SENATE COMMITTEE ON INSURANCE

2001 – 2002 LEGISLATIVE SUMMARY

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December 19, 2002

Dear Colleague:

In the 2001-2002 Session, the Senate Insurance Committee approved, and the Governor subsequently signed, significant legislation dealing with a wide range of topics, including health insurance, the Healthy Families Program, low cost automobile insurance, homeowners insurance, and reforms in the operation of the Department of Insurance. The committee held eleven informational hearings on subjects of importance to consumers. The topics covered were personal privacy issues related to access to medical and financial information, Medicare HMO "pullouts" from various counties, dangerous vehicles declared "salvage" by insurers yet returned to the roads, auto body repair fraud, Healthy Families, the state of health insurance, hospital seismic safety compliance, Zurich American and its failure to pay a claim for damage to the State Capitol, financial surveillance of insurance companies, the Department of Managed Health Care and its oversight priorities, and mold and terrorism exclusions from insurance policies.

The operations of the Department of Insurance also came under close scrutiny as legislation was evaluated by the committee. Throughout the committee's hearings about bills, a "reality check" was performed on the department's representations and capabilities. This reality check was necessitated by past abuses of departmental authority. While it is always appropriate for a committee of the Legislature to ask, "Can this department really do what this bill requires?" or "What is the department's current policy about the topic in this proposed new law," the Senate Insurance Committee has a special duty to the People of California. Vigorous oversight of the business practices of the California Department of Insurance will remain a linchpin in the committee's efforts to ensure a *public benefit* outcome from departmental activities.

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 my personal thanks to members of the committee. Working together, we have created sound public policy on behalf of all Californians.

All the best,

Jackie Speier, Chair
Senate Insurance Committee

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AUTOMOTIVE

BILLS SIGNED INTO LAW

SB 81 (SPEIER) Chapter 95, Statutes of 2001

Allows victims of crime who are injured by their own car during the course of a crime, and who report the crime to police, to make a claim for their injuries under the uninsured motorist coverage of their automobile insurance policy.

SB 1427 (ESCUTIA/SPEIER) Chapter 742, Statutes of 2002

Extends, until January 1, 2007, two pilot low cost automobile insurance programs in the counties of Los Angeles and San Francisco, increases the income ceiling for eligible applicants to household incomes of up to 250% of poverty, reduces the price of a low cost automobile insurance policy to $347 per year in Los Angeles and $314 in San Francisco, effective March 1, 2003, if the Insurance Commissioner does not order a different price, includes medical coverage of $1,000 as a policy benefit, reduces the down payment for time payment to 15% of the policy cost, becomes operative along with SB 180 (Speier, Chapter 666, Statutes of 2002, extending the sunset of proof of insurance at registration), and makes related changes.

AB 1902 (REYES) Chapter 703, Statutes of 2002

Requires that insurers determine whether a child passenger restraint system was in use by a child during an accident and, if so, requires that insurers replace it.

AB 2012 (FROMMER) Chapter 749, Statutes of 2002

Specifies that a warranty agreement offered by the warrantor of a vehicle protection product in connection with the sale of that product is an express warranty and not automobile insurance if certain requirements are met.

BILLS VETOED

SB 689 (PERATA)

Would have permitted an insurer to offer a discount to applicants who could demonstrate that they had automobile insurance in force, with limited exceptions, over several years.

BILLS NOT SENT TO THE GOVERNOR

SB 1990 (BURTON) Held in Senate Insurance Committee

Would have required the Department of Insurance, in consultation with insurers and consumer groups, to conduct a study of the rate approval process to improve the expeditiousness of the rate approval process while ensuring sufficient opportunity for adequate review by the department. The bill would have required the department to report its findings to the Legislature on or before November 1, 2003.

AB 5 (CALDERON) Held in Senate Insurance Committee

Would have placed into statute an explicit prohibition on the use of credit scores and other consumer credit information by insurers when underwriting or pricing private passenger automobile and homeowners insurance. A prohibition currently exists through the operation of the more general provisions of Proposition 103. The bill would have created explicit civil penalties for violating its provisions.

AB 1488 (CHAVEZ) Held in Senate Insurance Committee

Would have permitted an insurer to offer a discount to applicants who could demonstrate that they had automobile insurance in force, with limited exceptions, over several years.

SB 1648 (SPEIER) Defeated on the Assembly Floor

Would have prohibited insurers from having a financial interest in an auto body repair shop.
Assembly Floor Vote: Ayes 34 and Noes 17 (41 votes needed to pass)

DEPARTMENT OF INSURANCE

BILLS SIGNED INTO LAW

SB 80 (SPEIER) Chapter 630, Statutes of 2001

Imposes the same conflict of interest code on the Conservation and Liquidation Office as exists for the rest of the Department of Insurance.

SB 1974 (POLANCO) Chapter 358, Statutes of 2002

Allows the Insurance Commissioner to approve insurance policies and associated materials written in a language other than English.

SB 2093 (SPEIER) Chapter 899, Statutes of 2002

Requires workers' compensation insurance carriers and their reinsurers to report to the Department of Insurance all reinsurance contracts and the amount of ceded coverage held by a reinsurer for each primary carrier. The law also allows the Insurance Commissioner to use a reinsurer's deposit if a primary carrier is insolvent, and the reinsurer refuses to pay claims. SB 2093 also eliminates bonds as a form of workers' compensation deposit, allows the Department of Insurance to recover from underwriters the costs of conserving and liquidating underwritten title companies, and is operative upon enactment of AB 2007 (Calderon, Chapter 431, Statutes of 2002- Miscellaneous section of this report). See also AB 1183 (Calderon), Miscellaneous section of this report.

AB 584 (COX) Chapter 415, Statutes of 2001

Allows foreign or alien insurers to sell stock to fire and casualty broker-agents without obtaining a permit from the Insurance Commissioner if certain conditions are met.

AB 931 (FROMMER) Chapter 336, Statutes of 2001

Prohibits the Insurance Commissioner from accepting using or benefiting from travels reimbursements or payments made to the Commissioner or the Department of Insurance from specified entities.

AB 1874 (HORTON) Chapter 108, Statutes of 2002

Authorizes the Insurance Commissioner to mail license renewal applications to rental car agents and credit insurance agents, as specified.

AB 2856 (CHAVEZ) Chapter 437, Statutes of 2002

Authorizes the Insurance Commissioner to issue a communications equipment insurance agent license to a communications equipment vendor. This licensing program would become operative only if the Commissioner determines that the department has the personnel positions needed to carry out the licensing mandates or the positions have been authorized in a budget act. However, the law could also become operative if the Commissioner receives 50 or fewer applications for licensure from communications equipment vendors between January 1, 2003 and April 30, 2003.

AB 2984 (CALDERON) Chapter 203 Statutes of 2002

Implements a California Department of Insurance alternative to the National Association of Insurance Commissioners Model Act for achieving National Association of Registered Agents and Brokers reciprocity under the federal Gramm-Leach-Bliley Act. The law also establishes provisions regulating retail sales practices, solicitations, advertising, and offers of any insurance product or annuity to a consumer by a depository institution or any person engaged in those activities at the office of a depository institution or on behalf of a depository institution.

AB 3023 (COMMITTEE ON INSURANCE) Chapter 760, Statutes of 2002

Authorizes administrative law judges (ALJs) from the Department of Insurance to hear cases involving allegations of unfair competition or unfair practices under the Insurance Code and provides that these ALJs be insulated from supervision by either the legal branch of the Insurance Department or the Insurance Commissioner.

BILLS NOT SENT TO THE GOVERNOR

SB 834 (ESCUTIA) Held in Assembly Insurance Committee

Would have required insurers who sell homeowners insurance, commercial insurance or fire policies to annually submit to the Insurance Commissioner a record of loss experience, per exposure, for each geographic area, for examination, and a community service statement for each ZIP Code served by the insurer. The community service statement would have included a series of elements for auto policies, homeowner policies, and commercial policies. The bill also would have established a civil penalty of up to $15,000 for failing to comply with a data call or up to $30,000 per month, and $120,000 in the aggregate if the failure is willful.

SB 1679 (POLANCO) Held in Senate Appropriations Committee

Would have required every insurer to include information concerning community development investments in the annual report filed with the Insurance Commissioner. The bill would also have allowed insurers to advertise that they have made community development investments, as specified.

SB 1861 (ALARCON) Held in Assembly Insurance Committee

Would have required every insurer to include information concerning community development investments and charitable grants in the annual report filed with the Insurance Commissioner.

SB 1972 (POLANCO) Held in Assembly Insurance Committee

Would have permitted agents/brokers to place a low cost insurance policy with a non-admitted insurer domiciled in Mexico through a surplus line insurance broker for the sole purpose of covering the costs of shipment and burial of a deceased insured to Mexico.

AB 1384 (COX) Held in Senate Insurance Committee

Would have prohibited the Insurance Commissioner from accepting travel reimbursements or payments, except under certain conditions, from specified entities and individuals.

EARTHQUAKE

BILLS SIGNED INTO LAW

SB 708 (SPEIER) Chapter 727, Statutes of 2001

Expands an existing earthquake claims mediation program to include auto body and residential property claims, extends the life of the mediation program to 2006, requires the Department of Insurance to investigate consumer complaints filed with the department by attorneys, requires the department to make public the legal opinions of the Insurance Commissioner, places new limits on the "extraordinary circumstances" that insurers can invoke as a defense against a regulatory action for unfair claims settlement practices, and requires the department to develop training standards for earthquake claims adjusters by December 31, 2004.

AB 1118 (CORBETT) Chapter 895, Statues of 2001

Makes the funds in the California Residential Earthquake Recovery Fund available for expenditure until December 1, 2004, and appropriates the entire amount of funds not previously appropriated from that fund, not to exceed $1,500,000, to the Department of Insurance for purposes of the program.

BILLS NOT SENT TO THE GOVERNOR

SB 706 (SPEIER) Held in Assembly Appropriations Committee

Would have revised the definition of "available capital" to exclude unearned premiums (money needed to pay refunds to policyholders who cancel before the end of a policy period), and would have created an unearned premium reserve account to pay refunds to policyholders.

AB 940 (KEELEY) Held in Senate Judiciary Committee

Would have added two new voting members to the board of the California Earthquake Authority, would have required that existing reports also be sent to the Chairperson of the Assembly Judiciary Committee and the Joint Legislative Audit Committee, and would have required the Joint Legislative Audit Committee to review a seismic event report after a major earthquake.

AB 1182 (CALDERON) Placed on Assembly Inactive file

Would have allowed reinsurers of the California Earthquake Authority to use derivatives and other financial tools to expand the claims-paying capacity of the authority, would have indemnified reinsurers for their material misstatements that were based upon authority documents, and would have allowed other, broadly specified, forms of financial contracts to be used by the authority to expand its claims paying capacity.

HEALTH INSURANCE

BILLS SIGNED INTO LAW

SB 37 (SPEIER) Chapter 172, Statutes of 2001

This law requires health care service plans, Medi-Cal, and certain disability insurers to provide coverage for all routine patient care costs relative to the treatment of an enrollee or insured diagnosed with cancer and accepted in a clinical trial meeting specified requirements, if the enrollee's treating physician determines such participation has a meaningful potential to benefit the enrollee or insured.

SB 59 (ESCUTIA) Chapter 800, Statutes of 2002

The version of the bill in committee would have required the Department of Health Services and the Managed Risk Medical Insurance Board (MRMIB) to develop five demonstrations projects in urban or rural areas that expand on the Rural Health Demonstration Projects. After the bill left the committee, it was substantially amended. In its final form, this law requires MRMIB to report to the Legislature by January 30, 2004, if federal funding is attained, regarding new uses of federal State Children's Health Insurance Program funding for the provision of health coverage to children in vulnerable populations.

SB 283 (SPEIER) Chapter 667, Statutes of 2002

Eliminates the fraction of a first month's premium paid by a new enrollee in the Healthy Families Program.

SB 454 (INSURANCE) Chapter 277, Statutes of 2001

Defines the term "health insurance" and "specialized health insurance" by the types of disability insurance policies included or excluded within the definition.

SB 455 (INSURANCE) Chapter 328, Statutes of 2001

Allows for technical clean-up language for the health insurance bills of 2000.

SB 456 (SPEIER) Chapter 635, Statutes of 2001

Provides a statutory framework to create the Office of HIPAA Implementation to coordinate and guide statewide compliance with the federal Health Insurance Portability and Accountability Act.

SB 492 (SCOTT) Chapter 540, Statutes of 2002

As initially heard in committee, the bill would have added a dentist to the Advisory Committee on Managed Care and extended the deadline for publishing proposed regulations governing dental service plan uniform medical quality audits.

As passed by the Legislature, the law extends the exemption from clinic licensure requirements from January 1, 2003, to January 1, 2008, for specified clinics.

SB 493 (SHER) Chapter 897, Statutes of 2001

Creates an Express Lane Eligibility Program for the Women, Infants and Children program and for the Food Stamp program to expedite enrollment in Medi-Cal and Healthy Families.

SB 587 (SOTO) Chapter 897, Statutes of 2001

Requires general acute care hospitals to provide critically ill or terminally ill patients with a care summary prior to discharge.

SB 686 (ORTIZ) Chapter 790, Statutes of 2002

Changes the way the Department of Managed Health Care calculates administrative assessments on health care service plans.

SB 801 (SPEIER) Chapter 15, Statutes of 2002

The version of the bill heard before the committee would have required the Director of the Department of Managed Health Care, or the Insurance Commissioner, to assist in non-binding negotiations between a health care provider and a health care service plan or a disability insurer, when a new contract cannot be negotiated. The bill was later substantially amended to deal with health care facilities and women, infants and children's nutrition.

SB 1038 (POLANCO) Chapter 515, Statutes of 2002

The version of the bill heard before the committee would have allowed the Healthy Families Program to participate in the federal discounted bulk purchase of childhood vaccines. The bill was later substantially amended to deal with renewable energy.

SB 1092 (SHER) Chapter 792, Statutes of 2002

As initially heard in committee, the bill would have defined "grievance" to include any written or oral expression of dissatisfaction and would declare that where the plan is unable to distinguish between a grievance and an inquiry, the plan shall deem the matter to be a grievance.

As passed by the Legislature, the bill requires that the Director of the Department of Managed Health Care adopt regulations to establish the Consumer Participation Program, with expected grants to consumer advocacy groups of approximately $350,000 per year.

SB 1219 (ROMERO) Chapter 380, Statutes of 2001

Requires plans that cover the traditional Pap smear test to cover liquid-based tests to screen for cervical cancer.

SB 1411 (SPEIER) Chapter 880, Statutes of 2002

Prohibits a health care service plan and a health insurer from imposing a copayment or deductible for hospital maternity services that exceed the most common amount of the copayment or deductible imposed for services provided for other medical conditions.

SB 1531 (SPEIER) Chapter 555, Statutes of 2002

Allows a Medicare beneficiary to obtain a Medicare supplement insurance policy on a guaranteed basis if the Medicare+Choice plan (Medicare-HMO) reduces its benefits, increases the cost-sharing amount or discontinues a provider currently furnishing services to the individual.

SB 1877 (JOHNSON) Chapter 227, Statutes of 2002

Repeals the sunset date on legislation permitting qualified associations to offer their members a health care service plan, and allows these associations to pass administrative savings onto small business employers.

SB 1880 (MACHADO) Chapter 357, Statutes of 2002

Eliminates a sunset in existing law, thereby continuing State regulation of Multiple Employer Welfare Benefit Arrangements, increases the amount of cash surplus these organizations must maintain in order to be eligible for certification, and requires these organizations to annually file an actuarial opinion with the Insurance Commissioner.

SB 1913 (INSURANCE) Chapter 793, Statutes of 2002

Requires the Department of Managed Health Care and the California Department of Insurance to maintain a joint senior-level working group to ensure clarity so that health care consumers know who enforces the rights of consumers and so that department regulations are internally consistent.

SB 2010 (ALPERT) Chapter 1086, Statutes of 2002

As heard in committee, the bill would have exempted consumer discount health plans from the provisions of law related to physician referrals.

As passed by the Legislature, the bill authorizes the State Tax Credit Allocation Committee to become the State's Commercial Revitalization Agency to administer the Federal Community Renewal Tax Relief Act of 2000.

AB 59 (CEDILLO) Chapter 894, Statutes of 2001

Deems a child enrolled in the Food Stamp, Head Start or Women, Infants and Children programs eligible for Medi-Cal or Healthy Families Program (HFP), and creates a process to grant Medi-Cal eligibility to a child, and to his or her family, if the child is eligible for the free School Lunch Program. The bill would also direct the Department of Health Services and Managed Risk Medical Insurance Board to develop a process to streamline the Medi-Cal and HFP application and enrollment process for children participating in existing public programs serving low-income families.

AB 207 (MATTHEWS) Chapter 622, Statutes of 2001

Requires every health care service plan and disability insurer to issue to each of its enrollees and insureds a uniform card containing uniform prescription drug information, as specified.

AB 424 (THOMSON) Chapter 799, Statutes of 2002

Sunsets, with 3 exceptions, the Insurance Code requirements for conversion coverage for health insurance, and is a companion bill to AB 1401 (Thomson) that makes substantive changes to conversion coverage requirements.

AB 495 (DIAZ) Chapter 648, Statutes of 2001

Establishes the Children's Health Initiative Matching Fund (Fund). The law also authorizes county agencies, local initiatives, and county organized health systems to seek and obtain funds to provide comprehensive health insurance coverage to children in families whose incomes do not exceed 300 percent of the federal poverty level. These children are those who do not qualify for either Medi-Cal or the Healthy Families program. The law also authorizes the Managed Risk Medical Insurance Board (MRMIB) to administer the Fund and requires MRMIB and the State Department of Health Services (DHS) to coordinate activities necessary to achieve federal approval and funding for the program.

In addition, this law requires the participating local government entities to submit intergovernmental transfers to the Fund as the nonfederal matching requirement for federal participation in the federal State Children's Health Insurance Program. Finally, the law requires all administrative expenses of MRMIB and DHS to be paid from the Fund.

AB 760 (SHELLEY) Chapter 553, Statutes of 2001

Establishes the Pupil Athletic Access and Safety Program pilot project to provide grants to various private nonprofit organizations, in order to provide direct services and to promote pupil participation and safety in high school interscholastic athletics.

AB 938 (COHN) Chapter 817, Statutes of 2001

Requires a health care service plan to provide, upon request, a list of specified contracting health care providers within the enrollee's or prospective enrollee's general geographic area and adds additional information that health plans must provide on an existing disclosure form. This bill became operative July 1, 2002.

AB 1178 (CALDERON) Chapter 51, Statutes of 2001

Imposes the requirements of the Senior Insurance Law on direct-marketed health insurance products, and also extends by 90 days the July 1, 2001 deadline for compliance with long-term care insurance law.

AB 1282 (CARDOZA) Chapter 549, Statutes of 2002

Extends the geographic accessibility standard for a commercial health care service plan in counties with a population of less than 500,000 or those with less than two plans.

AB 1401 (THOMSON) Chapter 794, Statutes of 2002

Standardizes individual conversion health policies, provides uniform 36 month coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and Cal-COBRA, and creates a 3-year pilot program to expand access to coverage in the Major Risk Medical Insurance Program.

AB 1503 (NATION) Chapter 531, Statutes of 2001

Requires health care service plans to have a policy to enable enrollees to continue mental health treatment with their mental health treatment providers for a transitional period when their plan is switched by their employer.

AB 1795 (REYES) Chapter. 1056, Statutes of 2002

The bill was not heard in committee, was amended before the hearing, and then dealt with an unrelated topic.

AB 1860 (MIGDEN) Chapter 382, Statutes of 2002

Requires that female victims of sexual assault be provided information and services pertaining to emergency contraception.

AB 1996 (THOMSON) Chapter 795, Statutes of 2002

Requests the University of California (UC) to assess legislation proposing a mandated benefit or service, and to prepare a written analysis with relevant data on the public health, medical and economic impact of proposed health care service plan (health plan) and health insurance benefit

mandate legislation. Requires, for fiscal years 2002-03 to 2005-06, health plans and insurers to be assessed an annual fee in an amount determined through regulation to fund the actual and necessary expenses of UC in implementing this bill, and caps the total annual assessment on health plans and insurers at $2 million. Sunsets the provisions of this bill January 1, 2007.

AB 2052 (GOLDBERG) Chapter 336, Statutes of 2002

Prohibits a health care service plan or health insurer from making any change in premium rates or cost sharing after acceptance of a contract or after the annual open enrollment period.

AB 2085 (CORBETT) Chapter 796, Statutes of 2002

Allows an enrollee to file a grievance against his or her health care service plan using the plan's website, provided the plan has a website.

AB 2178 (GOLDBERG) Chapter 649, Statutes of 2002

Expands the definition of a "small business employer" to include employers of any size who are complying with local living wage requirements, and allows coverage for those employees who are subject to the living wage.

AB 2179 (COHN) Chapter 797, Statutes of 2002

Requires the Department of Managed Health Care to develop regulations to ensure enrollees have access to needed health care services in a timely manner.

AB 2420 (RICHMAN) Chapter 798, Statutes of 2002

Prohibits a health care service plan from requiring a health care provider to be at financial risk for injectable medications.

AB 2551 (NATION) Chapter 276, Statutes of 2002

Makes clarifying changes regarding continuity of mental health care.

AB 2907 (COHN/THOMSON) Chapter 925, Statutes of 2002

Establishes a "Health Care Providers' Bill of Rights" and prohibits certain provisions in contracts between health care service plans or health insurers and health care providers. Specifically, the law prohibits any contract issued, amended or renewed on or after January 1, 2003 between a health care service plan, or health insurer, and a health provider from containing a term that would allow the plan or insurer to unilaterally change a material term of the contract except under specified conditions, and otherwise not unless: 1) The contract requires at least 45 days' notice to the health care provider of the change; and, 2) The provision has first been negotiated and agreed to by the provider and the plan or health insurer.

AB 3048 (HEALTH) Chapter 760, Statutes of 2002

Makes several technical, conforming changes and corrections to the Health and Safety Code and the Insurance Code.

BILLS VETOED

SB 117 (SPEIER)

Would have prohibited a health care service plan from assigning to any entity the responsibility for payment of a claim for emergency services and care, unless the Independent Practice Association or medical group demonstrated to the Department of Managed Health Care that it paid those claims on a timely and fair basis.

SB 1413 (CHESBRO)

Was not heard in committee because it was substantially amended before the hearing and referred to another committee.

AB 142 (RICHMAN)

Would have prohibited a health care service plan contract from requiring or allowing a health care service provider to assume or to be at any financial risk for certain injectable medications.

AB 843 (CHAN)

As initially heard in committee, the bill would have allowed Medi-Cal applicants who have been enrolled in the last 14 months in a managed care plan to re-enroll with their same health care plan without being required to repeat the Medi-Cal managed care options process.

As passed by the Legislature, the bill would have required the Department of Health Services, when sufficient funding is available, to develop an electronic process to confirm information regarding the eligibility of a newborn child whose mother was receiving Medi-Cal benefits on the newborn's date of birth.

AB 937 (KORETZ)

Would have required, beginning July 1, 2002, health care service plans that cover hospital, medical and surgical expenses, and that pay their providers on a capitated basis, and the Department of Health Services, to develop risk-adjusted, capitated provider reimbursement rates for the treatment of human immunodeficiency virus (HIV) infected enrollees.

AB 1147 (THOMSON)

The version of the bill heard before the committee would have revised the notification requirement that all employers provide to their former employees about the availability of

continued health care coverage. This subject was dropped from the bill when the bill was later amended to appropriate $2.6 million from the General Fund to the Department of Health Services in support of county maternal and child health services.

AB 1451 (LIU)

Would have required the Secretary of the California Health and Human Services Agency to establish and chair a Long-term Care Financing Task Force and would have required the task force to report to the Legislature by September 1, 2002 on alternatives for financing long-term care insurance.

BILLS NOT SENT TO THE GOVERNOR

SB 103 (SPEIER) Held in Conference Committee

Would have required that if a health care service plan and provider cannot agree on a new contract, then the existing contract shall be extended until the insured's next open enrollment, and the terms of the extended contract shall be previously agreed upon.

SB 146 (HAYNES) Held in Assembly Appropriations Committee

Was not heard in committee because it was substantially amended before the hearing and thereafter dealt with another topic.

SB 279 (SPEIER) Held in Senate Insurance Committee

Would have required health care service plans that offer a plan that covers hospital, medical or surgical expenses to also offer a plan covering children's health services to families whose income are greater than 250% of the federal poverty level. The bill would also have specified the minimum plan benefits and set the maximum copayment for a child at $250 per year, and for a family at $500 per year. The bill would also have limited the monthly premium to $35 per child, to a maximum of $100 per family.

SB 458 (ESCUTIA) Held in Assembly Health Committee

Would have required health plans to file a copy of any advertisement with the Department of Managed Health Care.

SB 461 (TORLAKSON) Held in Assembly Health Committee

Would have established a Catastrophic Prescription Drug Insurance Program for specified retired members of the State Teachers' Retirement System.

SB 598 (CHESBRO) Held in Senate Insurance Committee

Would have authorized the Board of Administration of the Public Employees' Retirement System to employ or contract directly with doctors and medical groups, and would have allowed private employers to contract with the board to provide health benefit plans.

SB 599 (CHESBRO) Placed on Assembly Inactive File

Would have required health care service plans to provide coverage for substance-use disorders on the same basis as they would provide coverage for any other medical care.

SB 604 (VASCONCELLOS) Held in Assembly Health Committee

Would have created the Health and Wellness Promotion Advisory subcommittee within the Department of Managed Health Care Clinical Advisory Panel to advise the Legislature on revisions of medical testing and services believed to be appropriate for health promotion, and would have required health care service plans and disability insurers to provide a health promotion benefit, as specified, without a copayment.

SB 785 (ORTIZ) Held in Assembly Appropriations Committee

Would have allowed parents to enroll in the Healthy Families Program and Medi-Cal, would have adjusted the monthly family contributions as specified, and would have allowed the Managed Risk Medical Insurance Board to pay "reenrollment fees" for assisting subscribers in completing the annual eligibility review packet.

SB 1344 (HAYNES) Held in Assembly Appropriations Committee

Would have prohibited a health care service plan, health insurer or health provider from denying a patient request for coverage for treatment on the basis that it is futile. The bill was amended to require the Health and Human Services Agency to convene a work group to examine issues related to denial of life-sustaining health care.

SB 1354 (KUEHL) Held in Senate Insurance Committee

Would have required health care service plans, disability insurers and the Medi-Cal program to provide the same medical coverage concerning genetic diseases or medical conditions as are provided to an individual whose family medical history indicates a predisposition for a certain disease or medical condition. This bill's provisions were specifically limited to adults who were adopted, and for whom there is no medical history that predates the adoption.

SB 1414 (SPEIER) Held in Senate Appropriations Committee

Would have established the Healthy California Program to provide health insurance coverage to all citizens and legal immigrants residing in California.

SB 1461 (SPEIER) Held in Assembly Health Committee

As initially heard in committee, the bill would have provided for the regulation of a consumer discount health care program by the Department of Managed Health Care.

SB 1621 (SCOTT) Held in Senate Appropriations Committee

Would have required a health care service plan to make any change in premium rates or coverage only during the annual open enrollment period.

SB 1638 (SCOTT) Held in Assembly Health Committee

Would have required that health care service plans and health insurers provide coverage, up to $1,500, for hearing aids to all enrollees and subscribers under 18 years of age.

SB 1669 (CHESBRO) Defeated in Assembly

The version of the bill heard before the committee would have required a health care service plan to offer coverage in 4 counties which have no plans if the plan offers coverage in a county that has more than 3 plans. The bill was amended to declare the intent of the Legislature to implement recommendations of the Legislative Analyst's Office study concerning the operations of health care service plans in rural areas. Vote: Ayes 26, Noes 8. (41 votes needed to pass)

SB 1718 (VACONCELLOS) Held in Senate Insurance Committee

Would have required plans to reimburse a physician and surgeon at a reasonable rate for administering a Hepatitis B virus vaccination.

SB 1758 (FIGUEROA) Held in Assembly Health Committee

Would have required health care service plans and health insurers that received a rebate from a pharmaceutical company for brand name prescription medications over the prior 5 years to distribute those rebates to subscribers, as specified.

SB 1881 (SCOTT) Held in Senate Insurance Committee

Would have prohibited a non-contracted provider of emergency services from billing an enrollee or insured until the health care service plan or health insurer has been provided a complete claim and the plan or insurer has failed to promptly pay the claim.

SB 1912 (INSURANCE) Placed on Assembly Inactive File

Would have amended the current role of the Advisory Board to the Department of Managed Health Care to offer advisory assistance to the Center for Medicare and Medicaid Services if the Director determines there is a need to protect the safety of enrollees.

SB 1917 (CHESBRO) Held in Assembly Health Committee

The version of the bill heard before the committee would have required the Governor to request that the Secretary of the United States Department of Health and Human Services increase the payment rate for Medicare+Choice in all rural areas. The bill was later substantially amended to require a health care service plan to notify the Department of Managed Health Care at least 10 business days prior to filing a petition commencing a case for bankruptcy.

SB 1971 (POLANCO) Held in Assembly Appropriations Committee

Would have required the Department of Health Services and the Managed Risk Medical Insurance Board to convene a task force to develop a single page application that could be used to apply to the Healthy Families Program and the Medi-Cal program.

SB 2033 (SPEIER) Held in Assembly Appropriations Committee

Would have required a health care service plan or its subcontractor to provide every contracted emergency room with continuous emergency room on-call services for every specialty, and a list that delineates the name of that on-call specialist.

AB 32 (RICHMAN) Held in Senate Appropriations Committee

Would have expanded access to health insurance by reforming and consolidating Medi-Cal and the Healthy Families Program under the California Health Care Program.

AB 482 (CEDILLO) Held in Senate Insurance Committee

Would have allowed small employers to offer the Healthy Families Program (HFP) to all their employees. The small employer would have paid half of the HFP premium. The other half of the premium would have been paid by the State for employees with incomes below 250% of the Federal Poverty Level, and by employees if their incomes were above that level.

AB 684 (KEHOE) Held in Senate Insurance Committee

Would have allowed the director of the Department of Managed Health Care to make public all confidential financial information of a risk-bearing organization.

AB 1522 (THOMSON) Remained in Conference Committee

Would have required a provider organization to continue to provide healthcare services to patients for one year after its contract is not renewed with a health care service plan or disability insurer or be subject to disciplinary action and fines.

AB 1853 (KORETZ) Withdrawn from Senate Insurance Committee by the author, and committee agreed to holding hearing in 2003 on the topic of the bill.

Would have required the Department of Managed Health Care to hold hearings regarding risk-adjusted provider capitation rates for chronic health conditions, and would have required the Department to report its findings to the Legislature.

LIFE, FIRE, AND DISABILITY

BILLS SIGNED INTO LAW

SB 658 (ESCUTIA) Chapter 583, Statutes of 2001

Requires insurers to provide claimants with information about what constitutes unfair claims settlement practices, makes appraisal voluntary on the part of the insured, and makes voluntary appraisal applicable to policies originated on or after January 1, 2002.

AB 1180 (CALDERON) Chapter 102, Statutes of 2001

Requires commercial insurers and workers' compensation insurers to provide a premium and a loss history report within 10 business days of a written request authorized by the insured, when the policy is canceled or non-renewed or other conditions exist.

BILLS NOT SENT TO THE GOVERNOR

SB 1678 (POLANCO) Held in Assembly Insurance Committee

Would have defined the measure of recovery under an open fire policy.

AB 2169 (CHAVEZ) Held in Senate Insurance Committee

Would have reduced the minimum guaranteed interest rate on deferred annuities to 1 ½% for all deferred annuities originated in 2003 and 2004, and for the entire term of the contract.

LICENSING

BILLS SIGNED INTO LAW

SB 63 (SCOTT) Chapter 174, Statutes of 2001

Makes technical and clarifying changes to the law on limited licenses (AB 393 (Scott)-Chapter 321, Statues of 2000). Specifically, this bill: 1) Requires limited licenses for employees of insurers and producers, under specified circumstances; 2) Clarifies that an insurer may not rely upon a certificate of authority to avoid licensing employees who are otherwise required to be licensed; 3) Creates a credit insurer license; 4) Also provides for an exception to licensure with respect to officers, directors or employees of an insurer whose executive, administrative, managerial or clerical activities are only indirectly related to soliciting, negotiating or effecting the sale of insurance.

LONG-TERM CARE

BILLS SIGNED INTO LAW

SB 1613 (DUNN) Chapter 675, Statutes of 2002

Technical cleanup to SB 898 (Dunn), Chapter 812, Statutes of 2000. This bill clarifies that insurers may file new policy forms for long-term care policies for approval by the Department of Insurance after January 1, 2003.

MISCELLANEOUS

BILLS SIGNED INTO LAW

SB 1136 (POLANCO) Chapter 448, Statutes of 2001

Repeals the sunset clause in two sections of the Insurance Code governing the extent and manner in which surplus line or nonadmitted insurers can advertise in California.

AB 1183 (CALDERON) Chapter 296, Statutes of 2001

Allows the California Insurance Guarantee Association (CIGA) to increase for one year the premium paid by member companies from the current 1% of net direct written premium to 2%, thereby triggering an increase in the premiums paid on all lines covered by CIGA, and requires new audits of CIGA. See also AB 2007 (Calderon), below and SB 2093 (Speier), Department of Insurance section of this report.

AB 1193 (STEINBERG) Chapter 253, Statutes of 2001

Prohibits insurers from canceling or refusing to renew a policy of a religious or educational organization, or other nonprofit organization organized and operated for religious, charitable or educational purposes, solely on the basis that one or more claims has been made as a result of a hate crime committed against the person or property of the insured during the preceding five years.

AB 1486 (DUTRA) Chapter 429, Statutes of 2002

Allows private mortgage insurers to insure home loans up to 103 percent of the fair market value of the real estate. This bill applies to first and second mortgages.

AB 2007 (CALDERON) Chapter 431, Statutes of 2002

Extends the 2% California Insurance Guarantee Association (CIGA) cap through December 31, 2007, expands CIGA's board to include one public member approved by the President pro Tempore of the Senate, one public member approved by the Speaker of the Assembly, one public member appointed by the Insurance Commissioner, one labor member appointed by the Insurance Commissioner, and makes operation of this bill contingent upon enactment of SB 2093 (Speier, Chapter 899, Statutes of 2002). See also AB 1183 (Calderon) above, and SB 2093 (Speier), Department of Insurance section of this report.

AB 2142 (CHAVEZ) Chapter 84, Statutes of 2002

Eliminates a restriction on California commercial financial guaranty companies that strictly limited the ability of these companies to insure unrated commercial financial obligations, but still

maintains general insurer solvency standards for these insurers and the authority of the Insurance Commissioner to oversee these insurers.

AB 2144 (COMMITTEE ON INSURANCE) Chapter 140, Statutes of 2002

Requires the California Life and Health Insurance Guarantee Association to pay all unpaid reinsurance premiums due for periods before and after the date of an order for liquidation or rehabilitation if the association elects to succeed to the rights of the insolvent insurer.

AB 2354 (DUTRA) Chapter 520, Statutes of 2002

The bill makes five changes to existing law: 1) Allows large insurers ($1 billion in assets/$200 million in surplus) admitted to do business in California to invest in derivatives, as described; 2) Requires the board of directors of an eligible insurer to establish guidelines governing the use of derivatives; 3) Requires the Department of Insurance to review the guidelines and their amendments; 4) Requires the Insurance Commissioner to disapprove the guidelines if the insurer is unable to show that the guidelines are sufficient to prevent financially unsound or hazardous transactions or practices; and, 5) Allows the department to charge for its regulatory oversight of derivative transactions.

AB 2778 (CALDERON) Chapter 347, Statutes of 2002

Allows insurers to make material changes to the mutual funds underlying variable annuity contracts without prior approval of the Insurance Commissioner, but only if the Insurance Commissioner finds that the condition or method of operation of the insurer is not hazardous to the public or its policyholders, and only if the insurer has complied with all other relevant laws.

BILLS VETOED

AB 1176 (CALDERON)

As initially received by committee, this bill would have authorized a health care provider or facility, and an employer or carrier, to contract for reimbursement rates that are different from the official medical fee schedule.

As passed by the Legislature, the bill contained several substantive provisions to follow up SB 71 (Burton- workers compensation), a bill that was vetoed in 2001.

BILLS NOT SENT TO THE GOVERNOR

SB 1763 (Ortiz) Held in Assembly Insurance Committee

Would have required insurers to cover damages caused by mold.

Informational Hearings 2001-2002

The committee held eleven informational hearings regarding a mix of health and property insurance issues, as noted below:

1/30/01: Proposed Expansion of the Healthy Families Program.

This hearing, held jointly with the Health and Human Services Committee and Budget Subcommittee #3, examined the policy of extending the Healthy Families Program (HFP) to parents. Testimony indicated the need to eliminate the disparity between single parent and two parent families when determining eligibility for the Medi-Cal program, and the need to eliminate all non-federal requirements for verification of information necessary to establish eligibility for Medi-Cal and HFP. The committees heard testimony about the need to simplify administration of the Medi-Cal program, and to increase the enrollment of two million Californians who are eligible for Medi-Cal and HFP, but who fail to enroll. There was further testimony asking for equitable treatment of two parent families who apply for the Medi-Cal program, and testimony urging the State to encourage family unity by easing the disparity between single parent and two parent households in the Medi-Cal eligibility determination process.

As a result of the hearing, SB 336 (Ortiz--vetoed 2002) was introduced to limit independent documentation by both Medi-Cal and HFP applicants and recipients to the level of independent documentation required by federal law, with specified exceptions. Additionally the bill would have revised the definition of an unemployed parent for purposes of Medi-Cal eligibility, and would have required implementation of most its provisions upon implementation of the HFP parent expansion waiver.

2/7/01: State of Health Insurance--The CEO Perspective.

The purpose of the hearing was to provide the Legislature and the leaders of California health insurance plans, medical groups, and hospitals the opportunity to talk about what is important to them, how they see health insurance evolving. The issues discussed included the fiscal solvency of medical groups, the uninsured, medical errors, emergency room closures, medical privacy, affordable prescriptions, seismic retrofitting of hospitals, nursing shortages, Health Insurance Portability and Accountability Act compliance, and health insurance mandates.

5/16/01: Part One: OSHPD Update on Hospital Seismic Compliance
Part Two: HIPAA Compliance: What Leadership Role Should the State Have?

Part One:

This hearing, held jointly with the Senate Health and Human Services Committee, involved an update on compliance with hospital seismic laws, and on compliance with the Health Insurance Portability and Accountability Act (HIPAA, 1996). Testifying at the hearing was the Office of Statewide Health Planning and Data (OSHPD). OSHPD reported that while the vast majority of

hospitals had submitted seismic evaluation plans by the January 1, 2001 deadline, as required by law, none had specifically identified potential costs; furthermore, hospitals did not indicate if they were contemplating closing operations due to seismic compliance costs. The hearing was an attempt to identify the true costs of the law requiring hospitals to meet seismic safety standards by 2008.

Part Two:

HIPAA reformed the healthcare system with provisions that: 1) Improved portability and continuity of health insurance coverage for groups and individuals; 2) Combated waste, fraud and abuse in health insurance and healthcare delivery; and, 3) Simplified the administration of health insurance. Although HIPAA called for administrative simplification, the process to get there is very complex and costly. There are 9 categories of administrative simplification with compliance required 24 months after each Final Rule becomes effective. The first Final Rule was for "transactions and code sets" and was effective 8/17/2000 with the compliance date of 10/16/2002. The other 8 Final Rules will probably be effective by the end of 2002.

The impact of these rules could be significant cost savings for providers, but service delivery could suffer interruptions, as businesses that deal with health insurance will require technical re-engineering. HIPAA compliance will require system-wide reassessments and workforce education and State regulations may need to change. The costs to comply with HIPAA have been estimated to be four times as much as the costs of Y2K compliance. Currently there is no state-wide plan for HIPAA compliance and the federal penalties for non-compliance are significant. As a result of the hearing, SB 456 (Speier—Ch. 635, Statutes of 2001) was introduced to create an Office of HIPAA Implementation to coordinate statewide compliance with HIPAA.

8/22/01: <u>Zurich American Insurance Group and its alleged failure to properly claim for damage to State Capitol caused by vehicle owned by Dick Simon Trucking</u>

In early 2001, a tractor-trailer rig slammed into the historic California State Capitol, killing the driver and causing millions of dollars of smoke and fire damage. It was later determined by the California Highway Patrol and other State investigators that the driver had a history of severe mental health and behavioral problems, that he intentionally rammed the Capitol, and that the trucking company, Dick Simon Trucking, was aware of a long history of inappropriate conduct by the driver.

This hearing was originally called to focus on several insurers that refused to pay for approximately $12 million in damage caused by Dick Simon's truck. As a result of the hearing being *scheduled*, all but one insurance carrier paid claims made by California, netting taxpayers $6 million in payments.

The committee then convened and took testimony regarding the remaining carrier, Zurich American Insurance Group, and its failure to pay. This claim, approximately $6 million, remains unpaid as of December 2002. The State filed suit in Sacramento Superior Court seeking recovery. No trial date has been set.

The historic Capitol was restored and is once again open to the public.

11/28/01: Personal Privacy At Risk: An examination of harm that might be caused by legal access to an individual's financial, medical and "public document" information

This joint hearing with the Senate Privacy Committee examined the harm that might be caused by legal access to the financial, medical and public document information of individuals. In part, the hearing revealed that the State was selling birth and death record information in CD-ROM format to private companies. Within a week after the hearing the Governor issued an executive order halting the sales and subsequently the Department of Health Services sponsored legislation, SB 1614 (Speier, Ch. 712, Statutes of 2002), to put procedures in place for future sales of these records. In the future, the information will be available without a mother's maiden name and without social security numbers.

12/12/01: Medicare HMO Pullouts and Coverage Erosion

An estimated 84,000 California senior citizens and the disabled lost Medicare-HMO coverage on January 1, 2002. The purpose of this hearing was to understand the reasoning behind the announced Medicare+Choice (Medicare-HMO) withdrawals and benefit reductions, and to ensure that accusations of "red-lining" cannot be justified.

In some counties, seniors living on one side of the street will be able to maintain their Medicare-HMO coverage while their neighbors across the street will lose it. SB 1531 (Speier—Ch. 555, Statutes of 2002) was introduced to provide more guaranteed coverage of Medicare supplement policies (Medi-Gap). It specifically allows a Medicare beneficiary to obtain a Medicare supplement insurance policy on a guaranteed basis if the Medicare-HMO reduces its benefits, increases the cost-sharing amount or discontinues (for other than good cause relating to the quality of care) a provider currently furnishing services to the individual.

1/16/02: Financial Surveillance of Insurance Companies--Are we doing enough or rolling the dice?

The committee examined whether the department's financial surveillance personnel are able to adequately foresee, and to prevent insolvencies. The hearing led to enactment of SB 2093 (Speier, Ch. 899, Statutes of 2002) establishing additional standards for deposits by workers' compensation insurers and for underwritten title insurers.

1/30/02: Total Loss Salvage Vehicles.

Insurers explained how they sell vehicles that they have declared a "total loss." A total loss is supposed to be declared when the costs of repairs due to an accident exceeds the worth of the vehicle. Consumers explained how they had unknowingly purchased salvage vehicles. The California Highway Patrol presented enforcement perspectives. This hearing led to enactment of SB 1331(Speier, Ch. 670, Statutes of 2002) which significantly toughened the registration process for rebuilt salvage vehicles.

2/6/02: Department of Managed Health Care Oversight Hearing--Priorities and Actions.

The Department of Managed Health Care (DMHC) became operational on July 1, 2000. The DMHC's stated mission is to work toward an accountable and viable managed health care delivery system that promotes healthier Californians. The committee reviewed the recent efforts of the DMHC to:

- Ensure accountability through enforcement of the provisions of the Knox-Keene Act- the law authorizing State regulation of health care plans;
- Develop and launch public education and awareness efforts;
- Provide an annual HMO report card;
- Operate the HMO Help Center in order to help Californians resolve their problems with HMOs;
- License and conduct medical surveys and financial examinations of HMOs;
- Maintain a toll-free physician phone line so that the Office of Plan-Provider Relations is informed early of systemic problems that may affect consumers.

As a result of the hearing, SB 1913 (Committee on Insurance, Chapter. 793, Statutes of 2002) was introduced to require the DMHC and the State Department of Insurance to maintain a joint senior level working group to maximize cooperation, ensure clarity for health care consumers about which department enforces their patients' rights, and to ensure that each department's regulations are as consistent as possible.

4/3/02: Mold and Terrorism Exclusions.

Mold, a ubiquitous organism, has been the focus of increasing health concern. Inhalation of mold can cause human toxic effects, exacerbate immunologic reactions and can cause infections. The powerful health effects, broad exposure, and lack of standards have generated litigation, and some authorities have speculated that mold might generate more litigation than asbestos.

Recent high profile cases of mold infestation and the rising number of buildings with identified mold problems have increased the visibility of this issue, and generated significant concern in the public health community. This hearing assessed the reluctance of insurers to provide coverage for two risks-- mold and terrorism-- as well as the lack of authority by the Department of Insurance to force coverage in these areas of risk. At a following hearing, the committee heard and passed SB 1763 (Ortiz) granting coverage for mold as an ensuing loss. That bill failed passage in the Assembly Insurance Committee.

10/28/02: An Assessment of Efforts by Insurers to Prevent Auto Body Repair Fraud.

Certain insurers were asked why they were withholding documents from State investigators who had identified auto body fraud at shops that were recommended by insurers. The hearing has led to numerous follow-up actions, including a working agreement by the Department of Insurance and the Bureau of Automotive Repair to share information on fraud investigations.