SENATE COMMITTEE ON INSURANCE

1999 – 2000 LEGISLATIVE SUMMARY

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December 18, 2000

Dear Colleague,

In the 1999-2000 Session the Senate Insurance Committee approved and the Governor subsequently signed significant legislation dealing with the newly formed Department of Managed Care, mental health coverage, a process for challenging insurance coverage decisions, low-cost automobile insurance and increased funding for insurance fraud investigations. Additionally, the committee held a series of investigative hearings regarding the settlement practices of the Department of Insurance and identified shortcomings were addressed by legislation signed by the Governor.

The complexity of insurance issues confronting Californians prompted the committee to hold 17 fact-gathering hearings over the two-year cycle in an attempt to craft solutions to such problems as the growing number of medically uninsured, dwindling prescription benefits for seniors, financially faltering medical groups, the threat that compliance with new seismic standards may bankrupt hospitals, the instability of the California Earthquake Authority and rampant auto insurance fraud. I invite you to review the transcripts and staff reports from these hearings—they are a valuable resource.

The committee's end-of-session report includes a summary of all measures heard by the committee, including bills that were not sent to the Governor.

I want to extend a personal thanks to members of the committee and their staff for their participation in what I believe was a highly productive session for insurance reform.

All the best,

Jackie Speier, Chair
State Senator Insurance Committee

TABLE OF CONTENTS

BILLS SIGNED INTO LAW

AUTOMOTIVE

SB 171 (ESCUTIA) AUTOMOBILE INSURANCE: LIFELINE POLICIES
Chapter 794, Statutes of 1999

Creates a pilot "low cost automobile insurance policy" in Los Angeles County for drivers in eligible low income households, priced initially at $450 per year for a good driver over the age 25, with a surcharge for younger eligible drivers, and establishes that coverage limits be $10,000 for bodily injury to one person, $20,000 for bodily injury to two persons, and $3,000 in property damage. Makes related changes.

SB 363 (FIGUEROA) AUTOMOTIVE INSURANCE: COVERAGE FOR DAMAGED: CHILD SAFETY RESTRAINT SYSTEMS
Chapter 183, Statutes of 1999

Requires automobile insurance policies to cover replacement of child safety seats involved in accidents.

SB 527 (SPEIER) AUTOMOBILE INSURANCE: LOW-COST POLICIES
Chapter 807, Statutes of 1999

Creates a pilot "low cost automobile insurance policy" in San Francisco County for drivers in eligible low income households, priced initially at $410 per year for a good driver over the age 25, with a surcharge for younger eligible drivers, and establishes that coverage limits be $10,000 for bodily injury to one person, $20,000 for bodily injury to two persons, and $3,000 in property damage. Makes related changes.

SB 940 (SPEIER) INSURERS: FEES
Chapter 884, Statues of 1999

Increases funding for fighting auto insurance fraud and for helping Consumers with complaints about auto insurance agents and companies, while eliminating the requirement in law that fees on all licensees be increased at the same percentage rate.

SB 1022 (JOHNSTON) AUTOMOBILE INSURANCE: GOOD DRIVER DISCOUNT: REPRESENTATIVE OF INSURER
Chapter 309, Statutes of 1999

Clarifies existing law regarding the offer and sale of a Good Driver Discount automobile insurance policy by defining a representative to include employees of insurers. The bill states that the law regarding offer and sale of such a policy by an agent or representative representing one or more insurers having common ownership, management or control is not to be construed to either permit a representative to transact insurance, or to exempt a representative who does transact insurance, from licensing under the Insurance Code.

SB 1296 (POLANCO) PROPERTY AND LIABILITY INSURANCE: AUTOMOBILE INSURANCE
Chapter 313, Statues of 1999

Limits the grounds for nonrenewal of homeowners or auto insurance and extends to all coverage provided by a policy agreement between the insurer and the insured to exclude a named driver from coverage.

SB 1297 (SCHIFF) RECIPROCAL INSURERS: UNLAWFUL REBATES
Chapter 314, Statues of 1999

Repeals Insurance Code Section 1490 that prohibits reciprocal insurers from offering rebates to customers, thus permitting these insurers (i.e. some automobile clubs) to offer small advertising specialty items at the time of sale to potential consumers.

SB 1731 (LEWIS) INSURANCE
Chapter 175, Statutes of 2000

Establishes new statutory rules for the “assigned risk plan” responsibilities of auto liability insurers who discontinue selling insurance in California. The “assigned risk plan” refers to a state-authorized plan in which high-risk drivers who are unable to obtain coverage in the voluntary market are assigned by the California Automobile Assigned Risk Plan to auto insurers on a random basis commensurate with their market share. Among the key provisions, the bill requires an insurer that discontinues writing automobile liability insurance, but retains its license to write such business, to continue to pay the assigned risk plan (Plan) assessments and receive Plan assignments until its prior-established quota has been filled, unless another insurer is allowed to assume those obligations.

SB 1988 (SPEIER) INSURANCE FRAUD
Chapter 867, Statutes of 2000

- Directs the Bureau of Automotive Repair (BAR) to establish a pilot program for inspecting repaired vehicles for the purposes of identifying fraud and allows consumers to ask BAR to inspect auto body work done on their vehicles.

- Requires insurers to prove to the Insurance Commissioner (IC) that they have inspection programs that effectively identify auto body fraud.

- Requires the Department of Insurance (DOI) to produce a standardized auto body repair "consumer bill of rights " to be given by all insurers to policyholders.

- Requires DOI to maintain a record of auto body shops that are denied the right to participate in an insurer's direct repair program.

- Authorizes the IC to declare any region of the state an auto insurance fraud " crisis area"--such a declaration would double fines for committing fraud and require insurers to report to the Department of Insurance all claims filed within the first 90 days of a policy.

- Raises fines for solicitation of false insurance claims.

- Requires a 10-year revocation of license for a physician or a chiropractor upon second conviction of certain types of fraud; and stipulates that engaging in insurance fraud shall constitute cause for disbarment or suspension of a license to practice law.

- Restricts ownership of certain medical facilities to licensed physicians.

AB 802 (DUTRA) INSURANCE POLICIES: DISCLOSURE OF FINANCE CHARGES
Chapter 388, Statutes of 1999

Requires every insurance policy, and insurance premium billing statement, to disclose the amount of periodic finance charges and any associated annual percentage rate. If the finance charge is a fixed fee, regardless of the amount of the loan on the balance due, the disclosure is not required to include the annual percentage rate associated with those charges. This bill would not apply to any insurance policy or premium finance billing where the same information is otherwise disclosed to the insured as required by any other provision of state or federal law.

AB 1050 (WRIGHT) INSURANCE: FRAUDULENT CLAIMS
Chapter 885, Statutes of 1999

Enacts the Organized Crime Prevention and Victim Protection Act of 1999 which increases funding for, and imposes additional requirements related to, prevention of auto insurance fraud. Double joined with SB 940.

AB 1432 (OLLER) INSURANCE: SERVICE OF PROCESS: TAX CREDIT
Chapter 808, Statues of 1999

Permits a insurer premium tax credit equal to the amount that would be due on the premium paid by previously uninsured motorists who participate in either of the two Low-Cost Automobile Insurance Pilot Programs (Pilot Program) and clarifies that a corporate officer of a foreign insurer can accept service of process in this state.

AB 1848 (MADDOX) INSURANCE
Chapter 210, Statues of 2000

Permits insurers to physically inspect cars prior to offering comprehensive or collision insurance, when such coverage was not offered on the car before, provided the insurer requires that all vehicles for which new coverage is requested be physically inspected.

AB 2904 (COMMITTEE ON INSURANCE) LOW-COST AUTOMOBILE INSURANCE
Chapter 1033, Statues of 2000

Conforms “years of driving experience” as used in the Low Cost Automobile Insurance program to the same standard set forth in Proposition 103.

DEPARTMENT OF INSURANCE

SB 1524 (FIGUEROA) INSURANCE: FINES AND PENALTIES
Chapter 1089, Statutes of 2000

Stipulates how the insurance commissioner may use settlement monies for public outreach purposes.

SB 1805 (ESCUTIA) MARKET CONDUCT EXAMINATIONS
Chapter 971, Statutes of 2000

Makes market conduct examinations performed on insurance companies public, under specified circumstances.

SB 2107 (SPEIER) INSURANCE: PENALTIES FOR UNFAIR COMPETITION OR DECEPTIVE ACTS
Chapter 1091, Statutes of 2000

Requires that all settlement monies be deposited in the State Treasury, that no settlement monies may be used to pay for promotions featuring the Insurance Commissioner (IC), and that no settlement monies may be directed to a private nonprofit agency unless authorized by specific statute. Also prohibits the IC from delegating the authority to approve a settlement agreement with an insurer.

SB 2199 (HAYDEN) SLAVERY ERA INSURANCE POLICIES
Chapter 934, Statutes of 2000

Requires the Insurance Commissioner to ask insurers doing business in California for records/information on slaveholder insurance policies sold by insurers during the Slavery Era. Declares that descendants of slaves have the right to full disclosure about these policies which covered slave owners financially when slaves were unable to work.

AB 427 (SCOTT) INSURANCE: DELINQUENCY PROCEEDINGS
Chapter 768, Statutes of 1999

Clarifies that existing law prohibiting state agencies from employing legal counsel other than the Attorney General (AG) without the AG's consent applies not only to state agencies, but also to state officers and commissioners. Requires the chief executive officer (CEO) of the Department of Insurance (DOI) Conservation and Liquidation Office (CLO) to be confirmed by the Senate.

EARTHQUAKE

AB 964 (ARONER) EARTHQUAKE INSURANCE
Chapter 715, Statutes of 1999

Requires the California Earthquake Authority (CEA) to issue a report to the Legislature on the status of the CEA residential retrofit program, and changes the requirements for participation in the authority.

AB 1453 (COMMITTEE ON INSURANCE) EARTHQUAKE INSURANCE: MEDIATION: RETROFIT PROGRAM
Chapter 796, Statutes of 1999

Extends the sunset date for the Department of Insurance Earthquake Mediation Program from January 1, 2000, to January 1, 2005, and extends the sunset date for the Department of Insurance Earthquake Retrofit Grants and Loan Program from July 1, 2000, to July 1, 2003, with an increase in spending authority.

HEALTH INSURANCE

SB 5 (RAINEY) HEALTH CARE BENEFITS: BREAST CANCER SERVICES
Chapter 537, Statutes of 1999

Prohibits the denial of enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer. This applies to health care service plan contracts and certain policies of disability insurance that are issued, amended, delivered, or renewed on or after January 1, 2000.

SB 41 (SPEIER) DISABILITY INSURANCE: CONTRACEPTIVE COVERAGE
Chapter 538, Statutes of 1999

Enacts the Women's Contraception Equity Act by requiring disability (health) insurers that provide prescription drug benefits to cover a variety of prescription contraceptive methods approved by the federal Food and Drug Administration as of January 1, 2000 subject to exemption for religious employees, as specified.

SB 59 (PERATA) HEALTH CARE COVERAGE
Chapter 539, Statutes of 1999

Requires health plans and health insurers to adopt and follow specified policies and procedures when determining whether to authorize or deny treatment, and requires adoption of a standard Medi-Cal notice form.

SB 64 (SOLIS) HEALTH INSURANCE: MANAGEMENT AND TREATMENT OF DIABETES
Chapter 540, Statutes of 1999

Requires every health care service plan and disability (health) insurer to provide coverage for the management and treatment of diabetes mellitus including equipment, supplies, medications, outpatient self-management education and medical nutrition therapy as medically necessary or medically appropriate.

SB 87 (ESCUTIA) MEDI-CAL: ELIGIBILITY OF CHILDREN
Chapter 1088, Statutes of 2000

Sets forth requirements and procedures for providing uninterrupted health coverage through the Medi-Cal program, and for reviewing Medi-Cal eligibility for specified beneficiaries, when California Work Opportunity and Responsibilities to Kids benefits have been terminated.

SB 148 (ALPERT) HEALTH CARE COVERAGE: PHENYLKETONURIA (PKU)
Chapter 541, Statutes of 1999

Requires every health care service plan contract (except specialized health care service plan contracts) and specified disability insurance policies, that provide coverage for hospital, medical, or surgical expenses and that are issued, amended, delivered or renewed in this state on and after July 1, 2000, to provide coverage for the testing and treatment of phenylketonuria under the terms and conditions of the plan. The bill defines such treatment coverage to include the cost of formulas and special food products, which are part of a physician-prescribed diet.

SB 168 (SPEIER) HEALTHY FAMILIES PROGRAM
Chapter 845, Statues of 2000

The bill, when heard before the committee, made a variety of changes to the Healthy Families Program; however, the bill was completely re-written to deal with immunizations.

SB 180 (SHER) HEALTH FAMILIES PROGRAM
Chapter 691, Statues of 2000

Requires the Department of Health Services to contract with community-based organizations to help families learn about and enroll in the Healthy Families and Medi-Cal programs. However, the bill was completely re-written to deal with food facilities.

SB 189 (SCHIFF) HEALTH CARE COVERAGE: GRIEVANCES: INDEPENDENT MEDICAL REVIEW
Chapter 542, Statutes of 1999

Requires the creation or reform of dispute resolution systems related to patient complaints against health plans and health insurers.

SB 205 (PERATA) HEALTH COVERAGE: CANCER SCREENING TESTS
Chapter 543, Statutes of 1999

Requires health insurers to cover all generally medically accepted cancer screening tests.

SB 260 (SPEIER) HEALTH CARE COVERAGE: RISK-BEARING ORGANIZATIONS: FINANCIAL SOLVENCY
Chapter 529, Statutes of 1999

Requires the regulation of risk-bearing provider organizations to help ensure the financial solvency of medical groups and continuity of care for patients to be overseen by a Financial Solvency Standards Board.

SB 265 (SPEIER) HEALTH CARE COVERAGE: RISK-BEARING ORGANIZATIONS: FINANCIAL: SOLVENCY
Chapter 810, Statutes of 2000

Revises existing law to conform to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), including requiring a health care service plans and disability insurers who offer health insurance in the individual market to issue their two most popular health coverage products to individuals who are eligible for HIPAA coverage. The bill contains premium rate limits at 170% of standard rates for the HMO products and the MRMIP rate for the PPO products. Both rates are based on age and geographic area.

SB 349 (FIGUEROA) EMERGENCY SERVICES AND CARE
Chapter 544, Statutes of 1999

Defines emergency services and care to include screening, examination, and evaluation to determine if a psychiatric emergency medical condition exists.

SB 559 (BRULTE) HEALTH CARE PROVIDERS: PREFERRED RATES
Chapter 545, Statutes of 1999

Effective July 1, 2000, with respect to contracts providing for the payment of preferred reimbursement rates by payors for health care services rendered by health care providers, imposes certain disclosure and related requirements on contracting agents who sell, lease, assign, transfer, or convey a list of contracting providers and their contracted preferred reimbursement rates to other payors or contracting agents. This bill imposes certain requirements on payors who seek to pay a preferred reimbursement rate, and provides that the failure to comply with these requirements renders the payor liable to pay the nonpreferred rate.

SB 737 (COMMITTEE ON INSURANCE) SMALL EMPLOYER HEALTH INSURANCE: ENROLLMENT OF DEPENDENTS
Chapter 434, Statutes of 1999

Conforms state law to federal regulations by providing that an eligible employee for small employer health insurance who has declined coverage during a previous enrollment period may enroll himself or herself and his or her dependents when a person becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption.

SB 764 (SPEIER) HEALTH CARE: INSURANCE: MEDICARE SUPPLEMENTS
Chapter 706, Statutes of 2000

The bill brings the state law into conformance with the federal law governing Medicare Supplemental Insurance.

SB 1105 (CHESBRO) HEALTH: YOUTH PREGNANCIES
Chapter 754, Statutes of 1999

Repeals a provision in existing law that requires, beginning July 1, 1999, the Community Challenge Grant Program to only be implemented if the State Department of Health Services (DHS) receives federal financial participation for implementation pursuant to a federal waiver for family planning services provided under the state-only Family Planning Program.

SB 1177 (PERATA) HEALTH CARE: UNFAIR PAYMENT PRACTICES: EMERGENCY PHYSICIANS
Chapter 825, Statues of 2000

The bill, when heard before the committee, would prohibit health care service plans from engaging in unfair payment practices relating to claims submitted by an emergency physician or a hospital emergency department. However, the bill was completely re-written and duplicates AB 1455 (Scott) to deal with the issue of unfair payment patterns in general.

SB 1732 (BURTON) HEALTH CARE PROVIDERS: PREFERRED RATES
Chapter 1069, Statutes of 2000

Removes the requirement that every contracting agent that sells its list of health care providers and their reimbursement rates, disclose to the providers whether those payors or other contracting agents include Workers' Compensation insurers.

SB 1746 (FIGUEROA) HEALTH CARE SERVICE PLANS: TERMINATION OF PROVIDER
Chapter 849, Statutes of 2000

Revises the requirements of a health care plan (plan) for notifying enrollees when terminating a contract with a primary care provider (provider). Specifically, 30 days prior to terminating a contract with a provider, a plan must provide a written notice of the termination to enrollees who are at that time receiving a course of treatment from that provider or to enrollees who are designated as having selected that provider for their care. The notice must include instructions on selecting a new provider. The bill requires a plan that relies on providers to have a process in place to assure that patients who do not have a provider have access to medical care, including specialists. If an enrollee has not been notified of termination, the enrollee is not required to have the approval of a provider to authorize a referral within the plan, and all self-referrals within the plan shall be approved for a period of 60 days from the date of the termination of the enrollee's provider or until a provider is assigned or chosen, whichever is earlier. This automatic approval does not apply if the enrollee's plan utilizes a process for automatically assigning enrollees to a provider, or if the enrollee otherwise has direct access to a provider. A plan may not retroactively assign an enrollee to a new provider to avoid financial responsibility for any enrollee self-referrals. The bill is not applicable to a health plan contract that provides benefits to enrollees through preferred provider contracting arrangements, if the health plan does not require the enrollee to choose a provider.

SB 1764 (CHESBRO) HEALTH CARE: ALCOHOL AND OTHER DRUG ABUSE: COVERAGE
Chapter 305, Statutes of 2000

Prior to being heard in the Senate Insurance Committee, the bill required health plans and insurers to provide coverage for the treatment of alcohol and other drug abuse or dependency. The bill was amended to require the Legislative Analyst to review: (1) existing data and research relating to the cost effectiveness of substance abuse treatment parity in health care service plans and disability insurance policies and report its findings to the Legislature; (2) existing research and survey a sample of health care service plans in order to report to the Legislature on the range and utilization of substance abuse treatment services offered by health care service plans and disability insurance policies in California and the impact on the costs of these services to the employer or employee; (3) existing information on private resources available statewide that provide alcohol and drug treatment services, survey and catalogue organizations statewide that provide alcohol and drug treatment, including community-based and faith-based organizations, and the number of clients served by these organizations, and report is findings to the Legislature.

SB 1814 (SPEIER) MEDI-CARE SUPPLEMENT REFORM
Chapter 707, Statutes of 2000

The bill requires the State Insurance Commissioner to annually prepare a rate guide which would provide information on all the Medicare supplement insurance policies and contracts which are sold in California. The guide is to be distributed through the Health Insurance Counseling Advocacy Program offices, upon request by telephone and on the State Department of Insurance's website. This bill makes several changes to existing Medicare supplement insurance policies including the extension of an open enrollment period to individuals under 65 years of age who are eligible for Medicare due to a disability. It also allows that a change in benefits provided by an employer-sponsored Medicare supplement insurance plan would trigger the right to a guarantee issue of an Medicare supplement insurance policy and expands the guarantee issue list of policies to include a plan which would provide a prescription drug benefit.

SB 2083 (SPEIER) HEALTH CARE SERVICE PLANS
Chapter 696, Statutes of 2000

The bill, when heard before the committee, provided clean-up and implementation language to assist the new Department of Managed Care and Financial Solvency Standards Board in implementing SB 260. However, the bill was completely re-written to expand the authority of San Mateo County to provide specified health care services.

SB 2046 (SPEIER) HEALTH CARE: PRESCRIPTIVE DRUG COVERAGE
Chapter 852, Statutes of 2000

Would prohibit health care service contracts and disability insurance contracts from excluding coverage for a drug prescribed for a chronic and seriously debilitating condition.

SB 2094 (COMMITTEE ON INSURANCE) DISABILITY INSURANCE: HEALTH INSURANCE: DEFINITION
Chapter 1067, Statues of 2000

The bill provides for technical clean-up language for the Senate's managed care reform bills of last year.

SB 2136 (DUNN) HEALTH CARE PROVIDERS: MULTIPLE AUDITS
Chapter 560, Statutes of 2000

The bill establishes, through the Department of Managed Care and the Quality Advisory Group, a uniform quality audit process for individual and group health care providers.

SJR 1 (SPEIER) MEDICARE COVERAGE
Chapter 63, Statutes of 1999

Memorializes the federal government to: (1) ensure that persons dropped by Medicare HMOs have access to other HMOs or Medigap policies that cover prescription drugs; (2) work with the states to assist these enrollees to obtain new Medicare coverage; and (3) rescind the determination that enrollees who are disabled and under 65 years of age are not guaranteed the same rights as older Medicare enrollees.

AB 12 (DAVIS) HEALTH CARE COVERAGE: SECOND OPINIONS
Chapter *531, Statutes of 1999*

Requires health care service plans and health insurers to provide or authorize second medical opinions.

AB 39 (HERTZBERG) HEALTH CARE COVERAGE: CONTRACEPTIVE DRUGS
Chapter *532, Statutes of 1999*

Establishes the Women's Contraception Equity Act, which requires health care service plan contracts to cover prescription contraceptive methods.

AB 55 (MIGDEN) HEALTH CARE COVERAGE: INDEPENDENT MEDICAL REVIEW
Chapter *533, Statutes of 1999*

Establishes an independent medical review system (IMRS) for unresolved consumer complaints against health plans and health insurers.

AB 78 (GALLEGOS) HEALTH CARE COVERAGE: DEPARTMENT OF MANAGED HEALTH CARE
Chapter *525, Statutes of 1999*

Transfers responsibility for the implementation of programs to the Department of Managed Care in the State Business, Transportation, and Housing Agency, established pursuant to the bill, and makes conforming changes. Establishes in the State Department of Managed Care an Advisory Committee on Managed Care to assist and advise the director of the State Department of Managed Care on various issues. Establishes in the department an Office of Patient Advocate, in order to provide educational material to plan enrollees and to render advice and assistance to enrollees.

AB 88 (THOMSON) HEALTH CARE COVERAGE: MENTAL ILLNESS
Chapter *534, Statutes of 1999*

Requires a health care service plan contract or disability insurance policy to provide coverage for the severe mental illnesses of a person of any age, and for the serious emotional disturbances of a child.

AB 136 (MAZZONI) DRUG PARAPHERNALIA: CLEAN NEEDLE AND SYRINGE EXCHANGE PROJECTS
Chapter *762, Statutes of 1999*

Exempts from criminal prosecution public entities and their agents and employees who distribute hypodermic needles on syringes to participants in clean needle and syringe projects authorized by the public entity pursuant to a declaration of a local emergency due to the existence of a critical local public health crisis.

AB 215 (SOTO) HEALTH CARE COVERAGE
Chapter *530, Statutes of 1999*

Places a moratorium on the State Department of Corporation's authority to issue health plan licenses with waivers or limited licenses.

AB 285 (CORBETT) HEALTH CARE COVERAGE: MEDICAL ADVICE SERVICES
Chapter *535, Statutes of 1999*

Requires any in-state or out-of-state business entity engaged in the business of providing telephone medical advice services to a patient in California to be registered with the Department of Consumer Affairs (department).

AB 525 (KUEHL) HEALTH BENEFITS
Chapter *347, Statues of 2000*

Requires a health care service plan, a disability insurer, and a Medi-Cal managed care plan to provide a specified written statement to potential enrollees informing them that: (1) some hospitals and other providers do not provide reproductive health services and, (2) specified contacts can assist in ensuring needed health care services.

AB 549 (GALLEGOS) HOSPITAL MORTGAGE INSURANCE
Chapter *825, Statutes of 1999*

Permits the Office of Statewide Health Planning and Development, at the request of a hospital, to commission an independent study of market need and feasibility, as required for participation in federal mortgage insurance programs. The costs of a study will be paid for by the requesting hospital.

AB 892 (ALQUIST) HEALTH CARE SERVICE PLANS: HOSPICE CARE
Chapter *528, Statutes of 1999*

Adds hospice care to the basic health care services required to be provided by health care service plans (except specialized plans) which are issued, amended or renewed on or after January 1, 2002, and requires the State Department of Corporations to adopt regulations, as specified. Requires the State Commissioner of Corporations to adopt regulations for hospice care and requires an annual report by the Commissioner each January 15th, starting in the year 2002, of changes in federal systems that require a change in state regulations for hospice care.

AB 918 (KEELEY) HEALTH CARE SERVICE PLANS
Chapter *1043, Statutes of 2000*

The bill, when heard by the committee, required health care service plans to annually update the actuarial report required by regulations, and required the report to contain an opinion of a qualified actuary as to whether the capitation payments to providers are computed appropriately. However, the bill was completely re-written to deal with energy issues.

AB 936 (REYES) HEALTH CARE COVERAGE: MEDICARE SUPPLEMENT COVERAGE
Chapter *716, Statutes of 1999*

Provides additional open enrollment opportunities for Medicare beneficiaries who have been terminated by their Medicare managed care health plans.

AB 1015 (GALLEGOS) MEDI-CAL ELIGIBILITY
Chapter *946, Statues of 2000*

The bill requires the Managed Risk Medical Insurance Board (MRMIB) to expand health coverage eligibility to the uninsured parents of children eligible for the Healthy Families Program; and requires this bill to be implemented only to the extent that federal financial participation is available and funds are appropriated specifically for this purpose.

AB 1032 (THOMSON) HEALTH COVERAGE: FEDERALLY RECOGNIZED CA INDIAN TRIBES
Chapter *701, Statutes of 2000*

The bill permits federally recognized Indian tribes to make participation payments on behalf of tribe members participating in the California Major Risk Medical Insurance Program (MRMIP) and the Access for Infants and Mothers Program (AIM).

AB 1049 (AANESTAD) HEALTH INSURANCE: DISABILITY INSURERS
Chapter *88, Statutes of 1999*

Requires disability insurers (health insurers) to indicate on policyholder identification cards whether a separate telephone number must be called to verify eligibility for benefits and coverage, and to provide a related written notice to policyholders.

AB 1419 (LONGVILLE) PLANS: REVENUES & EXPENSES
Chapter *523, Statutes of 2000*

The bill, when heard by the committee, would required the Department of Corporations to annually collect and publish data on revenues and expenses of health plans licensed and operating in California. However, the bill was completely re-written to deal with highways.

AB 1455 (SCOTT) INSURANCE: CLAIMS DISPUTE RESOLUTION
Chapter 827, Statutes of 2000

Prohibits a health care service plan from engaging in an unfair payment pattern in its reimbursement of a provider, authorizes the Director of the Department of Managed Care to investigate a report of this conduct, and authorizes the Director to impose sanctions on a health plan that has been found to have engaged in an unfair payment pattern.

AB 1465 (MACHADO) MULTIPLE EMPLOYER WELFARE ARRANGEMENTS: FILING REQUIREMENTS
Chapter *317, Statutes of 1999*

Extends the January 1, 2001, sunset date in current law authorizing multiple employer welfare arrangements (MEWAs) to January 1, 2004. In addition, the bill requires the state departments of Corporations and Insurance to submit an evaluation by January 1, 2002.

AB 2168 (GALLEGOS) HEALTH CARE COVERAGE
Chapter *426, Statutes of 2000*

It clarifies existing law to ensure that health care service plan enrollees with HIV or AIDS have access to a specialist. This provision sunsets on January 1, 2004.

AB 2327 (GALLEGOS) CONSUMER INFORMATION PROGRAMS: CONFIDENTIALITY OF COMMUNICATIONS
Chapter *139, Statues of 2000*

The bill would extend specified protections and immunities in existing law to the Health Rights Hotline, a program operated by the Center for Health Care Rights for another three years and also apply protections to six additional Health Consumer Assistance programs relating to discrimination and retaliation.

AB 2415 (MIGDEN) HEALTH CARE: HEALTHY FAMILIES PROGRAM: MEDI-CAL: ELIGIBILITY
Chapter *944, Statutes of 2000*

The bill deletes a requirement that Healthy Families Program (HFP) eligibility for children who are qualified aliens is dependent upon federal participation; provides that a child who is a qualified alien shall not be determined ineligible for HFP, solely on the basis of his or her date of entry into the United States, only to the extent funds are appropriated in the annual Budget Act.

AB 2537 (THOMSON) INSURANCE: PAYMENT OF CONTESTED HEALTH CARE CLAIMS: RECERTIFICATION OF DISABILITIES
Chapter *241, Statutes of 2000*

The bill makes specified changes regarding the payment of claims paid by disability insurers, and makes a technical Insurance Code change.

AB 2616 (MARGETT) HEALTH INSURANCE: PAYMENT OF CLAIMS
Chapter *844, Statutes of 2000*

The bill prohibits disability insurers from requesting information that is not reasonably necessary to determine liability for the payment of a claim and would require them to pay providers the cost, as specified, of duplicating all information they request in connection with a contested claim. The bill would also extend the sunset of, for one year, the exemption from the requirements of the Senior Insurance Law for direct response disability insurance.

AB 2900 (Committee on Health) Health care: Healthy Families Program: advisory panel
Chapter 945, Statues of 2000

The bill, when heard by the committee, corrected a technical drafting error related to the Healthy Families Program advisory panel members. However, the bill was completely re-written to deal with Medi-Cal.

AB 2903 (COMMITTEE ON HEALTH) HEALTH CARE COVERAGE
Chapter *857, Statutes of 2000*

The bill provides for technical clean-up language for the Assembly's managed care reform bills of last year.

LICENSING

SB 941 (SPEIER) INSURANCE: LICENSEES
Chapter *782, Statutes of 1999*

The bill allows the Insurance Commissioner to deny license applications for specified reasons, and requires the commissioner to suspend or revoke the license of an insurance agent convicted of specified federal crimes relating to insurance activities. It requires that all insurance records be open and available for inspection. It increases penalties for specified violations of insurance agent licensing laws, and specifies that these penalties would reimburse the commissioner for the costs of investigation, examining, and prosecuting the violation.

SB 1077 (BURTON) INSURANCE: AGENTS AND BROKERS
Chapter *753, Statutes of 1999*

Makes substantive changes to provisions of the Insurance Code relating to an insurer's authority to terminate or amend an agency or brokerage contract, and responsibility to provide compensation for or continue coverage under a policy subject to contract termination.

AB 393 (SCOTT) INSURANCE: PRODUCTION AGENCIES
Chapter *321, Statutes of 2000*

Reforms licensing law related to sales of insurance. Generally, the bill clarifies that insurers must obtain licenses for their solicitors, creates a limited license for sales of personal lines of insurance, creates a new credit insurance license, and makes exceptions to all of these new standards under specified circumstances.

AB 478 (COX) INSURANCE: SURPLUS LINE BROKERS: CERTIFICATES
Chapter *255, Statutes of 1999*

Exempts a surplus line broker certificate issued to an insurance purchaser as evidence of insurance through a non-admitted insurer from the requirements that apply to a certificate or verification of insurance coverage used in general lines of insurance. Requires that every non-admitted insurer submit a list of all California surplus line brokers authorized by the insurer to issue policies on its behalf in California and any additions to, or deletions, from that list with other currently required documents before the surplus line broker can place any coverage with such an insurer.

AB 509 (CALDERON) INSURANCE: AUTOMOTIVE LUBRICANT PRODUCT WARRANTIES
Chapter *238, Statutes of 1999*

Specifies that auto lubricant warranties are not automobile insurance.

AB 845 (MADDOX) INSURANCE COMMISSIONER: CEASE AND DESIST ORDERS
Chapter *260, Statutes of 1999*

(1) Authorizes the Department of Insurance to issue a cease and desist order against any person that transacts insurance business without a license; (2) Establishes a fine for violating a cease and desist order; and (3) Permits any person receiving a cease and desist order to have a hearing, as specified.

AB 2639 (CALDERON) INSURANCE: INSURANCE BROKERS
Chapter *1074, Statutes of 2000*

Requires an application for insurance submitted by an insurance broker to show that the person is acting as an insurance broker, and would make a presumption, for licensing purposes only, that the person is so acting if certain conditions exist.

LIFE, FIRE AND DISABILITY

SB 249 (JOHANNESSEN) VETERANS: FARM AND HOME PURCHASES: LIFE OR DISABILITY INSURANCE
Chapter *472, Statutes of 1999*

Requires the Secretary of the State Department of Veterans Affairs to conduct a study of the life and disability insurance coverage that is being provided for the purchasers of farm and homes under the Veterans Farm and Home Purchase Act to determine what other life and disability insurance is available that would provide equal or better coverage and a more equitable or lower cost to the purchasers. Requires that copies of the study be submitted to the Senate Committee on Veterans Affairs, the Assembly Committee on Veterans Affairs, and the fiscal committees from each house on or before January 1, 2000.

SB 374 (LEWIS) INSURANCE CLAIMS: PRIORITIES: LIFE INSURERS
Chapter *868, Statutes of 1999*

Clarifies the preference given to specified types of claims in liquidation proceedings conducted by the Insurance Commissioner.

SB 423 (JOHNSTON) INSURANCE: ANNUITIES AND SURPLUS LINES
Chapter *694, Statutes of 2000*

Permits life insurers to issue contracts containing guaranteed variable living benefits. This measure was introduced to enable the marketing of guaranteed annuity products by life insurance companies.

SB 439 (POOCHIGIAN) INSURANCE: FIRE AND CASUALTY BROKER-AGENTS AND LIFE AGENTS
Chapter *186, Statutes of 1999*

Makes technical, non-substantive changes to continuing education requirements applicable to insurance agents.

AB 2312 (HOUSE) TAXATION: INSURERS: GROSS PREMIUMS TAX
Chapter *614, Statutes of 2000*

Requires that insurers that do not include the premium tax in a quoted price for life insurance tell potential purchasers about the existence and amount of the premium tax.

LONG-TERM CARE

SB 475 (DUNN) LONG-TERM CARE INSURANCE: RATE GUIDE: DATA COLLECTION
Chapter 669, Statutes of 1999

Requires the Insurance Commissioner, in consultation with representatives of the Health Insurance Counseling and Advocacy Program, to annually prepare a consumer rate guide for long-term care insurance.

SB 738 (COMMITTEE ON INSURANCE) LONG-TERM CARE PROGRAM
Chapter *802, Statutes of 1999*

Extends until January 1, 2005 eligibility for the asset protections provided by long-term care policies purchased under the terms of the California Partnership for Long-Term Care Pilot program. The bill provides, in addition to the existing requirement that the State Department of Health Services certify long-term care policies and health care service plan contracts under the program, that the State Department of Insurance approve these policies and contracts.

SB 870 (VASCONCELLOS) LONG-TERM CARE INSURANCE
Chapter *947, Statutes of 1999*

Makes comprehensive, substantive changes to the long-term care insurance law that affects individual and group policy benefits and establishes and modifies marketing and disclosure requirements.

SB 898 (DUNN) LONG-TERM CARE & RENEWAL
Chapter *812, Statutes of 2000*

The bill, when heard by the committee, would establish a loss ratio/solvency standard for the Insurance Commissioner's review of premium increases for long-term care insurance. However, the bill was substantially re-written to require long-term care insurance premiums and specified policy conditions to be guaranteed renewable or non-cancelable, and require prior approval of the Department of Insurance before the insurance can be offered or the rate increased.

SB 2111 (DUNN) LONG-TERM CARE INSURANCE: RATE GUIDE: DATA COLLECTION
Chapter *560, Statutes of 2000*

The bill is a clean-up bill to SB 475 (Dunn) signed into law last year, which would make technical changes, including a revision of the Long-Term Care (LTC) consumer rate guide to consist of a rate history section and a policy comparison section.

MISCELLANEOUS

SB 641 (LEWIS) TITLE INSURANCE
Chapter *187, Statutes of 1999*

Requires out-of-state title insurers to meet the same requirements under state law that are applied to in-state title insurers. In addition, the bill requires investment of funds held in a title insurer's premium reserve accounts to meet the requirements of current law governing trust fund investments.

SB 1500 (BURTON) INSURERS: UNFAIR PRACTICES
Chapter *280, Statutes of 2000*

Requires the Insurance Commissioner to identify on a show cause order regarding unfair competition why a practice is unfair or deceptive.

SB 1528 (HUGHES) INSURANCE
Chapter *170, Statutes of 2000*

Increases from 5% to 10% the proportion of company assets that a California-based insurance company may invest in one or more subsidiaries. The bill also specifies that state law shall not preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons if the arrangements meet the standards governing transactions between registered insurers and their affiliates.

SB 2156 (JOHNSTON) INSURES: REBATES
Chapter *255, Statutes of 2000*

It expressly defines that a holder of an "extended reporting period policy or endorsement" ("tail coverage endorsement") is not a member of the issuing domestic mutual insurer ("mutual"). The tail coverage endorsement is issued only after the termination or expiration of a "claims made" insurance policy. A substantive amendment was made in the Assembly, subsequent to approval by the Senate Insurance Committee, which deleted language that would have changed the current requirement that all directors of a mutual be policyholders to requiring that only a majority of the board be policyholders.

AB 329 (SCOTT) INSURANCE: COMPENSATION: FEES
Chapter *883*, *Statutes of 1999*

Allows a liability insurer to review bills submitted for the defense of its Insured, but prohibits a liability insurer from compensating a reviewer based on (1) a percentage of the amount by which a bill is reduced, (2) the number of claims or cost of services for which the reviser has denied payment, or (3) an agreement that no compensation will be due unless one or more bills are reduced for payment.

AB 600 (KNOX) INSURANCE CLAIMS OF HOLOCAUST VICTIMS
Chapter *827, Statutes of 1999*

Enacts the Holocaust Victim Insurance Relief Act of 1999 which requires the State Insurance Commissioner to establish and maintain a registry regarding insurance policies issued in Europe to victims of the Holocaust during the Nazi period.

AB 905 (DUTRA) MORTGAGE GUARANTY INSURANCE
Chapter *10, Statutes of 2000*

Allows private mortgage insurers to insure home loans up to 100% of the fair market value of the real estate.

AB 1013 (SCOTT) STATE EMPLOYEES
Chapter *446, Statutes of 1999*

As heard by the committee, the bill dealt with health plan payments of claims by providers; however, the bill was later gutted and amendments were added relating to collective bargaining issues.

AB 1081 (CALDERON) INSURANCE: SURPLUS LINES
Chapter *498, Statutes of 1999*

Abolishes the sunset on a statute governing exceptions to when a nonadmitted insurer shall post a pre-answer bond.

AB 1456 (SCOTT) CREDIT INSURANCE: RATES
Chapter *413, Statutes of 1999*

Establishes credit insurance rates based on a target of a 60 percent loss ratio or any other loss ratio as may be dictated after applying factors contained in current law for all lines of credit insurance, including those for life, disability, involuntary unemployment, and property, by January 1, 2001. This bill also requires the Insurance Commissioner to annually make available to the public actual loss ratios.

AB 1979 (WESSON) INSURANCE: FALSE AND FRAUDULENT CLAIMS
Chapter *470, Statutes of 2000*

Exempts reinsurance contracts from the requirement of printing a statement advising that anyone who makes a false claim is guilty of a crime that may be subject to a fine and state imprisonment.

AB 1983 (KUEHL) FAIR PLAN: BRUSH HAZARDS
Chapter *323, Statutes of 2000*

Provides that if the FAIR Plan policy of a property owner would be subject to a brush surcharge solely because of an adjacent property owner's failure to comply with applicable laws and ordinances regarding brush clearance requirements, the surcharge will instead be imposed on the FAIR Plan policy of the adjacent property owner. The FAIR Plan is the Fair Access to Insurance Requirements Plan, an insurance industry reinsurance association that equitably distributes the responsibility for insuring property not insurable through the normal insurance market.

AB 2251 (COX) INSURANCE: SALES: INTERNET: DISCLOSURE
Chapter 211, Statutes of 2000

Requires insurance companies and insurance agents and brokers who advertise on the Internet to disclose their name, state, and license number.

AB 2265 (ARONER) END-OF-LIFE CARE
Chapter *578, Statutes of 2000*

Subject matter gutted after passage from committee.

AB 2594 (COX) INSURANCE FRAUD
Chapter *843, Statutes of 2000*

Increases fines for the crimes of running and capping insurance claims from the existing maximum fine of $10,000 per offense to a new maximum of $50,000 per offense.

AB 2905 (ASSEMBLY INSURANCE COMMITTEE) SURETY COMPANY RESERVE FUNDS
Chapter *141, Statutes of 2000*

Allows reserve accounts of surety companies from undertakings of bail to be maintained in U. S. government bonds, Treasury certificates, repurchase agreements and money market funds backed by the U. S., and other obligations for which the U. S. is pledged.

VETOED BILLS

DEPARTMENT OF INSURANCE

AB 481 (SCOTT) EARTHQUAKE INSURANCE

Would have established that in settlement agreements between the Department of Insurance and an insurer for unfair claims settlement practices, the Insurance Commissioner shall give first priority to policyholders, and the agreement may provide for remediation, payment to policyholders or both. Required that funds earmarked for consumer education be deposited in the Insurance Fund.

HEALTH INSURANCE

SB 114 (ESCUTIA) HEALTH CARE SERVICE PLANS: DISABILITY INSURERS: MEDICARE SUPPLEMENTS.

This bill would have required plans and insurers that offer Medicare supplement contracts (Medigap) on a guaranteed basis to any Medicare beneficiary whose coverage has been terminated by a managed care plan participating in the federal Medicare program, to also offer those Medicare supplement contracts on a guaranteed basis to Medicare beneficiaries eligible by reason of disability whose coverage is terminated by a managed care plan participating in the federal Medicare program, if no other participating managed care plan is available in the beneficiaries' geographic area. The premium rates for contracts offered to these beneficiaries who are 64 years of age or younger could not exceed the highest rate for covered beneficiaries who are 65 years of age under the same contract.

SB 1047 (MURRAY) HEALTH INSURANCE ACT OF 1999

Would have required a report to the Legislature by January 1, 2000, analyzing the feasibility of consolidating the Medi-Cal, Healthy Families, and the Access for Infants and Mothers (AIM) programs, and creating a single public insurance purchasing pool.

SB 1053 (POOCHIGIAN) HEALTH COVERAGE: CHOICE OF PROVIDERS

Would have required health care service plans to allow a patient to obtain covered services from any participating physician outside of the patient's service area for conditions that, in the opinion of the enrollee's primary care or treating physician, has a likelihood of causing death, loss of limb, or loss of vital bodily function.

SB 1630 (HAYDEN) ASSISTED REPRODUCTIVE TECHNOLOGY

This bill would have prohibited a licensed tissue bank from providing assisted reproductive technology procedures and services related to oocyte donation unless its medical directors met specified requirements. This bill would have required the State Department of Health Services to develop a standardized written summary regarding assisted reproductive technology and oocyte donation procedures that physicians and surgeons would be required to provide to their patients.

SB 1839 (SPEIER) PROSTATE CANCER – CLINICAL TRIALS

It would have required health care service plans and insurers to provide coverage for routine patient care costs for treatment in specified Phases II, III and IV clinical trials, provided the treatment is being provided for life-threatening prostate cancer and the physician recommends participation in the clinical trial. The payment rate for a participating or contracting provider would be at the agreed upon rate and, in the case of a nonparticipating or noncontracting provider, the payment rate would be at the rate the plan or insurer would pay to a participating or contracting provider for comparable services, as specified. Required that this bill not be construed to prohibit restricting coverage for clinical trials to participating or contracting hospitals and physicians in California.

AB 58 (DAVIS) HEALTH CARE PRACTITIONERS

Would have provided that any person who makes a decision regarding medical necessity or appropriateness that denies, significantly delays, terminates, or otherwise limits, in whole or in part any diagnosis, treatment, operation, or prescription without possessing at the time of so doing a valid, unrevoked, or unsuspended certificate to practice medicine is guilty of a misdemeanor.

AB 93 (CEDILLO) CHILDREN: HEALTH: HEALTHY FAMILIES PROGRAM: ELIGIBILITY

The bill would have deemed any child who is enrolled in the Food Stamp Program, California Special Supplemental Food Program for Women, Infants, and Children, the federal Head Start program or the federal School Lunch Program to have met the income eligibility requirements for participation in the Medi-Cal Program and the Healthy Families Program. The bill also would eliminate the Quarterly Status Reports (QSRs) for Medi-Cal eligibility.

AB 217 (WILDMAN) HEALTH CARE COVERAGE: MEDI-CAL

Would have directed the State Department of Health Services to develop risk-adjusted capitated rates for treatment of Medi-Cal patients with HIV.

AB 469 (PAPAN) MEDI-CAL: MANAGED CARE PLANS

Would have made enrollment in certain Medi-Cal managed health care plans voluntary for aged, blind and disabled recipients of the federal Supplemental Security (SSI) program and specified low-income infants and children, and allows Medi-Cal beneficiaries in the California Children's Services (CCS) program to disenroll from mandatory managed care if certain conditions are met.

AB 536 (REYES) HEALTH CARE: BONE MARROW TRANSPLANT

Would have appropriated $1.5 million from the General Fund to a fund in the State Treasury created by this Act for the purpose of paying for blood collection and testing to identify suitable bone marrow donors.

AB 726 (GALLEGOS, JACKSON, SOTO) HEALTH CARE SERVICE PLANS: CONVERSION FROM NONPROFIT TO FOR-PROFIT STATUS

It would have required the fair market value of a nonprofit health care service plan that converts to for-profit status to be directed to the Managed Risk Medical Insurance Board.

AB 754 (ARONER) MEDI-CAL: MANAGED CARE SERVICES

The bill would have required the Department of Health Services (DHS) to determine final capitation rates for Medi-Cal managed care plans (plans) in writing for all aid codes at least 60 days prior to the effective date of each new rate period.

AB 1226 (RUNNER) HEALTH CARE

The bill, when before the committee, would have require health care service plan contracts that cover prescription drug benefits to provide coverage for pain management medications for terminally ill patients and for patients diagnosed with intractable pain, as defined. However, the bill was completely re-written to deal with veterans homes.

AB 1363 (DAVIS) SCHOOL HEALTH CENTERS

Would have established a variety of guidelines and requirements for school health centers and allowed those which met required conditions to be included as traditional and safety net providers that can contract with health plans participating in the Healthy Families Program.

AB 1722 (GALLEGOS) HEALTH CARE SERVICE PLANS: PRESCRIPTION DRUG BENEFITS

The bill, when before the committee, would have prohibited increases in the co-payments for prescription drugs which are covered as part of continuity of care. However, the bill was completely re-written to deal with Medi-Cal.

AB 1974 (MIGDEN) HEALTHY FAMILIES PROGRAM

This bill would have required the Managed Risk Medical Insurance Board, in conjunction with other agencies, to (1) develop an informational document for employers to distribute to employees concerning Healthy Families Program and Medi-Cal for children programs; to (2) establish processes for premium payments through payroll deduction and electronic fund transfer, and (3) to conduct community outreach and education campaigns.

BILLS NOT SENT TO THE GOVERNOR

AUTOMOTIVE

SB 345 (HAYNES) INSURANCE: MOTOR CARRIERS OF PROPERTY: DEFAULT JUDGEMENTS
Died in Senate Judiciary

Would limit an insurer's liability for payment of a final default judgment against an insured "motor carrier of property" to those actions where the insurer has notice of the claim within 120 days after the date of entry of the default related to the claim.

SB 519 (LEWIS) AUTO INSURANCE: LIMITED COVERAGE POLICIES
Died in Senate Insurance Committee

Would permit "named insured only" auto insurance policies to be sold, as specified.

SB 749 (HUGHES) RENTAL CAR INSURANCE LIMITED LICENSES
Died in Assembly Appropriations

Would created a license for an individual who sells rental car insurance.

DEPARTMENT OF INSURANCE

SB 896 (SPEIER) INSURANCE TAXATION: ADMINISTRATION
Died on the inactive file

Would transfer the processing and auditing of insurance gross premiums tax returns from the Department of Insurance to the Board of Equalization and would provide an unspecified appropriation to BOE for 1999-00.

EARTHQUAKE

SB 622 (SPEIER) INSURANCE: INCEPTION OF LOSS
Died in the Assembly Insurance Committee

Would codify a holding of the California Supreme Court in **Prudential-LMI** relative to "inception of the loss," thereby formally stating in statute that a homeowner may reasonably be delayed in the discovery of earthquake damage but still receive payment for the damage under an earthquake policy

SB 1925 (SPEIER) CALIFORNIA EARTHQUAKE AUTHORITY REFORM
Died in Assembly Insurance Committee

Would require participating insurers in the California Earthquake Authority (CEA) to offer earthquake insurance when requested by a homeowner, as specified, would establish a minimum rating for reinsurers which may be used by the CEA, and would create numerous other changes relative to the finances and operations of the CEA.

HEALTH INSURANCE

SB 18 (FIGUEROA) HEALTH CARE
Died in the Assembly Health Committee

Would provide that health care service plans and certain health insurers may not deny or alter treatment or care ordered by a licensed health care professional (other than a licensed physician or surgeon) unless the person authorizing the denial is at least as qualified as the original treating professional. Additionally, this bill would provide that, in the most severe cases, care may not be denied unless the reviewing professional physically examines the patient. This bill would also require public disclosure of the processes plans and certain health insurers use to authorize or deny care.

SB 92 (HAYDEN) HEALTHY FAMILIES PROGRAM
Died in the Assembly Health Committee

Would ensure Healthy Families eligibility for otherwise qualified children who legally immigrate to the United States after August 22, 1996, and would expand the program's definition of resident to include children whose parents moved to the state for a job commitment or to seek employment.

SB 102 (SOLIS) CHILDREN: HEALTHY FAMILIES
Died in the Assembly Appropriations

Would make several changes to the Healthy Families Program, including raising the income eligibility ceiling to 250% of the federal poverty level and using net annual household income for eligibility purposes.

SB 107 (POLANCO) HEALTH CARE COVERAGE: HEALTHY FAMILIES AND MEDI-CAL PROGRAMS
Died in the Senate Appropriations Committee

Would make several changes to the Healthy Families Program, including raising the income eligibility ceiling to 300% of the federal poverty level and delaying the requirement for family contributions until the 13th month of enrollment.

SB 112 (FIGUEROA) CHILDREN: HEALTHY FAMILIES PROGRAM: MEDICAL PROGRAM
Died in the Assembly Health Committee

Would change the rules governing payment of medical care providers by making the Healthy Families Program the payor for specified services rendered through. The Child Health and Disability Prevention Program.

SB 169 (SPEIER) HEALTH CARE SERVICE PLANS: STATE SYSTEMS: CONTACT SERVICE AREA
Died in the Assembly Health Committee

Would prohibit CalPERS, MRMIB and the State Department of Health Services from contracting or renewing a contract with an HMO that (1) participates in the federal Medicare program and (2) terminated coverage for Medicare HMO enrollees, unless that plan offers Medicare HMO coverage throughout the plan's entire proposed contracted service area.

SB 173 (APLERT) DENATL SERVICES: ACCESS PROGRAMS
Died in the Assembly Health Committee

SB 173, when heard before the committee, would have authorized funding for independent health care ombudsprograms in southern, central, and northern California and would have required health care service plans to bear the costs of the programs. However, the bill was rewritten later to deal with regulation of consumer discount health care programs.

SB 217 (BACA) HEALTH CARE COVERAGE
Died in the Senate Appropriations Committee

Would have required HMOs to conduct annual surveys of enrollees to identify their satisfaction with the plan and to report the results on the internet. It would also have required the plans to make available on the internet the names, addressees, telephone numbers, and areas of specialty of the providers in the health plan.

SB 254 (SPEIER) HEALTH INSURANCE
Died in the Senate Appropriations Committee

Would establish an external, independent review system in the Department of Corporations and the Department of Insurance to review a plan's or insurer's decision to deny benefits.

SB 271 (SPEIER) HEALTH COVERAGE: CONTINUATION OF COVERAGE
Died in the Senate Insurance Committee

Would have required HMOs and health insurers to offer additional coverage to former employees age 55 who enrolled in the first 18 months of continuation benefits after ending employment. The option would have allowed the former employee to continue coverage until the initiation of Medicare coverage. The bill also would have allowed spouses of separated employees to participate in continuation coverage on the same basis as the employee spouse by removing the current 5 year limitation on the spouse's access to continuation benefits.

SB 292 (FIGUEROA) DENTAL: INDEPENDENT REVIEW SYSTEM
Died on the Inactive File

The bill, when heard before the committee, would establish an external, independent review system for dental services in the Department of Corporations and the Department of Insurance to review a plan's or insurer's decision to deny benefits. However, the bill was completely re-written to deal with health care professionals authorized to render second opinions.

SB 337 (FIGUEROA) EMERGENCY SERVICES AND CARE
Died in the Senate Insurance Committee

Would have prohibited the expenditure or allocation of more than 15% of an HMO's gross revenues for administrative costs. This provision would not have applied to plans with fewer than 25,000 covered persons. It would also have provided that money derived from investment of premium income would be deemed to be money derived from revenue obtained from subscribers or enrollees of the plan.

SB 362 (ALPERT) HEALTH CARE COVERAGE: OVARIAN CANCER
Died on the Senate Unfinished Business File

Would have specified that a Disproportionate Share Hospital (DSH) that submitted plans for an eligible capital project in accordance with defined requirements could have submitted alternative final plans for a revised capital project and would have qualified for supplemental reimbursement if certain conditions were met.

SB 385 (COMMITTEE ON INSURANCE) MAJOR RISK MEDICAL INSURANCE
Died in the Senate Insurance Committee

Would have provided that the terms of 3 MRMIB board members appointed in 1998 and 1999, and confirmed by the Senate, when appropriate, would have been extended on a one-time basis. The terms of 2 members would have been extended by one year and the term of one members extended by 2 years, and that the determination regarding which appointing power receives which term extension shall be accomplished by lottery.

SB 420 (FIGUEROA) MANAGED CARE
Died in the Senate Insurance Committee

Would establish the Department of Managed Care Oversight within the Health and Human Services Agency, and would transfer regulation of health care service plans from the Department of Corporations to the new agency.

SB 421 (FIGUEROA) HEALTH CARE COVERAGE: CLINICAL PRACTICE GUIDELINES
Died in the Senate Insurance Committee

If health care service plans or certain disability insurers develop or use clinical practice guidelines, this bill would require the guidelines to be based on enumerated criteria.

SB 422 (FIGUEROA) HEALTH CARE SERVICES PLANS: PRIOR AUTHORIZATIONS: DENIALS
Died on the Assembly Desk

Would require health care service plans to provide the name and phone number of the health care professional who is responsible whenever a health care provider's request for prior authorization to provide services is denied.

SB 468 (POLANCO) HEALTH CARE COVERAGE: MENTAL ILLNESS
Died in the Assembly Appropriations Committee

Would require health insurers to cover most forms of mental illness under the same rates, terms and conditions as applied to other medical conditions. It exempted from its provisions the Medi-Cal program and specialized health insurance, such as for dental or optical coverage.

SB 566 (ESCUTIA) SCHOOL HEALTH PROGRAM
Died in the Senate Appropriations Committee

The bill, when heard before the committee, would require Healthy Families and Medi-Cal participating health plans to contract with school-based health care programs and reimburse them for services. The bill would also require the Department of Health Services and the Managed Risk Medical Insurance Board (MRMIB) to allocate twenty percent (20%) of its budget for community outreach to school-based outreach programs conducted by schools. However, the bill was completely re-written to deal with a School Health Center Grant Program.

SB 743 (ESCUTIA) HEALTHY FAMILIES PROGRAM
Died in the Assembly Appropriations Committee

The bill, when heard before the committee, would expand eligibility for the Healthy Families Program to families whose gross annual income is equal to or less than 250% of the federal poverty level. However, the bill was completely re-written to deal with an application tracking mechanism for the Medi-Cal and Healthy Families programs.

SB 744 (ESCUTIA) Healthy Families Program
Died in the Senate Insurance Committee

Would require that a child's family have a gross annual household income equal to or less than 300% of the federal poverty level for purposes of eligibility for the Healthy Families program.

SB 880 (SPEIER) HEALTH CARE: SCREENING TESTS: REIMBURSEMENT
Died in the Senate Appropriations Committee

Would require health care service plans and disability insurers to reimburse health care providers for mammography and cervical cancer screening tests at a rate equal to or greater than the reimbursement paid by the Medi-Cal program for those services, and require Medi-Cal to reimburse at a rate no less than the Medicare rate of payment for screening mammography and to reimburse providers at cost for cervical cancer screening.

SB 1181 (KNIGHT) HEALTH CARE SERVICE PLANS: WITHDRAWAL FROM A SERVICE AREA
Died in the Assembly Appropriations Committee

The bill, when heard before the committee, would require the Department of Corporations to notice and conduct public hearings upon receiving notification from a health care service plan of its intention to withdraw from a service area, would make withdrawals under prescribed circumstances, a violation of law, and would establish notification requirements for health care service plans and reporting requirements for the Department of Corporations. However, the bill was completely re-written to deal with health care discount programs.

SB 1224 (SPEIER) HEALTH CARE SERVICE PLANS: REGULATIONS
Died in the Assembly Appropriations Committee

The bill, when heard before the committee, would repeal requirements that the Commissioner of Corporations and the Insurance Commissioner consult prior to the adoption of regulations applicable to health care service plans, nonprofit hospital service plans, and certain disability insurers. However, the bill was completely re-written to require businesses with more than 50 employees to provide health coverage to all full-time employees as a condition of obtaining state services contracts.

SB 1259 (BRULTE) HEALTH COVERAGE: DENTAL SERVICES: REGISTERED DENTAL HYGIENISTS IN ALTERNATIVE PRACTICE
Died in the Senate Insurance Committee

Would have required health care service plans that cover dental benefits to cover services rendered by a registered dental hygienist in alternative practice. The bill would have prohibited any plan providing dental benefits from denying membership to registered dental hygienists in alternative practice if membership is required in order for those services to be covered by the plan.

SB 1401 (SCHIFF) HEALTH CARE COVERAGE PLANS
Died in the Senate Insurance Committee

Would have corrected an erroneous section number assigned to Section 13933 of the Health and Safety Code, relating to health care service plans dealing with the responsibilities of a health care service plan with respect to disputed health care services for its enrollees.

SB 1821 (SHER) HEALTH PROGRAMS: ELIGIBILITY
Died in the Assembly Appropriations Committee

The bill would deem that children eligible for food stamp, WIC, or federal school lunch programs have met income eligibility requirements for the Medi-Cal and Healthy Families Programs.

SB 1922 (SPEIER) PRESCRIPTION CO-PAYMENT EQUITY
Died in the Senate Appropriations Committee

Would require a health care service plan that provides a prescription drug benefit to impose a uniform co-payment and supply limitation on all pharmacies which provide prescription drugs to enrollees.

SB 1993 (JOHNSTON) HEALTHY FAMILIES PROGRAM: COMMUNITY PROVIDER PLAN
Died on the Senate Inactive File

Would require that the Managed Risk Medical Insurance Board (MRMIB), for a two-year period, designate in each geographic area a community provider or plans that have at least 95 percent of the available traditional safety net providers, as determined by the board, in its provider network. If no participating health plans meet the threshold requirements, the plan that has the highest percentage of traditional and safety net providers in its network is to be designated ad the community provider plan. A participating plan that is not designed as a community provider plan in one year of the designation may be designated so in the second year if the plan is able to attain the 95 percent threshold.

SB 2007 (SPEIER) QUALITY IN HEALTH CARE: CONTRACTS ACT
Died in the Senate Appropriations Committee

Would have required the director of the Department of Managed Health Care to establish and maintain a system of receiving, reviewing, and acting on provider complaints. Specific complaints could have included current or proposed reimbursement methodology for health care services. The director would have been required to review, and approve or modify the contract terms within 60 calendar days. The bill would also have required the director to determine whether or not the terms of a contract compromised patient care and to deem those terms of the contract unenforceable. Providers or plans would have had the right to seek court review of a director's determination that a contract is unenforceable.

SB 2022 (SPEIER) HEALTH INSURANCE: COVERAGE EXCLUSIONS FOR PREEXISTING
Died in the Senate Insurance Committee

Would prohibit health plans and insurers that issue individual coverage from imposing a preexisting condition exclusion for pregnancy or maternity care

SB 2069 (PERATA) HEALTH CARE: UTILIZATION REVIEW
Died in the Senate Insurance Committee

Would require health plans and disability insurers that require utilization review or management to follow specified procedures, including communicating by facsimile decisions regarding the approval of requests by providers for health services to enrollees and insureds.

SB 2093 (COMMITTEE ON INSURANCE) DISABILITY INSURANCE: HEALTH INSURANCE: DEFINITION
Died in the Assembly Health Committee

Would define the term "health insurance" by the types of disability insurance policies included within the term and excluded from the term.

AB 138 (GALLEGOS) HEALTH CARE OMBUDSPROGRAM
Died in the Senate Appropriations Committee

Would require the Department of Corporations to fund several ombudsprograms to help consumers resolve grievances against health plans.

AB 142 (SHELLEY) HEALTH CARE SERVICE PLANS: COMPLAINTS
Died in the Senate Appropriations Committee

Would require the Department of Corporations and health care service plans to make additional efforts to assist consumers who have complaints against their health plans.

AB 368 (KUEHL) PERSONS: PROSTHETIC DEVICES
Died in the Senate Appropriations

Would have required health care service plans (health plans), disability insurers (health insurers), and the Medi-Cal program to provide coverage for prosthetic devices for individuals with low vision.

AB 440 (CORBETT) HEALTH CARE PROVIDERS: WITHHELD FUNDS
Died in the Senate Judiciary Committee

Would have prohibited any medical group, independent practice association (IPA) or health plan contract with a provider from containing a "withhold" provision unless the contract also discloses specified information regarding the criteria for withholding funds. Would specify applicable time periods for repayment of withholds to providers.

AB 573 (CARDENAS) HEALTH COVERAGE: DEAF & HEARING IMPAIRED PERSONS: AUDITORY PROSTHESS
Died in the Senate Appropriations Committee

Would have required health care service plans (health plans), disability insurers (health insurers), and the Medi-Cal program to provide coverage for auditory prostheses for hearing impaired persons.

AB 591 (WAYNE) HEALTH INSURANCE: COVERAGE FOR CLINICAL TRIALS
Died in the Senate Appropriations Committee

Would have required health care service plans (health plans) and disability insurers (health insurers) to cover specified patient costs associated with specified clinical trials for life threatening conditions or treatment in conjunction with studies related to the prevention, early detection or treatment of cancer if there is no clearly superior, non-investigational treatment alternative available.

AB 610 (JACKSON) HEALTH CARE COVERAGE: CHILDREN'S CANCER
Died in the Senate Appropriations Committee

Would require health care service plans and insurers to cover routine patient costs incurred during Phase II and Phase III clinical trials of children's cancer.

AB 691 (COMMITTEE ON HEALTH) HEALTH CARE COVERAGE: MEDICAL GROUPS: PHARMACEUTICALS
Died in the Senate Appropriations Committee

Would prohibit a health care provider organization from assuming financial risk from a health care service plan in providing or prescribing pharmaceuticals unless the provider organization meets specified conditions regarding contracting for and controlling the financial risk assumed.

AB 698 (CORBETT) HEALTH CARE SERVICE PLANS
Died in the Senate Appropriations Committee

Would direct the Department of Corporations to create a system to ensure the financial soundness of arrangements between health plans and risk-bearing provider groups.

AB 735 (KNOX) HEALTH CARE SERVICE PLANS: LATE PAYMENTS: PENALTY
Died in the Senate Insurance Committee

Would establish a mechanism to ensure that health care service plans and disability insurers provide timely payment of claims and basic information regarding contested claims and denials to health care providers.

AB 1388 (AANESTAD) SMALL EMPLOYER HEALTH COVERAGE: MEDICAL SAVINGS
Died in the Senate Insurance Committee

Would require the Managed Risk Medical Insurance Board (MRMIB) to enter into contracts to provide health care coverage through medical savings accounts (MSA).

AB 1621 (THOMSON) HEALTH CARE COVERAGE: PRACTICE OF MEDICINE
Died on the Assembly Floor

The bill, when before the committee, would clarify the definition of the practice of medicine, expedite health care service plan (plan) and Department of Corporations review of consumer complaints, expand the role of the Attorney General with regard to complaints against plans, and establish an independent medical review system for specified, unresolved consumer complaints against plans. However, the bill was completely re-written to deal with disproportionate share hospitals.

AB 1887 (CEDILLO) HEALTH INSURANCE: CALIFORNIA HEALTH INSURANCE PURCHASING POOL: EMPLOYERS
Died in the Senate Appropriations Committee

Would establish a pilot program in San Diego County for the Healthy Californians Program, which would have provided health care coverage through a purchasing pool for employees of small employers, and the employees' dependents aged 19 and over. It would also have provided for a state subsidy of 50 percent of the premium for employees with household incomes of less than 250% of the federal poverty level and those employees over 250% would share equally in the costs.

AB 2261 (ZETTEL) HEALTHY FAMILIES PROGRAM: APPLICATION ASSISTANCE
Died in the Senate Insurance Committee

Would allow participating health plans to provide direct application assistance in Medi-Cal and Healthy Families.

AB 2299 (GALLEGOS) HEALTHY FAMILIES: DENTAL AND VISION BENEFITS: ELIGIBILITY
Died in the Senate Appropriations Committee

Would make the Healthy Families Program dental and vision benefits available to children who meet HFP family income eligibility criteria, but are ineligible because they already are covered by a health plan that does not provide these benefits.

LICENSING

SB 1017 (LEWIS) INSURANCE LICENSING
Died on the Senate Inactive File

Would delete the provision of the Insurance Code that exempts broker/agents licensed prior to 1992 from specified educational requirements as a condition of licensure. Double joined with AB 393.

AB 274 (BALDWIN) VETERANS: HOME AND FARM PURCHASES: LIFE AND DISABILITY INSURANCE
Died on the Assembly Inactive File

Would require the Secretary of the State Department of Veterans Affairs to conduct, or cause to be conducted, an actuarial study of the life and disability insurance coverage for veterans who purchase farms and homes under the Veterans' Farm and Home Purchase Act of 1974.

MISCELLANEOUS

SB 539 (FIGUEROA) DELINQUENCY, ADMINISTRATIVE SUPERVISION
Died in the Senate Appropriations Committee

Would enhance the authority of the Department of Insurance to seize and conserve the assets of insolvent or delinquent insurers. The bill would require officers and agents of insolvent insurers to cooperate with the Commissioner in insolvency proceedings, allow the Commissioner to file claims on behalf of policyholders, and require persons possessing property or records concerning the insolvent insurer to provide such items to the Commissioner.

SB 769 (JOHNSON) INSURANCE: TITLE POLICIES: RATES
Died in the Senate Insurance Committee

This was a spot bill.

SB 1738 (HAYDEN) CONSUMER PROTECTION: INSURANCE AND HEALTH CARE: CONSUMER PROTECTION
Died in the Senate Appropriations Committee

Would create the Insurance Policyholder and Patient Association, a nonprofit consumer-based association to protect and advocate on behalf of policyholders and patients regarding insurance and health care issues. The bill would also require the Department of Motor Vehicles (DMV) and insurers to mail membership information to consumers in regular vehicle registration or other mailings.

SB 2168 (POLANCO) TITLE INSURANCE: TITLE INSURERS
Died in the Assembly Insurance Committee

Would prohibit any person or entity that generates hazard disclosure statements from providing compensation or other inducements to real estate agents in exchange for the referral of customers, prohibits real estate agents from receiving any compensation or inducement for referring customers to persons who sell natural hazard disclosure statements, and expands the definition of “title business.

AB 374 (CUNNEEN) INSURANCE: DIGITAL SIGNATURES
Died in the Senate Insurance Committee

Would require the Insurance Commissioner to develop standards to permit digital signatures and public keys for use in insurance contracts.

AB 2215 (ASHBURN) TITLE INSURERS: SALE OF REAL ESTATE-RELATED PRODUCTS AND SERVICE
Died in the Senate Insurance Committee

Would: (1) authorize title companies and title insurers to undertake and insure the search of public records that set forth the specific boundaries of governmentally-created zones, districts, maps, or other delineated areas affecting property; and (2) allow title insurers to insure or indemnify the accuracy of information contained in natural hazard disclosure reports.

1999 -2000 INFORMATIONAL HEARINGS

The Senate Insurance Committee held 17 informational hearings during the 1999-2000 Session. Key issues examined included the Insurance Commissioner's settlement practices; the financial problems of medical groups; the erosion of prescription drug benefits for seniors, the medically uninsured and auto insurance fraud. Contact the Committee for copies of hearing reports. Hearings marked with an * are available for view on the committee's website.

DEPARTMENT OF INSURANCE OVERSIGHT HEARING
February 25, 1999

Insurance Commissioner Quackenbush and senior management of the Department of Insurance (DOI) responsible for agent and insurer licensing, field audits and enforcement responded to questions from the committee regarding the costs of auto insurance, agent abuses of insureds, bad faith by insurers, financial constraints on the Department of Insurance, earthquake insurance problems, and related issues. Legislation sparked by this hearing, passed and signed into law by the Governor, resulted in increased funding for consumer service functions of the DOI, improved funding to fight auto insurance fraud, a crackdown on rogue agents, low cost auto insurance, and legislation to ensure the rights of earthquake policyholders after a quake.

MEDPARTNERS PROVIDER NETWORK, INC.
March 10, 1999

The Senate Insurance Committee held an informational on March 10, 1999, for the purpose of providing an update on the status of the seizure by the Department of Corporations of MedPartners Provider Network, Inc. (MPN), a licensed limited Knox-Keene health care service plan. Of immediate concern to the committee was the effect the seizure and continued day-to-day operations were having on the delivery of health care services to its 1.3 million enrollees, and the payment of providers providing services to those enrollees.

INDEPENDENT MEDICAL REVIEW
August 12, 1999

The purpose of this hearing was to take testimony from health care experts in other states that use independent medical review (IMR). In brief, these experts were asked to explain what aspects of IMR work and which do not work so that California might learn from their experiences and craft effective IMR legislation. All 50 states require plans to operate a grievance system where patients may appeal denial of care decisions. In addition to that grievance process, many states have recognized the importance of providing patients with access to further appeals denied services to an IMR system.

CALIFORNIA EARTHQUAKE AUTHORITY
October 13, 1999

The committee examined the California Earthquake Authority to determine if it is fulfilling the original intent of the legislation. Policies in force have plummeted since the CEA was created, and there remain issues outstanding about its finances. CEA CEO David Knowles answered questions regarding these issues, as well as about the scope of coverage under a CEA policy, the CEA's coverage vs. coverages available prior to the Northridge quake, and he also gave an overview of the CEA's seismic retrofit program. A committee report is due in January.

RETROFITTING HOSPITALS
October 13, 1999

The American Red Cross testified that a major earthquake along the combined segments of the Hayward Fault would dislocate 370,000 people and render 150,000 homes uninhabitable--80 percent of the displaced people would be from multi-family dwellings. The importance of retrofitting homes to minimize damage from an earthquake was emphasized.

Witnesses discussed ways to improve the attractiveness of a California Earthquake Authority (CEA) policy as a product that homeowners can depend on to financially protect property against earthquake damage. Much of the testimony concerned the untested ability of the CEA to pay claims and the fact that there are less than 900,000 policyholders.

The seismic safety standards of SB 1953 were discussed with state regulators explaining compliance details while hospital representatives said the high cost of compliance, estimated at as much as $24 billion, could bankrupt many hospitals.

AUTO BODY FRAUD *
October 27, 1999

Auto body fraud costs California consumers over $500 million annually, according to Bureau of Automotive Repair officials who testified that 40 percent of the work they inspect is fraudulent. The percentage of auto body work inspected by insurers varies greatly among carriers with a low of ten percent to a high of 58 percent. Insurer direct repair programs were hailed as money savers for insurers and consumers but blasted as " pressure points " that promote fraud. Also California has over two million " junk " or " prior salvage " vehicles on the road today--some of these vehicles are unsafe to drive, stated witnesses. A full report with legislative recommendations was issued in January 2000.

AUTO INSURANCE FRAUD AND THEFT *
November 1, 1999

The scale and scope of auto insurance fraud and theft, their relationship to violent crime and drug trafficking, the inadequacy of regulatory efforts by occupational licensing agencies, needed changes in existing law, and improvements in the operations of state agencies were all discussed at this hearing. The legislative recommendations from this hearing and the auto body fraud hearing were carried in SB 1988 (CH. 867, Statutes of 2000).

THE MEDICALLY UNINSURED
December 8, 1999

Health care experts testified that California has 7 million uninsured; i.e., 1 in 4 residents are without health insurance. Eighty four percent (84%) of the uninsured are in working families and seventy percent (70%) are in poor families at or below 200% of the Federal Poverty Level. California's figures compare unfavorably to the states who have instituted comprehensive state actions to expand coverage to the uninsured.

To study solutions to California's uninsured problem, the hearing was divided into four study segments; Health Care Costs in the U.S. and California, An analysis of California's Uninsured, California's Uninsured Children and California's Working-Poor Uninsured and a Low Cost Basic Health Policy. Key points made were as follows:

- Although national health expenditures have plateaued in recent years, they are now expected to increase again which will raise premiums differentially depending on the type of plan and employer. Rising costs are due largely to inflation, technological change, pharmaceutical costs and the salaries of health care workers.
- According to UCLA researchers, California's uninsured have been increasing at a rate of 50,000 per month. Compared to the rest of the US, California's job-based coverage is lower and its uninsured rate is higher. Medi-Cal coverage has fallen faster than job-based insurance has risen, leaving more uninsured. Most of the uninsured (70%) have family incomes below 200% of poverty (less than $27,000 for a family of 3).
- Solutions focused on revamping and consolidating the current Medi-Cal and Healthy Families programs to create a simple seamless approach to governmental coverage. There was discussion on the worth of subsidized programs for small employers with low wage earners

ACCESS TO HEALTH INSURANCE IN RURAL AREAS
January 19, 2000

Witnesses testified regarding unique obstacles to health care access in rural areas. Programs to improve access were described. Statistics were presented about the decline of access to affordable health insurance in the rural counties of California. Testimony was then given by providers and patients about their personal experiences with the unique problems in the rural counties that make access to care more difficult than in the urban counties. Options were then explored for solutions at the county, state and federal levels.

CALIFORNIA'S HOSPITAL EMERGENCY ROOM CRISIS
March 22, 2000

Witnesses testified that hospital emergency rooms in California are overwhelmed, underfunded and dangerous**.** Medical directors claimed that health plans failed to pay for certain services while plan representatives disputed the charges, claiming that they were billed improperly. Parties agreed to review disputed bills.

NORTHRIDGE EARTHQUAKE CLAIMS *
May 10, 2000

Over 300 Northridge area residents attended a town hall hearing on the failure of insurers to honor earthquake policies related to the 1994 Northridge earthquake. The committee eventually worked with over 100 homeowners in an attempt to have their claims reviewed by either their insurer, or the Department of Insurance.

OVERSIGHT HEARING ON THE DEPARTMENT OF INSURANCE'S SETTLEMENT PRACTICES *
May 23, 2000

Witnesses informed the committee about how insurers were directed by the Commissioner to pay private vendors or nonprofit foundations as a condition of settling disputes related to credit insurance, the Northridge earthquake and title insurance. The Commissioner and his staff left the hearing before completing their testimony. Witnesses testified that the foundation funded with earthquake settlement monies gave grants to projects with no connection to earthquakes while bona fide earthquake projects had their grant applications ignored or rejected. The hearing issues are included in the committee's report, Department of Insurance: In Rubble After Northridge. The report documents that the Commissioner abused the power of office.

CONTINUATION OF OVERSIGHT HEARING ON THE DEPARTMENT OF INSURANCE'S SETTLEMENT PRACTICES *
June 5, 200

The Commissioner and his staff answered queries regarding settlement negotiations with insurers over earthquake and title insurance matters. They claimed that the settlements reached were consistent with the disputed market conduct practices despite staff recommendations calling for more significant monetary penalties. Insurers testified regarding the tactics used by the Department to reach a settlement. The hearing issues are included in the committee's report, Department of Insurance: In Rubble After Northridge. The report documents that the Commissioner abused the power of his office.

ACTING INSURANCE COMMISSIONER CLARK KELSO'S FIRST 30 DAYS *
August 9, 20000

The acting commissioner provided the committee with his transitional plan following the resignation of Commissioner Quackenbush on July 10, 2000.

HOW CAN THE STATE PROTECT SENIOR CITIZENS FROM DWINDLING PRESCRIPTION DRUG BENEFITS?*
October 24, 2000

This hearing, held in Los Angeles at the nation's largest senior citizens living center, explored the obstacles confronting seniors in need of prescription medicines. The committee heard testimony from seniors about the critical choices of either paying for food and electricity versus buying their medications. The HMOs presented their perspective about why they are having to reduce the prescription benefits in the Medicare HMO plans, including not covering any brand name medications. The Department of Health Services also reported on the status of SB 393 which provides that seniors pay no more than the Medi-Cal price for their medications.

IS THE CALIFORNIA EARTHQUAKE AUTHORITY (CEA) ENOUGH?*
November 2, 2000

This hearing was held in Napa, an area stuck by a mild earthquake two months earlier. Claimants testified that their earthquake policies (CEAs) were too limited to be of any financial assistance. The committee worked with local assistance officials to help clear up misunderstandings with claimants. Numerous suggestions were made to improve the CEA policy and earthquake assistance in general. The suggestions included making the CEA policy easier to understand, offering a policy with lower deductibles and lower prices, and offering a limited policy to cover parts of a house most likely to be damaged. Discussion also centered on ways to accelerate the claims settlement process.

DWINDLING PRESCRIPTION DRUG BENEFITS FOR SENIORS—PART II*
November 29, 2000

At San Francisco City Hall, drug manufacturers testified regarding the reasons why their medications cost more in California than in other countries. Options for reducing the cost of prescriptions for seniors were explored. The pharmaceutical industry presented arguments to explain the explosive costs of medications in the context of them enjoying profits and engaging in direct-to-consumer advertising. Testimony was also given to explore the various existing state and federal programs that could be used or expanded to provide prescription coverage for seniors and the uninsured.