

HEALTH INSURER ACCOUNTABILITY ACT COMMITTEE
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 ID# 1342149

October 25, 2011

Ms. Dawn McFarland
 Initiative Coordinator
 Office of the Attorney General
 1300 "I" Street
 Sacramento, CA 95814

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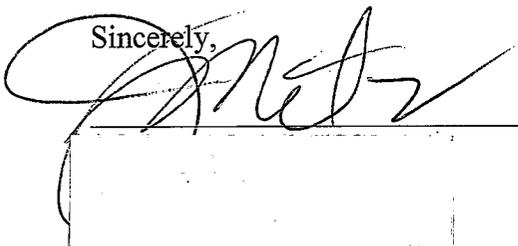
INITIATIVE COORDINATOR
 ATTORNEY GENERAL'S OFFICE

Re: Request for Title and Summary for Proposed Initiative

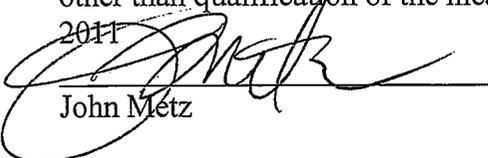
I hereby request that the Attorney General, pursuant to Elections Code § 9001(a), prepare a title and summary of the attached proposed statewide ballot measure pursuant to Elections Code section 9002. The text of the measure: "The Health Insurer Accountability Act of 2012," a check for \$200 payable to the State of California, my signed statements, pursuant to Elections Code §9608 and §9001(b), and the address at which I am registered to vote are included with this letter. I am the public contact person. The other public contact information is found in the letterhead above.

Thank you for cooperation and assistance with this matter.

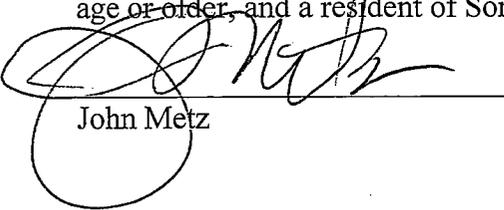
Sincerely,



I, John Metz, acknowledge that it is a misdemeanor under state law (Section 18650 of the Elections Code) to knowingly or willfully allow the signatures on an initiative petition to be used for any purpose other than qualification of the proposed measure for the ballot. I certify that I will not knowingly or willfully allow the signatures for this initiative to be used for any purpose other than qualification of the measure for the ballot. Dated this twenty-fifth day of October, 2011


 John Metz

I, John Metz, declare under penalty of perjury that I am a citizen of the United States, 18 years of age or older, and a resident of Sonoma County, California.


 John Metz

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

Health Insurer Accountability Act of 2012

SECTION 1. Chapter 1.2 (commencing with Section 10198.10) is added to Part 2 of Division 2 of the Insurance Code, to read:

Chapter 1.2 Health Insurer Accountability

10198.10 – Why We Need These Laws – The People of California find and declare that:

(a) The purpose and intent of this Act is to: protect all consumers, providers and the public from unfair, deceptive or dishonest acts or practices by Health Insurers and arbitrary, unjustified health insurance rates; ensure that Health Insurers are held accountable for their actions; and encourage a transparent, accountable and trustworthy health insurance marketplace;

(b) When Health Insurers engage in unjust practices, we all suffer. People lose their jobs, families lose their homes. Health care providers stop providing the real care people need and health care facilities close their doors. Real people become sicker, poorer, go bankrupt and die sooner. California's economy is weakened – while Health Insurers' profits grow;

(c) Health Insurers are involved in a majority of the transactions by which Consumers, both businesses and individuals, either purchase for others or receive health care related benefits;

(d) A majority of Providers work for or have their decisions directed or influenced by Health Insurers;

(e) Unfair, deceptive, dishonest practices by Health Insurers are problems increasingly faced by Consumers, Providers and the public;

(f) Excessive, unjustified and arbitrary increases in the cost of Health Insurance, based on dubious, unverified data provided by Health Insurers to justify the rates they charge, have made it unaffordable and unavailable to millions of Californians;

(g) Health Insurers must be held accountable for their actions;

(h) Existing law does not provide Californians with adequate protection; and

(i) The provisions of this Act are necessary to fulfill its purpose.

10198.11 – A Health Insurer Is Prohibited From Engaging in Any Unfair, Deceptive, Dishonest or Fraudulent Act or Practice

Any unfair, deceptive, dishonest or fraudulent act or practice by a Health Insurer, its employees, representatives, agents, ostensible agents, or any person over whom it has control or influence, by contract or otherwise, is prohibited.

10198.12. - You Will Be Told What You Are Buying and Get What You Were Told

(a) Every person shall have the right to receive accurate information, understandable to the person to whom it is being marketed or sold, about any Policy that the person may become bound by, prior to its sale or purchase.

(b) Any Policy that contains any provision, or has any label, description of its contents, title, heading, backing, or other indication of its provisions which is unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the Policy is offered, delivered or issued, shall not be approved, offered, delivered or issued in California

(c) The words used in a Policy must be interpreted:

(1) As they are defined in commonly available dictionaries, unless a special meaning, given to a word or phrase by a Health Insurer or a Court, has been clearly explained to the person to whom it is being sold, in writing, prior to the sale and purchase of the Policy, and such special definition is included in the Policy; and

(2) As an ordinary person, not an insurance expert, lawyer or judge, would understand them, in light of the representations made in any advertisement, sales or marketing material and/or what the person was told by any representative of the Health Insurer, as well as the contents of the Policy; and

(d) The words shall not be interpreted based on any belief or intent of a Health Insurer of which the person was not clearly informed, in writing, prior to the sale and purchase of a Policy.

(e) Any limitation on the Policy benefits that is not clearly disclosed to the person in writing, prior to the sale and purchase of a Policy, shall be void and unenforceable.

(f) No benefit shall be limited or eliminated during the term of a Policy without the prior written consent of each affected person and a prompt refund to each such person by the Health Insurer, reflecting the fair market value of the limited or eliminated benefit. In the case of a minor, such consent shall be provided by an adult having legal authority to act for the minor.

(g) A Health Insurer shall disclose to each Claimant all benefits, coverage, time limits or other provisions of any Policy(ies) issued by that Health Insurer, and any

applicable law upon which the Health Insurer intends to rely or with which it is required to comply, that may apply to the claim presented by the Claimant, and shall immediately disclose to the Claimant any additional benefit that might be payable under any such Policy(ies), and cooperate with and assist the Claimant in determining the full extent of the Health Insurer's liability.

10198.13. - Health Insurers Are Required To Tell Us The Truth, The Whole Truth and Nothing But The Truth

(a) If a Health Insurer seeks to have a Government Regulator, Judicial Officer or any person rely on any fact, testimony, document or other information submitted by the Health Insurer, or by any person in support of the Health Insurer's position, in connection with any determination related to any: policy application; rate making; rulemaking; complaint filed by any person against a Health Insurer; marketing or sale of any Policy; or any claim for a benefit by any person, a person with firsthand knowledge of the material facts contained therein shall certify, under penalty of perjury, that the fact, testimony, document and/or other information does not include any false or misleading information about, or fail to disclose, any fact that is material to the application, rate making, rulemaking, complaint, marketing or sale of any Policy, or claim for a benefit.

(b) No Government Regulator or Judicial Officer is permitted to consider any fact, testimony, document or other information in making any determination related to any application, rate making, rulemaking, complaint, marketing or sale of any Policy, or any claim for a benefit filed by any person against a Health Insurer, unless the Health Insurer complies with the requirements of §10198.13(a).

(c) A Health Insurer is charged with actual knowledge of all information known to any of the Health Insurer's employees, representatives, agents, or ostensible agent or contained in any document, record or other thing in its or their possession, in whatever form it is kept or maintained, or was required to be kept or maintained.

10198.14. - Covered Services Will Be Paid For Promptly

Unless otherwise agreed to in the Policy, payment to a Provider for any covered health care service shall be made no later than thirty (30) days after the receipt of the billing and all reasonably required documentation, subject only to: a) the claim contesting rules provided in Insurance Code §10123.13(a), (b) and (d), and §10123.147, and b) the privacy and confidentiality requirements in §10198.21.

10198.15. - Providing A Covered Health Care Service Will Not Be Punished – Denying A Covered Health Care Service Will Not Be Rewarded

(a) Any arrangement of any kind between a Health Insurer and a Provider, which penalizes a Provider when a covered health care service is provided or rewards a Provider when a covered health care service is denied, is prohibited, contrary to public policy and shall be unenforceable and void.

(b) The language in subdivision (a) shall be included, verbatim, in all written agreements between a Health Insurer and a Provider.

10198.16. - You Will Be Told Every Reason Why Any Benefit Is Being Delayed, Limited or Denied

(a) When any benefit is delayed, limited or denied, the Health Insurer shall provide the Claimant with a detailed written statement of all the reasons for that determination, including: all facts, policy provisions and law upon which the Health Insurer relied; and the name(s), qualifications and any personal interest(s), including economic interest(s), unrelated to the patient's health, which a reasonable person might believe may affect the person's professional judgment, of each person who provided any material input for, or made, any such determination, within three (3) days of the request for the benefit or completion of any test or examination reasonably required to make the determination that the benefit should be provided, delayed, limited or denied, whichever is later.

(b) In any urgent, emergent or other situation, where a person's health or property may be in jeopardy, the Health Insurer's determination must be expedited to prevent any harm that might be caused by a delay in providing the determination.

(c) A person with firsthand knowledge of the material facts contained in any determination to delay, limit or deny the provision of any benefit shall certify, under penalty of perjury, that the information upon which the determination was made does not include any false or misleading information about, or fail to disclose, any fact that is material to the determination.

(d) Any reason for the delay, limiting or denial of a benefit, which a Health Insurer knew or should have known which is not specifically stated in the initial oral or written communication from the Health Insurer delaying, limiting or denying a benefit, is deemed to be waived and the Health Insurer is estopped from asserting the reason.

(e) A Health Insurer is bound by the information and determination in each such oral or written communication.

10198.17. – A Denial of A Benefit May Only Be Made by Properly California Licensed And Qualified Persons

(a) A Health Insurer shall not refuse to authorize any health care service that is covered by the Policy and that is recommended by a person's appropriately licensed Provider, unless all of the following requirements are satisfied:

(1) Any clinical or non-clinical basis for such refusal is determined by an appropriately California licensed Provider or other person, with the education, training, and relevant expertise that is appropriate for evaluating the specific

clinical or non-clinical issue(s) involved in the denial, and who has disclosed any personal interest(s), including economic interest(s), unrelated to the patient's health, which a reasonable person might believe may affect the Provider's or other person's professional judgment; and

(2) The name and qualifications of each such Provider and/or other person has been disclosed to the Claimant;

(b) The Health Insurer and each person acting pursuant to paragraph (a)(1) shall be liable for all reasonably foreseeable consequences of a determination made pursuant to this section.

10198.18. - You Will Have a Fair Chance to Prevail in a Dispute with a Health Insurer

(a) Each Health Insurer shall establish an Internal Review Procedure that ensures each person that an appeal of a decision by a Health Insurer to delay the provision of, limit or deny any benefit shall be completed within three (3) days of a request that is made on or after the date on which the detailed written statement of all the reasons for the delay of the provision, limitation or denial of any benefit was required to have been sent to and received by the person.

(b) The detailed written statement to be issued following any Internal Review Procedure, shall include all reasons upon which the Reviewer(s) relied for supporting any such delay of the provision of, limitation or denial, including: all facts, policy provisions and law upon which the Reviewer(s) relied; and the Reviewer's(s) name(s), qualifications and any personal interest(s), including economic interest(s), unrelated to the patient's health, which a reasonable person might believe may affect the person's professional judgment, of each person who provided any material input for, or made, any such decision.

(c) A person with firsthand knowledge of the material facts contained in any Internal Review Procedure's determination that supported a determination to delay, limit or deny the provision of a benefit, shall certify, under penalty of perjury, that the Review was not based upon information which included any false or misleading information about, or failed to disclose, any fact that is material to the determination.

(d) Any person shall have three (3) years from the date on which the detailed written statement provided by §10198.16 was received by the person to file an appeal of that decision.

(e) Any provision in any agreement that limits any person's ability to obtain, increases the cost of obtaining, or shortens the time for obtaining full redress for any harm done through any violation of any provision of this Act, except as mandated by existing law, is prohibited, contrary to public policy and shall be unenforceable and void.

10198.19. - You Will Not Be Forced To Give Up Your Rights

(a) Any provision in any agreement or Policy that contradicts or limits any of the rights or remedies granted by this Act and/or acts as a waiver of Civil Code §1542 or any provision of this Act is prohibited, contrary to public policy and shall be unenforceable and void.

(b) Any provision in any Policy that limits any of a person's constitutionally protected rights is prohibited, contrary to public policy and shall be unenforceable and void.

10198.20. – A Health Insurer Is Required to Treat You Fairly

(a) Every Health Insurer shall be subject to the laws of California applicable to any other business, including, but not limited to: the Unruh Civil Rights Act (Sections 51 through 53, inclusive, of the Civil Code); the antitrust and unfair business practices laws (Parts 2 (commencing with Section 16600) and 3 (commencing with Section 17500) of Division 7 of the Business and Professions Code); the Consumer Legal Remedies Act (Part 4 (commencing with Section 1750 of Division 3 of the Civil Code); the Unfair Practices laws (Part 2, Chapter 1, Article 6.5, commencing with Section 790) and the Insurance Frauds Prevention Act (Chapter 1, Article 1. commencing with Section 1871) of Division 1 of the Insurance Code); the California Code of Regulations Sections 2695.1-7, 11-16; and Title 13., Chapter 10, Sections 549,550, 550.5, 551.5 inclusive, of the Penal Code). This subdivision does not constitute a change in, but is declaratory of, the existing law.

(b) Every Health Insurer owes the duties of a fiduciary to each of its Policyholders and any Beneficiary of the terms of its policy(ies).

10198.21. - Your Privacy and Confidentiality Must Be Protected

(a) Every person shall own his/her own health care records and related information, including without limit all information contained in that person's designated record set, as that term is defined and/or used in 45 CFR §164.524, §164.501 and §160.103.

(b) Every person mentioned in §10198.21(a) shall have access to and obtain a copy of the information mentioned in §10198.21(a) at any time during regular business hours within one (1) day after a request for access by or on behalf of that person has been made, or at any time, to the extent they are maintained digitally and accessible through the Internet or otherwise.

(c) To the extent permitted by federal law, notwithstanding any other provision of law, no Health Insurer shall disclose, give, loan, share, convey, sell, trade, license, rent or lease any person's health care records or related information, or any part thereof, to any other person without the express prior written informed consent and authorization of the person, obtained no more than seven (7) days prior to any such

disclosure, except as provided in California Civil Code §56.10(b)(1)-(4), (6)-(9), (c)(2) [but only with regard to a governmental agency], (c)(5) [but only with regard to a public body responsible for licensing or accrediting a provider of health care or health care service plan], (c)(6), (7), and (12)-(15). The written informed consent and authorization shall comply with the provisions of California Civil Code §56.11. This informed consent may be provided electronically if it is executed by an electronic signature as provided by Title 2.5 (commencing with §1633.1) of Part 2 of Division 3 of the Civil Code.

(d) Prior to any transaction listed in subsection (c) the Health Insurer shall disclose to the person any compensation or other benefit which has been or may be received by the Health Insurer in exchange for such transaction.

10198.22. - "Cover-up / Silencing Clauses" Are Prohibited

Any provision in any settlement agreement or Policy requiring any person to keep silent about anything relating to a grievance or dispute with a Health Insurer, or the settlement or other resolution of such dispute, other than complying with the provisions of §10198.21, is prohibited, contrary to public policy and shall be unenforceable and void.

10198.23. - "Gag Rules" Are Prohibited

(a) Any arrangement of any kind between a Health Insurer and a Provider that limits a Provider's ability to advocate on behalf of any person for any reasonable, medically appropriate health care service option which might be available, or to disclose any act or omission of a Health Insurer which may be a violation of any law, regulation or ethical standard, is contrary to public policy and shall be unenforceable and void.

(b) The language in subdivision (a) shall be included, verbatim, in all written agreements between a Health Insurer and a Provider.

10198.24. - You Can't Be Forced or Influenced to Violate the Law and "Whistle Blowers" Will Be Protected

(a) It is prohibited for any person to instruct or influence any person, directly or indirectly, to violate any provision of this Act or any related statute, regulation or the Common Law.

(b) No person who disputes a decision made by a Health Insurer, and no person listed in subsection §10198.25(a) who discloses information relating to a potential violation of this Act, or takes any other action authorized by this Act or any related statute, regulation or the Common Law shall be penalized, disciplined or harmed in any way, either directly or indirectly, for taking such action, by any person.

10198.25. - Health Insurers Are Accountable for the Consequences of the Decisions They Make or Influence

(a) A Health Insurer and each of its employees, representatives, agents, ostensible agents, or any person over whom it/she/he has control or influence by contract or otherwise, has the duty to exercise ordinary care when making or influencing decisions relating to the provision of health care services.

(b) Each person listed in subsection 10198.25(a) shall be subject to all provisions of this Act and liable for all damages to any person caused by its/his/her failure to exercise ordinary care.

(c) Each person listed in subsection 10198.25(a) shall be deemed to have influenced a decision relating to the provision of health care services whenever such person's act or practice, directly or indirectly, has a tendency to affect a Provider's decision related to a patient's health care.

(d) Nothing in this Act or any existing law shall cause a Health Insurer to be defined as a Health Care Provider.

(e) Nothing in this Act shall change the current liability of any Provider for professional negligence.

(f) Nothing in this Act creates any obligation on the part of a Health Insurer to provide any health care service that is not otherwise covered under the terms of the Policy and any applicable law.

10198.26. – We Will Have the Legal Right and Ability to Make Sure That Health Insurers Are Held Accountable

(a) Any license issued pursuant to the Health and Safety Code or the Insurance Code shall be suspended for any violation of this Act. The suspension shall begin 90 days after a final determination that a violation has occurred and continue until such time as the violation has ceased and all fines, penalties, damages, restitutions and/or disgorgements have actually been made and/or paid by the violator, and the violator has been enjoined from or has consented, in a form enforceable in any Court of competent jurisdiction, to refrain from engaging in such act or practice in the future.

(b) The Commissioner may also revoke in whole or in part the certificate of authority of a Health Insurer for a violation of this Act in addition to all other remedies provided under the law.

(c) Every person is granted the right, for that person and/or for, and in the name of, the people of the State of California, to:

(1) Enforce the provisions of this Act and any related statute, regulation or the Common Law, against any person who violates any of them, in any Court of competent jurisdiction;

(2) Compel restitution by any person, including disgorgement of all gains obtained as a result of any violation of any provision of this Act and any related statute, regulation or the Common Law;

(3) Obtain injunctive relief to inform the public of each proven violation and prevent or compel any action necessary to assure adherence to the provisions of this Act and any related statute, regulation or the Common Law by any person;

(4) Obtain payment from any person for all damages caused by that person, based on any violation of any provision of this Act and any related statute, regulation or the Common Law; and

(5) Obtain any other relief which the Court deems proper;

(6) Except that an attorney may not act as a Plaintiff in an action on behalf of the people of the State of California, based on a violation of any provision of this Act or any related statute or regulation, unless the attorney has personally suffered actual injury or lost money or property as a result of such violation.

(d) Punitive damages shall be awarded in instances where:

(1) One [1] violation has occurred, and it is proven by a preponderance of the evidence that the action or motivation of the person involved fraud, oppression or malice; or

(2) The same or similar violation, by the same person, has occurred on at least three [3] separate occasions and the violations are not proven, by clear and convincing evidence, to have been solely the result of mistake, inadvertence or excusable neglect.

(3) All punitive damages, after deducting all costs, expenses and fees incurred in obtaining them, shall be awarded to the State of California and deposited in a special fund, entitled the Department of Insurance Health Insurer Accountability Act Fund, to be administered by the Commissioner. Notwithstanding §13340 of the Government Code, all moneys in this fund are continuously appropriated to the Department for the sole purpose of implementing, enforcing, defending, and fulfilling the purpose of this Act.

(4) Attorney fees for obtaining any punitive damage award shall be limited to ten percent (10%) of any such award.

(e) (1) Notwithstanding any provision of any other statute, regulation or the Common Law, Insurance Code §1871.7 et seq. applies to a Health Insurer and

any other "person" as that term is defined in Insurance Code §10198.29(n). This paragraph does not constitute a change in, but is declaratory of, the existing law.

(2) Notwithstanding any provision of any other statute, regulation or the Common Law, Penal Code §549, §550(a) and (b), §550.5, and §551.5 apply to a Health Insurer and any other "person" as that term is defined in Insurance Code §10198.29(n). This paragraph does not constitute a change in, but is declaratory of, the existing law.

(3) Any intentional or grossly negligent violation of this Act shall subject a Health Insurer to the same penalties and remedies authorized in Insurance Code Chapter 12 (commencing with §1871) of Article 1 of Part 2 of Division 1, and Penal Code Chapter 10 (commencing with §549) of Part 1 of Title 13 for other acts of fraud related to the business of insurance.

(4) Any person bringing an action based on a violation of any provision referred to in subsection §10198.26(e) shall be compensated in the same manner and to the same extent as is currently prescribed in Insurance Code Chapter 12 (commencing with §1871.7) of Article 1 of Part 2 of Division 1 for a person who is an "original source" bringing an action based on a violation of that statute, in addition to any other compensation authorized or permitted under this Act or any other statute, regulation or the Common Law. However, it is not required that a person bringing an action based on a violation of any provision of this Act be an "original source" of the information upon which the action is based.

(5) Subsection §10198.26(e)(1) & (2) clarify the legal right of any qualified person to assist the State of California in the exercise of its police powers, to ensure that civil redress is enforced and civil remedies obtained when a wrongful act is committed, in violation of Penal Code Chapter 10 (commencing with §549) of Part 1 of Title 13. This paragraph does not constitute a change in, but is declaratory of, the existing law.

(f) Notwithstanding any other provision of law, any person who suffers loss of money or other property, or injury to any of that person's property or any legally protected right because of a violation of this Code by a Health Insurer, or any other person, as that term is defined in Insurance Code §10198.29(n), may bring an action in any court of competent jurisdiction, in the name of the people of the State of California, for any redress or relief available pursuant to this Act.

(g) No conduct, document, statement, communication, publication, broadcast, trade secret, or otherwise confidential information which violates or is connected with or relates to a violation of any provision of this Act, shall be confidential or privileged under Civil Code §47, Evidence Code §950, et seq., and §1115 et seq., or any other statute, regulation or the Common Law.

(h) No Health Insurer shall pass on to consumers the cost of any fine, penalty, restitution or punitive damage award it is ordered to pay to any other person. Such costs shall be paid from profits and a document attesting to the payment and the source of the payment certified as true under penalty of perjury signed by the officers of the Health Insurer, who exercise the functions of a chief executive and chief financial officer, by their personal knowledge, shall be filed with the Commissioner within 30 days of the order for such payment becoming final. Failure to file said statement or the filing of a false statement shall be punishable by a fine, to be imposed on and paid by the violating officer(s), equal to 50% of the original fine, penalty and/or punitive damage award. All such fines shall be payable to the Department, deposited in the special fund established under §10198.26(d)(3) of this Act.

(i) All damages available under this or any other applicable statute, regulation or the Common Law, as well as attorney fees, compensation for expert witness fees, costs, and the reasonable value of any time spent or expense incurred by any person as a plaintiff in bringing the action, shall be awarded to that person when that person is the prevailing party in an action based upon any violation of this Act or in defending this Act from any challenge to its validity or enforceability by any person.

(j) No Health Insurer shall indemnify any person for any sums paid by that person pursuant to a settlement, or awarded against that person in a judgment, based on any alleged violation of, or challenge to the validity or enforceability of, this Act.

(k) An action for a violation of any provision of this Act must be commenced within six (6) years of the date on which the person bringing the action had actual knowledge of the last violation upon which the action is based.

(l) The rights and remedies granted by this Act are cumulative and are in addition to any other procedure or remedy for any violation or conduct provided for in any other statute, regulation or the Common Law and are in addition to any civil penalty or disciplinary action sought by any regulatory agency pursuant to any other statute, regulation or the Common Law.

(m) To the extent consistent with the Constitutions of California and the United States, a violation of any provision of this Act that occurs in any other jurisdiction in the United States shall be enforceable in California, if the person violating any such provision conducts business in California or the breach affects any Californian.

(n) In any action brought pursuant to any provision of this Act, if any remedy is found to be preempted by Federal law that remedy is deemed invalid and is severed from this Act, for the purposes of any such affected action. That invalidity shall not affect any other provision or application of the Act which can be given effect without the invalid provision or application.

10198.27. - Any Person Who Functions Like A Health Insurer Will Be Treated Like A Health Insurer

Notwithstanding any other provision of law, any person who, for compensation, assumes any of another person's financial risk for the cost of any health care related service shall be subject to this Act and all other statutes and regulations governing the business of insurance.

10198.28. – Slowing Down “The Revolving Door”

(a) Any person employed by or with whom the California Department of Insurance, California Department of Managed Health Care (“DMHC”) or any other governmental agency that deals with health care–related matters contracts must disclose all potential conflicts of interest, prior to being employed or entering into such a contract.

(b) Any person employed by California Department of Insurance, DMHC or any other governmental agency that deals with health care–related matters in any of the three (3) most senior management level positions of any branch or division of any such department or agency, or any analogous position, however designated, is prohibited from receiving any compensation from or on behalf of any Health Insurer for three (3) years prior to and until three (3) years after employment by California Department of Insurance, DMHC or any other governmental agency that deals with health care–related matters.

10198.29. – The Definition of Some Important Terms in This Act

The following definitions shall apply to the provisions of this Act and all other applicable statutes and regulations:

(a) “Act” means the Health Insurer Accountability Act and/or any of its provisions;

(b) “Advertisement” means any written, printed, telephonic, electronic, digital or verbal communication of any kind published or disseminated by any means in connection with the offer, sale of, or any transaction related to any Health Insurance Policy;

(d) “Beneficiary” means any person who is intended to benefit from the terms of any Health Insurance Policy, pursuant to any policy provision, statute, regulation or the Common Law.

(e) “Claimant” means any person, including any Beneficiary, who asserts a right of recovery, or any person who a Health Insurer learns from any source may be owed any benefit, under a Policy or any person appointed by such person, or authorized by operation of law, to represent such person.

(f) “Consumer” means any person who contracts, or pays, for any person to receive, or any person who is entitled to receive or receives, a health care service or

benefit offered or paid for by a Health Insurer;

(g) "DMHC" means the Department of Managed Health Care.

(h) "Health care provider" or "Provider" means any person who delivers or furnishes any health care good or service;

(i) "Health Care Service" means a health care related service of any kind, including, but not limited to: (1) diagnostic tests or procedures; (2) medical or surgical treatments; (3) nursing; (4) chiropractic; (5) physical therapy; (6) occupational therapy; (7) speech pathology; (8) audiology; (9) professional mental health; (10) dental; (11) hospital; (12) prosthetic or orthotic services; (13) optometric care; (14) rehabilitative care; (15) long-term care; (16) any other service directly or indirectly related to the preservation, maintenance, or compensation for the cost or loss of the physical, emotional or mental health of a Consumer; or (17) any other health care service as defined in subdivision (b) §1345 of the Health and Safety Code;

(j) "Health Insurance" means any of the following: (1) any insurance included in Insurance Code §101 and §106; (2) "health care service plan" as defined in subdivision (f) Health and Safety Code §1345; (3) specialized health care service plan; or (4) any other insurance policy, contract or agreement which promises to pay for, or become liable to pay for, any health care related service or expense, regardless of what the contract, agreement or policy is called;

(k) "Health Insurance Policy" or "Policy" means a policy, contract, or other agreement to provide health insurance;

(l) "Health Insurer" means any person that offers, issues, sells, or delivers Health Insurance, as defined in §10198.29(j), or a Health Insurance Policy, as defined in §10198.29(k); any other insurer that pays for or may become liable to pay for any health care related service or expense; or any other person who acts in a similar capacity to any of the foregoing, regardless of business form or how it is organized, operated or named;

(m) "Knowingly committed" means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(n) "Person" means any: person; individual; consumer; group or individual policyholder; named or unnamed insured; enrollee; subscriber; or beneficiary, and any: Provider; member of any profession; Health Insurer; governmental subdivision, agency or other entity; private business; corporation; insurer, institution; association; organization; administrator; business trust; or foundation, and any other public or private entity, regardless of its form or how it is organized or operated or what it is named, and any employee, representative, agent, ostensible agent, or any person over whom any other person has control or influence by contract or otherwise;

(o) "Practice" means any individual act knowingly committed or any act committed on three or more occasions, whether or not knowingly committed.

(p) "Property" means anything to which monetary value may be attached, tangible or intangible, including without limit, any legally protected right or interest.

(q) "Rate" includes, but is not limited to, premium, rating factor, underwriting rule, copayment, coinsurance obligation, deductible, cost and expense a Consumer incurs in the claims process, or any other charge, fee or cost incurred, paid or required to be paid by a Consumer relating to a Policy.

(r) "Violation of this Act" means doing any act that is prohibited by this Act or failing to do any act that is required by this Act.

(s) "You", "We", or "Us" mean the People of California or any of them, or any other person affected by the provisions of this Act.

SECTION 2. The Heading of Title 13, Chapter 10, of the Penal Code is amended to read: "~~CRIMES AGAINST INSURED PROPERTY AND INSURERS INVOLVING INSURANCE~~"

SECTION 3. Section 550.5 is added to the Penal Code to read:

550.5. (a) For purposes of subdivision (a) and (b) of §550, the people of California find that, in addition to accepting and denying claims, insurers, including health insurers, regularly in the ordinary course of doing business, have in the past done, and may continue to do, any or all of the following:

(1) Present or cause to be presented written or oral statements as part of, in support of, or in opposition to claims for payment or other benefits pursuant to an insurance policy.

(2) Prepare or make written or oral statements that are intended to be presented to another insurer or claimant in connection with, in support of, or in opposition to a claim or payment or other benefit pursuant to an insurance policy.

(3) Conceal, or knowingly fail to disclose, the occurrence of an event that affects a person's initial or continued right or entitlement to an insurance benefit or payment, or the amount of a benefit or payment to which the person is entitled.

(b) The amendments made to §550 by this Act do not constitute a change in, but are declaratory of, existing law.

SECTION 4. Section 551.5 is added to the Penal Code to read:

551.5. For purposes of this chapter, "person" has the same meaning as that term is defined in §1019.29(n) of the Insurance Code.

SECTION 5. How This Act Must Be Interpreted and Take Precedence

(a) This Act must be liberally construed and applied to promote its purpose as stated in §10198.10.

(b) Any inconsistency, redundancy, uncertainty, or ambiguity in any provision in this Act must be interpreted in a manner to promote the purpose of the Act, as stated in §10198.10.

(c) The plain meaning of each Finding and Chapter Heading must be considered to be part of the substantive law for the purpose of interpreting the provisions of this Act.

(d) It is the will of the People of California that the provisions of this Act must take precedence over any current or future statute, regulation or decision in the Common Law that may conflict with or limit the most expansive interpretation of these provisions for the protection of Consumers, the general public and the State.

SECTION 6. If Other Measures Are On the Same Statewide Election Ballot

In the event that this measure and another measure or measures relating to Health Insurer acts or practices, consumer protection relating to health insurance, or any provision of this Act appear on the same statewide election ballot, any provision of the other measure(s) that do not further the purpose of this Act shall be deemed in conflict with this Act. In the event that this Act and another such measure or measures are approved by a majority of voters, the provisions of this Act shall prevail in their entirety over any provision of the other measure that does not further the purpose of this Act. Any provision of the other measure that does not further the purpose of this Act shall be null and void, except to the extent provided in Section 10 of Article 2 of the California State Constitution.

SECTION 7. The Only Ways This Act Can Be Amended

(a) No provision of this Act may be amended by the Legislature except to further the purpose and intent of that provision by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate. No amendment by the Legislature shall be deemed to further the purpose and intent of this Act unless it furthers the purpose and intent of the specific provision of this Act that is being amended.

(b) At least seven (7) days prior to any vote by the Legislature to amend any provision of this Act, each Legislator shall disclose to the Secretary of State any direct or indirect contribution or other direct or indirect benefit received from, promised or offered

by or on behalf of any Health Insurer for the three (3) years prior to such a vote. All of this information shall be posted on the Secretary of State's and Legislator's public websites, at least five (5) days prior to any such vote,

SECTION 8. When This Act Will Take Effect

To the fullest extent permitted by law, this Act shall apply to all Policies, contracts and agreements in effect at the time of the passage of this Act and to all acts or practices performed and Policies, contracts and agreements entered into from that date forward and as otherwise provided for in this Act.

SECTION 9. This Act And The Taxpayers of California Will Be Protected Against Frivolous Legal Challenges

It is the will of the People of California that any legal challenge to the validity or enforceability of this Act shall be acted upon by the Courts on an expedited basis and any fees, costs or expenses incurred by the taxpayers in connection with the defense of the Act shall be repaid to the taxpayers and deposited into the Department of Insurance Health Insurer Accountability Act Fund, established pursuant to §10198.26(d)(3) of this Act, within 90 days of a final judgment or settlement, by any person challenging this Act, when the People are the prevailing party by achieving some degree of success on the merits in defending such an action. Any person shall have standing to initiate and/or intervene in any action to defend the validity or enforceability of this Act and, when the People are the prevailing party, that person shall be awarded all fees, costs, compensation for expert witness fees, and the reasonable value of any time spent or expense incurred by that person in defending this Act.

SECTION 10. If A Court Determines That Any Provision Of This Act Is Invalid, The Rest Will Stay In Force To Accomplish Its Purpose and Protect Us

If any provision of this Act or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect any other provision or application of the Act which can be given effect without the invalid provision or application. To this end the provisions of this Act are severable. It is the will of the People of California that any invalid section, subdivision, paragraph, sentence, clause, phrase or word shall be severed from the remainder of the Act to preserve its remaining provisions and fulfill the purpose and intent of this Act.