision (b) of Insurance Code section 10273.7 will provide an extension of up to 15 days for the purpose of allowing the insurer to complete the submittal of the evidence required by paragraph (c)(1) of this Section 2274.55.

(e~~d~~) The insurer shall immediately notify the consumer of the action the insurer has taken pursuant to subdivision (c) of this Section 2274.55.

(f~~e~~) In the event the insurer reinstates the policyholder, certificate holder or other insured, it shall send a notice to this effect to:

California Department of Insurance
Rating and Underwriting Services Bureau
300 South Spring Street, 11th Floor
Los Angeles, California 90013

Adopt Section 2274.56. Factual Showings Required of Insurers in order to Demonstrate that a Rescission or Cancellation Is Lawful under Insurance Code section 10384.

(a) An insurer must demonstrate that a rescission or, if based on information submitted on or with the application, a cancellation was not or is not due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with the application before issuing the policy or certificate. In addition to providing information about the insurer's underwriting of the coverage proposed to be rescinded, an insurer may submit information pertaining to any internal or external review conducted prior to or after the rescission. To establish that it completed medical underwriting, and that it resolved all reasonable questions arising from written information submitted on or with the application, before issuing the policy or certificate, the insurer shall submit evidence of the following to the extent, if any, that the insurer undertook to perform the indicated activity:

(1) That the insurer followed its medical underwriting guidelines prior to issuance of the policy proposed to be rescinded;

(2) That the insurer sought to obtain the applicant's PHR (Personal Health Record), if available;

(3) That the insurer sought health history information from external verifiable sources other than the information provided by the applicant on the health history questionnaire;

(4) That the insurer obtained and evaluated commercially available medical underwriting information for the applicant, which may include commercially available claims data, claims data from prior insurers, if available, or commercially available pharmaceutical information;

(5) That the insurer checked the applicant's current or prior claims history with the insurer and its affiliates;

(6) That the insurer sought the applicant's medical records or an attending physician's statement if required by its medical underwriting guidelines;

(7) That the insurer checked the applicant's health history information obtained from all sources for inconsistencies;

(8) That the insurer underwrote the self-reported health information in light of the applicant's status as a layperson not schooled in medicine unless the insurer has documentable grounds to believe the applicant has formal medical training;

(9) That if the insurer was alerted to the need to check with the assisting agent when applicable, it contacted the agent and obtained information if the agent indicated awareness of any information not disclosed on the health insurance application which may be material to the insurer's underwriting of the application;

(10) That the insurer identified questions arising from the totality of information obtained from various sources about the applicant's health history and took appropriate follow-up measures to resolve any inadequate, unclear, incomplete, conflicting or otherwise questionable or inconsistent material information on the application prior to issuing a policy while applying its underwriting guidelines, including but not limited to, contacting the applicant by phone or mail to resolve inconsistencies and obtain missing or needed information;

(11) That the insurer reviewed the applicant's responses in, or submitted with, the application and identified all responses contained within the application or information submitted with the application that appear to be:

(A) inconsistent, ambiguous or incomplete,

(B) in conflict with information reported elsewhere on the application, or

(C) in conflict with any other information the insurer was aware of or in the insurer's possession, including but not limited to medical records, PHR data, prior claims history or an application submitted for coverage provided by the insurer on an earlier date or information provided by an assisting agent and resolved the questions arising from this review;

(12) That the insurer obtained clarification from the applicant, as reasonable and necessary, to resolve all inconsistencies and questions prior to issuing a health insurance policy and document such resolution and explanation of such inconsistencies and questions; and

(13) That the insurer resolved any inconsistencies it identified as a result of performing the activities referenced in paragraphs (a)(10) through (a)(12) of this Section 2274.56. The additional information necessary to resolve all reasonable questions or omissions may include, but is not limited to, information obtained through:

(A) the insurer's further communication with the applicant,

(B) a review of medical records and other sources of health history or health status information for each individual who has applied for insurance coverage, or

(C) a commercial pharmaceutical or medical information database.

(b) An insurer seeking to rescind, or to cancel on the basis of information submitted on or with the application, a policyholder’s, certificate holder’s or other insured’s health insurance coverage must submit all available evidence that the rescission or cancellation investigation preceding the rescission or cancellation complied with the requirements of Section 2274.78.

(c) In addition to the evidence submitted by the insurer pursuant to subdivisions (a) and (b) of this Section 2274.56, to demonstrate the lawfulness of a rescission the insurer shall submit evidence supporting its allegation that the applicant either performed an act or practice constituting fraud, or made an intentional misrepresentation of a material fact, to induce the issuance of coverage. The insurer shall submit evidence that the terms of the policy to be rescinded expressly prohibited fraud or intentional misrepresentation of a material fact and that the applicant was warned of this provision.

(d) To demonstrate an allegation of fraud, the insurer shall submit all available evidence of the following factual assertions:

(1) The insured provided a false answer on an application for health insurance coverage;

(2) The insured provided the false answer knowing of its falsity or with reckless disregard for its truth or falsity. In the case of omission of a required answer to a material question, the insured omitted the answer knowing of its necessity or with reckless disregard;

(3) The insured provided the false answer or omitted a necessary response for the purpose of inducing the insurer to grant the health insurance coverage; and

(4) The insurer granted such coverage in reliance upon the false answer or omission and would not have otherwise granted such coverage.

(e) To demonstrate an allegation of intentional misrepresentation of material fact, the insurer shall submit all available evidence of the following factual assertions:

(1) The insured made a misrepresentation in an application for health insurance coverage either by answering a question untruthfully or by omitting the required information;

(2) The insured knew the facts necessary to answer the question truthfully or provide the information requested at the time he or she completed the application;

(3) The insured answered the question untruthfully or omitted the requested information deliberately, and not due to mistake, inadvertence, carelessness, negligence or other innocent reason;

(4) The untruthful answer or omitted information was material to the insurer's acceptance of the risk in that it influenced the insurer's acceptance of the risk; and

(5) The application form and terms of coverage clearly and expressly warned applicants that an intentional misrepresentation of material fact in the application process, including subsequent requests for information, could result in later rescission of coverage.

(f) In cases involving cancellation on the basis of information submitted on or with the application and in cases involving rescission, Department staff shall, after reviewing the information received pursuant to paragraph (c)(1) of Section 2274.55 and any information received pursuant to subdivision (a) of Section 2274.61, determine whether the evidence, considered as a whole, establishes that the insurer has satisfied the requirements of Insurance Code section 10384.

(g) In cases involving cancellation on the basis of information submitted on or with the application and in cases involving rescission, the assigned administrative law judge shall, after any hearing pursuant to Section 2274.58, determine whether the evidence, considered as a whole, establishes that the insurer has satisfied the requirements of Insurance Code section 10384.

(h) Under no circumstances shall subdivision (a) of this Section 2274.56 be construed to create a requirement that an insurer must engage in each of the activities enumerated in paragraphs (a)(1) through (a)(13) of this section in order to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with the application.

Adopt Section 2274.57. Miscellaneous Factual Showings Required of Insurers.

In addition to any other evidence required to be submitted pursuant to this article, the insurer shall submit:

(a) Its evidence demonstrating that it has timely delivered to the policyholder, certificate holder or other insured any notice required under this article, Section 2274.78, or Insurance Code section 10273.4, 10273.6, 10273.7, 10384.17 or 10713, and that the form of any such notices complied with all applicable legal requirements; and

(b) Its evidence in support of any legal theory the insurer relies on for the proposition that its rescission, cancellation or failure to renew was lawful.

Adopt Section 2274.58. The Request for a Hearing pursuant to Insurance Code section 10273.7(c); Hearing Procedure.

(a) Within 15 days after receipt of an order by the commissioner to reinstate a policyholder, certificate holder or other insured, the insurer shall either reinstate the policyholder, certificate holder or other insured, or request a hearing pursuant to subdivision (c) of Insurance Code section 10273.7. In order to request a hearing pursuant to subdivision (c) of Insurance Code section 10273.7, the insurer shall submit any and all of the evidence required to be submitted pursuant to Sections 2274.56, 2274.57 or 2274.59 that is applicable, but for purposes of this Section 2274.58 the information shall be submitted to the commissioner at the following address:

Administrative Hearing Bureau
California Department of Insurance
45 Fremont Street, 22nd Floor
San Francisco CA 94105

(b) Simultaneously with the submittal described in subdivision (a) of this Section 2274.58, the insurer shall:

(1) Send one copy of the submittal to the address specified in subdivision (a) of Section 2274.55; and

(2) Send one copy of the submittal to the policyholder, certificate holder or other insured who requested review of the insurer's rescission, cancellation or failure to renew.

(c) The policyholder, certificate holder or other insured who requested review of the insurer's rescission, cancellation or failure to renew shall be deemed to be a party to the hearing.

(d) To the extent not inconsistent with this article, the hearing shall be conducted pursuant to the procedural provisions of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code, commencing with section 11400, except that the hearing shall be conducted by an

administrative law judge appointed by the commissioner pursuant to subdivision (b) of Insurance Code section 21.5.

(e) The administrative law judge shall exercise all powers relating to the conduct and course of the hearing. The administrative law judge shall take any action necessary or appropriate to the discharge of his or her duties, consistent with the statutory or other authority under which the commissioner functions. The administrative law judge shall conduct a de novo review of the evidence, including any evidence submitted in connection with the hearing that was not received by Department staff when it reviewed the insurer's request for a hearing under subdivision (b) of Insurance Code section 10273.7.

(f) The insurer shall identify in the submittal described in subdivision (a) of this Section 2274.58 each and every difference, if any, between that submittal and the information that the insurer submitted pursuant to paragraph (c)(1) of Section 2274.55.

(g) The insurer shall have the burden of proving, by a preponderance of the evidence, every fact necessary to establish that the insurer satisfied all legal requirements pertaining to the cancellation, rescission or nonrenewal.

(h) The insurer shall have the burden of presenting its evidence and witnesses first.

Adopt Section 2274.59. Affirmative Defense.

A policyholder, certificate holder or other insured shall be barred from requesting a review by the commissioner if the date of his or her request for review is more than 180 calendar days after the date the insurer sent the notice set forth in subdivision (b) of Section 2274.50, or the date coverage was terminated (if coverage was terminated), whichever is later in time. The running of this 180-day period shall be tolled, however, during such period as the policyholder, certificate holder or other insured is unable, due to substantial health reasons or other incapacity, to understand or appreciate the significance of such notice, or termination of coverage, and act upon it. The insurer shall have the burden to establish that the 180-day period had run, and had not been tolled, at the time of the policyholder's, certificate holder's or other insured's request for review by the commissioner. The insurer must assert the affirmative defense described in this Section 2274.59, and include all evidence available to the insurer in support of that assertion, in the submittal required pursuant to paragraph (c)(1) of Section 2274.55 and in any submittal required pursuant to subdivision (a) of Section 2274.58. In the event the insurer has not sent the notice set forth in subdivision (b) of Section 2274.50, the affirmative defense described in this section shall not obtain.

~~Adopt Section 2274.60. Effect of Insurer’s Failure to Make Timely Submittal.~~

~~In the event the insurer does not substantially comply with the information submittal requirements of paragraph (c)(1) of Section 2274.55, or of subdivision (a) of Section 2274.58, as the case may be, within the period of time within which the submittal in question is required to be made pursuant to that paragraph or subdivision, the insurer shall immediately reinstate the policyholder, certificate holder or other insured pursuant to subdivision (e) of~~

~~Insurance Code section 10273.7. No act of the commissioner shall be necessary in order for the requirement stated in the preceding sentence to become effective.~~

Adopt Section 2274.60~~1~~. Role of Department Staff.

(a) Department staff evaluating the insurer's request for a hearing under subdivision (b) of Insurance Code section 10273.7 shall have discretion to obtain from the policyholder, certificate holder or other insured, or from any other source, such additional evidence as in the opinion of staff may assist in the determination of whether the rescission, cancellation or nonrenewal is or is not contrary to existing law. Department staff shall make any such evidence reasonably available to the insurer and shall provide the insurer a reasonable opportunity to submit a response to that evidence.

(b) Department staff evaluating the insurer's request for a hearing under subdivision (b) of Insurance Code section 10273.7 shall in each case determine whether the evidence is or is not sufficient to establish that the insurer has satisfied all legal requirements pertaining to the cancellation, rescission or nonrenewal. In the event Department staff determines that the cancellation, rescission or nonrenewal is contrary to existing law, the order to reinstate the policyholder, certificate holder or other insured shall:

(1) Identify each provision of law which staff determines was not satisfied, and

(2) Cite the factual basis for each such determination.

(c) Department staff shall appear at any hearing requested pursuant to subdivision (c) of Insurance Code section 10273.7 and shall file with the court any evidence upon which staff rely for the proposition that the rescission, cancellation or failure to renew was contrary to existing law. The evidence submitted by Department staff may include information obtained at any time from any source, including information that the insurer provided in its submittal pursuant paragraph (c)(1) of Section 2274.55 but did not provide in its submittal pursuant to subdivision (a) of Section 2274.58.