SENATE COMMITTEE ON INSURANCE

2003 – 2004 LEGISLATIVE SUMMARY

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Dear Colleagues:

Insurance is a critical product for California's consumers. For example, after wildfires swept the Southern California region in 2003, reports of huge gaps in insurance coverage were front page news in major newspapers, and families who were underinsured were economically, as well as emotionally, devastated. "Medi-Cal planning" and insurance scams occur because the elderly fear economic ruin from lack of adequate health and long-term care insurance.

Gaps in homeowners insurance were addressed through many bills that arose after the Southern California wildfires. More work needs to be done because many California homeowners are underinsured and don't even know it. Gaps in health insurance were addressed when legislation was passed by this committee after careful consideration of the costs of each proposed mandate. Governor Schwarzenegger vetoed these mandate bills, leaving consumers in individual or group markets without secure, affordable coverage for hearing aids, substance abuse treatment, and reproductive health care. The committee remains committed to the process of bang-for-the-buck mandate analysis, and will continue to work with the University of California to identify cost-effective proposals.

The economic health of Californians is secured through adequate health insurance, homeowners coverage that is a rock when the storms of catastrophe are nearby, and life and disability coverage that is affordable and widely available. Throughout 2005 and 2006, this committee will remain dedicated to consumers and their needs. Ultimately, what's good for customers is what's good for business because, as we all know, the customer is always right.

All the best,

Jackie Speier
Chair, Senate Insurance Committee

TABLE OF CONTENTS

AUTOMOTIVE

BILLS SIGNED INTO LAW

SB 551 (Speier) Chapter 791, Statutes of 2003

Codifies existing regulations that prohibit an insurer from "steering" insureds or claimants to a particular automotive repair dealer and prohibits the insurer from suggesting or recommending that an automobile be repaired at a specific automotive repair dealer unless the claimant requested the referral or the claimant is informed, in writing, of his or her rights.

SB 841 (Perata) Chapter 169, Statutes of 2003

Permits an insurer to use persistency of automobile insurance coverage with that insurer, an affiliate, or another insurer as an optional rating factor in determining rates and premiums.

SB 1500 (Speier) Chapter 920, Statutes of 2004

Starting January 1, 2006, requires that all insurers electronically report auto insurance policies to the Department of Motor Vehicles (DMV), and requires the DMV to suspend the registration of those vehicle owners who allow auto insurance to lapse and who do not replace the policy within 45 days of being warned by the DMV that their registration will be suspended. See also AB 2709 (Levine) relative to DMV notifying law enforcement of insurance status.

AB 984 (Vargas) Chapter 439, Statutes of 2003

Defines "vehicle service contract" and provides that this type of contract does not constitute automobile insurance if it meets specified requirements and requires an obligor (one who is financially responsible for the performance of a contract) under a vehicle service contract who is not a seller to possess a vehicle service contract provider license.

AB 1181 (Ridley-Thomas) Chapter 360, Statutes of 2003

Requires that a policy of automobile insurance contain, at policy issuance and in each renewal notice sent prior to the renewal of the policy, disclosure of the information that was applied in determining the premium that was charged for the policy, and also requires that the policy specify, among other things, the traffic convictions and the number of at fault property damage and bodily injury accidents for each rated driver or vehicle.

AB 1274 (Chavez) Chapter 88, Statutes of 2003

Clarifies current law to distinguish between risk-based motor clubs, such as the American Automobile Association, and non-risk-based motor clubs that provide only maps and discount coupons. This bill specifies that the latter category of motor clubs is not subject to regulation by the State Insurance Commissioner of the State Department of Insurance.

AB 1985 (Wolk) Chapter 93, Statutes of 2004

Allows insurers to satisfy retention requirements regarding the theft of an insured vehicle by maintaining an electronic version of the original claim form for a minimum of three years, in lieu of maintaining the actual original claim form.

AB 2677 (Ridley-Thomas) Chapter 765, Statutes of 2004

Requires automobile insurers to provide consumers in California with a cost estimate for the lowest price automobile insurance at the limits the consumer has requested and for which the consumer is eligible, or referral to an agent or broker via a toll-free telephone number or Internet Web site, and additionally requires the Insurance Commissioner to make the insurer's toll-free phone number or Internet Web site information available on the Department of Insurance Internet Web site and through the department's consumer toll-free telephone line.

AB 2709 (Levine) Chapter 948, Statutes of 2004

Requires the Department of Motor Vehicles to inform law enforcement, after January 1, 2006, about the insurance status of a motor vehicle.

AB 2904 (Benoit) Chapter 85, Statutes of 2004

Changes the definition of a manufacturer, for purposes of excluding express warranties for automobile lubricants, treatments and other fluids from the definition of automobile insurance, reducing from 10 years to nine years the requirement that the manufacturer must have continuously produced and offered the product for sale in California.

AB 3088 (Horton) Chapter 787, Statutes of 2004

Creates a "supergroup exemption" in law so that insurers using dissimilar names, but who are owned by one parent company, are not required to quote the lowest rate from a sister company to a Proposition 103 good driver. Intended to preserve the Proposition 103 theory that two insurance products that have different costs must be priced differently.

BILLS NOT SENT TO THE GOVERNOR

SB 154 (Oller) Held in Senate Insurance

Would have provided that insurance rates, rules, and forms prescribed by insurers and approved by the commissioner pursuant to his or her regulatory authority would be deemed to comply with all applicable statutes and regulations, and would have further prohibited the Insurance Commissioner from challenging those previously approved items, except as specified.

SB 1291 (Burton) Held in Assembly Insurance Committee

Would have required the Insurance Commissioner to approve a class plan, a rating methodology, an underwriting or eligibility rule, or a policy form for use by an insurer if any other insurer had previously received approval and the approval remained in effect.

SB 1321 (Ortiz) Held in Senate Insurance Committee

Would have required the Insurance Commissioner to consider whether a proposed rate for homeowners or auto insurance is excessive relative to the insurance company's profit margin, and would have also specified when public hearings must be held on rate applications.

SB 1323 (Ortiz) Failed Passage Assembly Floor

As it passed the Senate Insurance Committee, the bill would have prohibited insurers from refusing to issue or renew homeowners' insurance unless the insured has more than two claims in two years, would have prohibited credit scoring for underwriting or rating homeowners' insurance, and would have prohibited insurers from reporting inquiries about coverage to industry databases, as specified. When it failed passage on the Assembly floor, the bill would have regulated the use of credit scores in underwriting homeowners' insurance policies and prohibited insurers from reporting that an insured has made an inquiry about coverage if no claim is filed.

AB 1318 (Maddox) Held in Senate Insurance Committee

Would have specified that an insurer is not required to notify the insured of the degree to which the insured was at-fault in an automobile accident.

AB 1729 (Bermudez) Failed passage Senate Floor

Would have sunsetted SB 841 (Chapter 169, Statutes of 2003) relative to "portable persistency" as of December 31, 2009, and would have required that the California Research Bureau contract with a nationally recognized actuarial firm to complete a study regarding whether "portable persistency" adversely affects low-income and previously uninsured individuals more so than the "loyalty discount" allowed by the Department of Insurance.

AB 2249 (Horton) Held in Senate Insurance Committee

Would have created a "supergroup" exemption in statute for auto insurers who offered insurance using similar names but through multiple corporate entities. This bill was ultimately incorporated within AB 3088 (Horton) and signed by the Governor.

DEPARTMENT OF INSURANCE

BILLS SIGNED INTO LAW

SB 618 (Scott) Chapter 546, Statutes of 2003

Authorizes the State Insurance Commissioner to suspend or revoke the license of an insurance agent who induces a client to make the agent (or a relative, domestic partner, business partner or friend) a beneficiary of a loan, gift, or future benefit; a life insurance or annuity policy; a bequest in a will; or an insurance product for which the licensee has received a commission. Also increases the fines for misrepresentation of the terms of an insurance policy and for violation of the senior insurance law.

AB 794 (Frommer) Chapter 310, Statutes of 2003

Requires the Department of Insurance to remove disciplinary, enforcement and licensing actions from the DOI's Web site 10 years from the date the actions become final.

AB 1227 (McCarthy) Chapter 596, Statutes of 2004

Establishes new penalties better tailored to enforcement actions against insurers for deficiencies found in their Special Investigation Units (SIU). Creates three new penalties within the SIU statutes, and would establish a procedure whereby a notice of noncompliance may be issued to the insurer.

AB 1252 (Jackson) Chapter 217, Statutes of 2003

Makes several technical changes to conform state law to the federal Gramm-Leach-Bliley Act. Specifically, this bill renames various continuing education requirements for long-term care insurance agents, adds "territory of the United States" to the list of non-resident jurisdictions, and repeals a provision of current law regarding reinsurance intermediaries not allowed under federal law.

AB 1598 (Corbett) Chapter 448, Statues of 2003

Appropriates $2,900,000 plus interest from the California Residential Earthquake Recovery (CRER) fund to the Department of Insurance to be used for the Earthquake Grants and Loans Program. Increases the amount the Department may spend administering the program by $25,000. Extends the program's sunset date to July 1, 2007.

AB 1728 (Assembly Insurance Committee) Chapter 599, Statutes of 2004

Includes three different cleanup provisions requested by the Department of Insurance (DOI): (a) requires quarterly financial reporting to the DOI and National Association of Insurance

Commissioners (NAIC); (b) conforms California law to the NAIC Model Holding Company Act; and (c) repeals invalid portions of the insurance code related to surety companies, plus provisions to improve anti-fraud investigations.

BILLS NOT SENT TO THE GOVERNOR

SB 850 (Ortiz) Gutted and amended in Assembly, held in Assembly Elections, Redistricting and Constitutional Amendments Committee

As introduced, would have granted the Insurance Commissioner (IC) the authority to deny proposed policy changes or exclusions. Gutted and amended in the Assembly to permit a vacancy on the general election ballot caused by the death or disqualification of the nominee to be filled by appointment by the Speaker of the Assembly or the Minority Leader of the Assembly, as specified, or by the President pro Tempore of the Senate or the Minority Leader of the Senate, as specified.

SB 1315 (Ortiz) Held in Assembly Insurance Committee

Would have required that insurers seeking to make a change to standard insurance forms file a copy of the form with the Insurance Commissioner (IC), and would have granted the IC the right to disapprove the form under specified circumstances.

HEALTH INSURANCE

BILLS SIGNED INTO LAW

SB 2 (Burton) Chapter 97, Statutes of 2003

Enacts the Health Insurance Act of 2003 to provide health coverage to specified individuals (and in some cases their dependents) who do not receive job-based coverage and who work for large and medium employers, as defined. Imposes a fee on employers, as specified, and makes available a credit against that fee for employers who provide coverage.

SB 142 (Alpert) Chapter 687, Statutes of 2004

As heard by the Senate Insurance Committee, the bill would have created the Medi-Cal to Healthy Families Accelerated Enrollment Program to provide temporary no share-of-cost Medi-Cal benefits to children awaiting determination of eligibility into the Healthy Families Program. The bill was subsequently gutted and used as a 2004 budget clean up measure and provides the State Department of Health Services one additional month (from July 1, 2005 to August 1, 2005) before being required to expand newborn screening through a competitive bid process.

SB 212 (Machado) Chapter 320, Statutes of 2003

Allows self-funded and partially self-funded Multiple Employer Welfare Arrangements (MEWAs) to invest up to 75 percent of excess funds in mutual funds. Specifies that excess funds are those over existing reserve and surplus requirements. Allows the State Insurance Commissioner to require MEWAs to dispose of an investment in certain circumstances.

SB 260 (Romero) Chapter 310, Statutes of 2004

As it left the Senate Insurance Committee, this bill would have required a contract between a health care service plan and a public hospital to have rates for services not less than the average rate paid to private hospitals in the same county. The bill was gutted and amended in the Assembly and now creates the California Prison Inmate Health Service Reform Act and authorizes the State Department of Corrections to enter into joint powers agreements with one or more health care districts in order to establish regional inmate health service joint powers agencies.

SB 580 (Senate Committee on Insurance) Chapter 12, Statutes of 2003

Revises the schedule of annual fees assessed on health plans by the Department of Managed Health Care. It reenacts a bill that was inadvertently chaptered out last year when a second bill amended the same section of the Health and Safety Code and was signed into law after the bill containing this provision.

SB 581 (Senate Committee on Insurance) Chapter 13, Statutes of 2003

Corrects drafting errors found in SB 1531 (Speier), expanding the availability of guaranteed issuance of Medicare supplement insurance and SB 2093 (Speier) regarding workers' compensation loss control consultation services, both chaptered in 2002.

SB 798 (Cedillo) Chapter 417, Statutes of 2003

Requires the Department of Managed Health Care to immediately notify a Mexican pre-paid health plan (PPHP) when it ceases to operate legally in Mexico that it is not in compliance with California law authorizing it to operate in-state, and that the PPHD must comply with the laws of Mexico, become licensed in California or cease operations in the state.

SB 853 (Escutia) Chapter 713, Statutes of 2003

Requires the Department of Managed Health Care to adopt regulations by January 1, 2006, to ensure enrollees have access to language assistance in obtaining health care services. Requires the Insurance Commissioner to promulgate by January 1, 2006, similar regulations applicable to health insurers that contract with providers for alternative rates to ensure that the insured have access to translated materials, language assistance and culturally competent health care services.

SB 1347 (Ducheny) Chapter 491, Statutes of 2004

Deletes the requirement that a Mexican pre-paid health plan provide benefits only for citizens of Mexico and their dependents and instead requires that it provide benefits only for Mexican nationals legally employed in San Diego and Imperial counties, and their dependents, as specified. Temporarily suspends a requirement that the medical director be licensed in California. Sunsets January 1, 2008.

AB 30 (Richman) Chapter 573, Statutes of 2004

As it left the Senate Insurance Committee, would have required the Managed Risk Medical Insurance Board to provide health insurance similar to the Healthy Families Program, but with a reduced benefit package, to uninsured, employed, childless adults who are in households with an income that does not exceed 200% of the federal poverty level. The bill was gutted and amended and now provides cleanup legislation to SB 151 (Burton) of 2003, that replaces the existing triplicate prescription pads used to dispense Schedule II narcotics with new forgery resistant pads that will be used for all controlled medications. It extends the use of triplicate prescription forms for dangerous drugs, until the alternative system can be implemented.

AB 175 (Cohn) Chapter 203, Statutes of 2003

Specifies that when a contracting agent sells, leases, or transfers a health provider's contract to a payor, that the rights and obligations of the provider are governed by the underlying contract between the provider and the contracting agent.

AB 254 (Montanez) Chapter 64, Statutes of 2004

Repeals "senior COBRA" continuation protections, which allow some employees over age 60 who have exhausted the normal time period under COBRA health insurance continuation to keep receiving benefits under COBRA until age 65, in order to allow seniors to enroll in lower-priced HIPAA coverage.

AB 321 (Cogdill) Chapter 411, Statutes of 2004

Requires "full" health care service plans to provide, upon the request of a group subscriber, the contract termination dates for major contracts in the group subscribers' geographic area.

AB 343 (Chan) Chapter 234, Statutes of 2004

Prohibits charging Healthy Families Program (HFP) applicants an application assistance fee. Permits a new subscriber in HFP to switch his or her choice of vision or dental plans once within the first three months of coverage.

AB 362 (Garcia) Chapter 80, Statutes of 2003

Requires the Department of Managed Health Care to maintain a database indicating, for each county, the names of the plans that operate in that particular county.

AB 373 (Chu) Chapter 139, Statutes of 2003

Requires, effective July 1, 2004, that any subscriber in the Healthy Families Program who is assigned to a federally qualified health center (FQHC), rural health clinic (RHC) or primary care clinic or to a physician, dentist or optometrist who is an employee of an FQHC, RHC or primary care clinic, be considered to have been assigned directly to the FQHC, RHC, or primary care clinic.

AB 1286 (Frommer) Chapter 591, Statutes of 2003

Allows an insured to continue to receive health care services for a specified time from a provider when a provider and a health care service plan fail to renew their contract. Also requires every plan to have, and submit to the State Department of Managed Health Care, a written continuity of care policy that describes how it will handle the block transfer of enrollees from a terminated provider to a new provider.

AB 1496 (Montanez) Chapter 579, Statutes of 2003

Requires the Director of the State Department of Managed Health Care to require health care service plans to promptly reimburse a health plan enrollee for any reasonable costs associated with health care services, subject to all of the following: (1) when the Director finds that the disputed health care services were a covered benefit under the terms and conditions of the health plan contract, (2) the services are found by the independent medical review organization to have been medically necessary, and (3) the health plan contract does not require or provide prior authorization before the health care services are provided to the enrollee.

AB 1524 (Richman) Chapter 866, Statutes of 2003

Expands the scope of the County Health Initiative Matching Fund to include health insurance coverage to a parent of an eligible child participating in the Healthy Families Program and whose income does not exceed 200 percent of the federal poverty level.

AB 1528 (Cohn) Chapter 672, Statutes of 2003

As heard by the committee, was one of several bills stating legislative intent to ensure access to health care coverage for all Californians and was referred to conference committee. The conference committee deleted the bill's intent language, inserting language that requires the Governor to convene a commission on health care quality and cost containment to research and recommend strategies for promoting high quality care and containing health care costs. The Commission is to issue a report by January 1, 2005 to the Legislature and the Governor, making recommendations for health care quality improvement and cost containment. This bill was

double-jointed to SB 2, also passed by the conference committee, approved by the legislature and signed by the Governor. See also SB 1349 (Ortiz) below.

AB 1596 (Frommer) Chapter 164, Statutes of 2004

Allows health plans and health insurers to provide internet links to comparative benefit matrices on the Department of Managed Health Care and Department of Insurance Web sites in lieu of providing the matrices themselves. Also modifies recently-enacted continuity of care law (see SB 244 and AB 1286 in this summary) by allowing the duration of covered services for a terminal illness to exceed 12 months from the contract termination date or the effective date of coverage for a new enrollee. Also excludes a newly covered enrollee of a health care service plan who is offered an out-of-network option, or who had the option to continue with a health plan or provider and voluntarily chose to change health plans, from continuity of care protections.

AB 1628 (Frommer) Chapter 583, Statutes of 2003

Requires a hospital to contact an enrollee's health plan to obtain the enrollee's medical record information before admitting the enrollee for post-stabilization care as an inpatient following emergency services in a non-contracting hospital, under certain circumstances, and prohibits a hospital from billing the enrollee if it fails to do so.

AB 1955 (Vargas) Chapter 376, Statutes of 2004

Allows a for-profit life insurer to be organized as a non-profit mutual benefit corporation, subject to essentially the same regulations and requirements governing for-profit insurers, including reserve requirements and the obligation to pay gross premiums taxes.

AB 2185 (Frommer) Chapter 711, Statutes of 2004

Requires health plans that cover outpatient prescription drugs also include coverage for inhaler spacers, nebulizers and peak flow meters when medically necessary for the treatment of childhood asthma, under the same general terms and conditions applicable to other covered benefits.

AB 2208 (Kehoe) Chapter 488, Statutes of 2004

Requires a health plan and a health insurer to provide employers or guaranteed associations with coverage for the registered domestic partner of a covered individual to the same extent, and subject to the same terms and conditions, as provided to the spouse of a covered individual; extends this requirement to all other lines of insurance regulated by the Department of Insurance.

AB 2429 (Chavez) Chapter 348, Statutes of 2004

Permits a contract between a fee-for-service provider and a Medi-Cal or Healthy Families health plan to be amended without the signature of the provider, under specified circumstances.

AB 2759 (Levine) Chapter 489, Statutes of 2004

Requires a health plan or health insurer that exits the individual health insurance market to provide continuation coverage to those it insured at the time of withdrawal under the same terms and conditions governing coverage under state law and the Health Insurance Portability and Accountability Act.

BILLS VETOED

SB 261 (Speier)

Would have specified the financial information filed with the Department of Managed Health Care by a risk-bearing organization (RBO), such as a medical group or independent practice association, that must be disclosed by DMHC to the public, and required annual registration of RBOs.

SB 1157 (Romero)

Would have prohibited health insurance policies from excluding coverage for injuries sustained while the insured was intoxicated or under the influence of any controlled substance.

SB 1158 (Scott)

Would have required group health plan contracts and all health insurance policies issued, amended, or renewed on or after January 1, 2005, to provide coverage for hearing aids, up to $1,000, to all enrollees, subscribers, and insureds under 18 years of age at least once every 36 months.

SB 1555 (Speier)

Would have required group and individual health insurance policies to provide coverage for maternity benefits. Would have excluded from the requirement certain types of insurance, including short-term limited duration health insurance.

AB 857 (Frommer)

Withdrawn from Insurance Committee prior to hearing and amended to establish an Autism Information Resource Center within the Department of Developmental Services. Referred to Senate Health Committee.

AB 1431 (Frommer)

Would have required third party administrators paying or adjusting provider claims on behalf of a medical group to be licensed by the Department of Insurance; would have provided a definition of "independent practice association" in the Knox-Keene Act.

AB 2289 (Chan)

Would have required full service health plans and health insurers to submit to their regulators information pertaining to the out-of-pocket costs borne by health insurance consumers.

AB 2684 (Lieber)

As referred to this committee, this bill would have required insurers to pay the beneficiary of a disability insurance policy that provides for death benefits the proceeds of the policy within 30 days after the death of the insured, and would have specified that if the policy is not paid within the 30 days, an insurer must pay interest. This bill was gutted and amended to extend to charitable Internal Revenue Code Section 501(c)(3) organizations, school districts' exemption from the requirement to verify an individual's legal status or authorization to work prior to providing employment services, and was re-referred to the Committee on Labor and Industrial Relations.

BILLS NOT SENT TO THE GOVERNOR

SB 26 (Figueroa) Held in Senate Insurance Committee

Would have required a health care service plan or health insurer to obtain prior approval of rate increases from the Department of Managed Health Care or Department of Insurance, as specified, and would potentially have required significant refunds of premiums previously collected.

SB 101 (Chesbro) Held in Senate Insurance Committee

Would have required that certain policies issued by health care service plans or disability health insurers include coverage for the medically necessary treatment of substance-related disorders, except caffeine-related disorders, on the same basis as any other medical condition.

SB 174 (Scott) Held in Senate Insurance Committee

As introduced, would have mandated that every group health care service plan contract and every health insurance policy provide coverage for hearing aids, up to $1,000, to all enrollees and subscribers, or insureds, under 18 years of age. As amended in committee, would have stated the intent of the Legislature to enact legislation that would require health care service plans and health insurers to provide coverage for hearing aids. See also SB 1158 (Scott), above, that was vetoed by the Governor.

SB 608 (Machado) Held in Senate Insurance Committee

Would have authorized a multiple employer welfare arrangement (MEWA) to apply for, and be issued, a probationary certificate of compliance valid for five years if it met specified financial, insurance, and other requirements.

SB 797 (Machado) Held in Senate Appropriations Committee

As introduced, would have required a health care service plan to contract to provide coverage for cancer screening tests. Bill was amended and withdrawn from Insurance Committee and re-referred to Senate Health Committee. As amended, it would have required the Department of Health Services (DHS) to establish a program, in consultation with an advisory panel, to provide osteoporosis screening and outreach services to eligible individuals during the month of May each year, or at other times during the year when deemed appropriate by DHS and other participating groups.

SB 921 (Kuehl) Held in Assembly Appropriations Committee

Would have established the California Health Care System (CHCS) administered by an elected commissioner who would head the California Health Care Agency. Would have provided health insurance to all California residents through a consolidated claims, financing, and administrative system, replacing all private health insurance policies and eliminating all health insurance premiums paid by residents and their employers, except for services not provided by CHCS. Would have required the commissioner to seek waivers from the federal government to merge all federal health care funds and any required state matching funds into the system. Would have granted the commissioner full power to supervise, plan and coordinate the delivery and financing of health care in California and provide a comprehensive, uniform benefit package to all residents.

SB 1192 (Chesbro) Held in Assembly Health Committee

As heard in committee, would have mandated that health plans and health insurers provide coverage for the medically necessary treatment of substance abuse disorders, including nicotine but excluding caffeine-related disorders, in a nondiscriminatory manner on the same basis as they provide any other medical care. Was amended to exclude nicotine-related disorders as well, to limit outpatient care to 20 visits per year, and to not go into effect unless the California Public Employees' Retirement System determined that it would be cost neutral with regard to its substance abuse treatment benefit package.

SB 1349 (Ortiz) Held in Assembly Appropriations Committee

As introduced, would have transferred regulatory oversight of the financial solvency of health care service plans from the Department of Managed Health Care to the Department of Insurance; would have directed that no plan rates be approved or remain in effect that are excessive, inadequate or unfairly discriminatory; and would have required plans seeking to change any rate to file an application with the Insurance Commissioner, as specified. Bill was gutted and amended to provide funding to the California Health Care Quality Improvement and Cost Containment Commission by requiring the Department of Managed Health Care and the Department of Insurance to levy a per-enrollee fee on health plans and health insurers, respectively, up to three hundred sixty-four thousand dollars ($364,000) for each of the 2004-05 and 2005-06 fiscal years only.

SB 1679 (Perata) Held in Senate Insurance Committee

As introduced, would have deleted the "emergency basis" provision from the requirement that the Department of Managed Health Care develop regulations regarding the provision of medical care following stabilization of an emergency medical condition, and would have required that those regulations define 30 minutes as the maximum allowable time in which a health plan could respond to requests for treatment authorization. As analyzed by committee (but never in print), this bill would have prohibited a health plan from delegating the payment of claims for non-contracted emergency services to a medical group, and would have created a voluntary arbitration process for health plans and non-contracting emergency care providers to resolve billing disputes.

SB 1843 (Karnette) Held in Senate Insurance Committee

Would have prohibited a hospital from discharging a newborn baby from the hospital less than 48 hours after a normal vaginal delivery or less than 96 hours after deliver by caesarian section without the consent of the mother.

SB 1918 (Senate Insurance Committee) Held in Senate Insurance Committee

Would have required the Fraud Division within the Department of Insurance to forward the names and supporting evidence of chiropractors suspected of engaging in workers' compensation fraud to the Board of Chiropractic Examiners (Board); would have included the Board in the lists of governmental agencies authorized to receive information from insurers regarding specific investigations of motor vehicle and workers' compensation insurance fraud.

AB 527 (Leno) Held in Senate Insurance Committee

As heard by the Senate Insurance Committee, would have created the Native American Tribal Casino Employee Health Protection and Portability Act to allow tribal gaming casino employers to provide health care coverage to each employee, dependents or domestic partners in a program designed similarly to the Healthy Families Program. Program would have been managed by a Native American Tribal Casino Employee Health Board. Fees paid by employers would have been collected by the Employment Development Department and deposited in the Native American Tribal Casino Employee Health Fund, along with various other potential revenues.

AB 621 (Nakanishi) Held in Senate Judiciary Committee

As heard by the Senate Insurance Committee, would have created a pilot program to purchase liability insurance for up to 100 physicians who only provide voluntary, unpaid medical services to indigent patients in under-served areas. Bill was gutted and amended to establish limitations on remedies for injury or damage suffered as a result of any act or omission occurring on or after January 1, 2005, of a health care provider or an employee or agent of the health care provider when the health care is provided pursuant to a contract with a governmental entity, and referred to Judiciary Committee.

AB 1213 (Vargas) Held in Senate Insurance Committee

Would have changed the requirement that risk-bearing organizations contract with health plans to provide them certain financial information by deleting the condition that the financial information be disclosed in a way that does not adversely affect the integrity of the contract negotiation process; would have specified that for risk-bearing organizations serving less than 10,000 individuals, certain records be disclosed for specified purposes only.

AB 1414 (Levine) Held in Senate Insurance Committee

Would have defined a "discount health program" as a person or entity that operates a program that charges a consumer a fee for accessing providers and health care services and products at a discounted rate; would have established certain requirements for the operation of these programs and would have made a violation of these requirements a crime; would have made the Department of Insurance responsible for enforcement of the bill and would have required it to charge programs a fee to cover those costs.

AB 1527 (Frommer) Reported out of Conference Committee, Held at Senate Desk

Stated legislative intent to increase the number of people in California with health coverage by building upon our existing employment-based health insurance system using a "pay or play" approach. One of several intent bills, including SB 2 and AB 1528, dealing with employer-provided healthcare referred to conference committee.

AB 1927 (Dymally) Failed Passage on Assembly Floor

As referred to this committee, AB 1927 was authored by Assemblymember Cohn and would have required a health plan that offers vision care benefits to contract with both optometrists and physicians and surgeons (opthamologists); it would have expanded the requirements for optometrists contracting with health plans; and it would have prohibited a specialized health plan that provides vision care coverage from discriminating against a clinic that provides certain vision care goods or services. This bill was gutted and amended so that, as considered on the Assembly Floor, it would have required hospitals (except for University of California facilities) to annually review the use of, and consult with, professional, technical and support staff.

AB 2389 (Koretz) Held in Senate Appropriations Committee

As referred to this committee, this bill would have required health insurers and health plans that contract with or own preferred provider organizations (PPOs) to pay providers not contracting with the PPO a "reasonable and customary" fee for anesthesiology, radiology and pathology services provided to enrollees in a hospital, and would have prohibited such a provider from billing an enrollee for any amount in excess of the reasonable and customary fee. The bill was not heard in committee in this form. It was gutted and amended to require certain labeling of unprocessed imported or blended beef, and re-referred to Health and Human Services Committee.

HOMEOWNERS/PROPERTY

BILLS SIGNED INTO LAW

SB 64 (Speier) Chapter 357, Statutes of 2004

Creates a mediation program that may be used by survivors of the 2003 Southern California wildfires. Under the program, insurers pay for a mediation when requested by homeowners, and the Department of Insurance assigns a mediator to attempt to settle disputes under policies without lawsuits about coverage provisions.

SB 1855 (Alpert) Chapter 385, Statutes of 2004

Requires insurers to disclose the additional costs of broader coverage than the consumer's current policy of residential property insurance coverage, to include additional information about the insured property on the declaration page and requires the insurer to pay full replacement value if the notice is not included in the disclosure statement. It also revises the disclosure form contained in the coverage and requires the Insurance Commissioner, by January 1, 2005, to report to the Governor and the Legislature on the effectiveness of the disclosure form.

AB 421 (Steinberg) Chapter 771, Statutes of 2004

As passed by the committee, the bill would have added several types of discrimination to the longstanding list of underwriting classifications that may not be used when issuing fire/liability insurance policies for single family and multi-family dwelling units. As enacted into law, the bill requires the Insurance Commissioner to conduct a study of the market for property and liability insurance for corporations that provide subsidized low- and moderate-income rental housing.

AB 444 (Vargas) Chapter 352, Statutes of 2003

Would allow the Department of Insurance to establish an expedited approval process for specified policies, contracts or agreements issued by large life insurers, and to establish a fee for that expedited process.

AB 996 (Wiggins) Chapter 647, Statutes of 2003

Extends to reproductive health services facilities the prohibition on insurers from canceling or refusing to renew a property insurance policy because the facility has been the victim of a hate crime. Expands this existing prohibition to also include anti-reproductive-rights crimes committed against reproductive health services facilities. Further prohibits an insurer from imposing an excessive or unfairly discriminatory premium because the facility has been the victim of a hate crime.

AB 1048 (Calderon) Chapter 144, Statutes of 2003

Amends the statutory definition of the California Earthquake Authority's "available capital" so that it does not include unearned premium, and makes related changes.

AB 1049 (Calderon) Chapter 442, Statutes of 2003

Prohibits insurers from basing adverse underwriting decisions on inquiries about policy coverage, when those inquiries are based merely on an record obtained from a 3rd party database.

AB 1191 (Wiggins) Chapter 571, Statutes of 2003

Requires insurers to provide policyholders with the reasons for the non-renewal of their homeowner's insurance policies and requires insurers to provide policyholders, upon request, with the reasons for the change in their annual premium.

AB 1727 (Assembly Insurance Committee) Chapter 148, Statutes of 2003

Requires homeowners and residential property or liability insurers to give a 20-day written advance notice of cancellation, except in the case of non-payment of premiums, or for fraud, for which a 10-day advance written notice of cancellation is required.

AB 1985 (Wolk) Chapter 93, Statutes of 2004

Allows insurers to satisfy document retention requirements for an auto theft claim by maintaining an electronic copy of the original claim form in lieu of maintaining the original claim form.

AB 2199 (Kehoe) Chapter 311, Statutes of 2004

Defines, under a homeowners policy, that payment of the replacement cost is measured by the amount that it would cost the insured to repair, rebuild or replace the thing lost or injured; specifies that if a policy requires the insured to repair, rebuild, or replace the damaged property in order to collect the full replacement cost, the insurer shall pay the actual cash value of the damaged property, until such time as the damaged property is repaired, rebuilt, or replaced; and requires once the property is repaired, rebuilt, or replaced the insurer shall pay the difference between the actual cash value payment and the full replacement cost reasonably paid to replace the damaged property, up to the policy limits stated in the policy. The bill also requires that homeowners generally have one year from the date that the first payment toward the actual cash value is made in order to collect the full replacement cost of the loss, subject to the policy limit, and that, in the event of a loss relating to a declared "state of emergency," that from the date that the first payment toward the actual cash value is made, no time limit of less than 24 months shall be placed upon the insured in order to collect the full replacement cost of the loss, subject to the policy limit. Finally, the bill specifies that a homeowner has the right to full replacement cost

even if the homeowner decides to rebuild or replace the property at a location other than the original insured premises.

AB 2490 (Maddox) Chapter 95, Statutes of 2004

Allows non-admitted insurers and surplus lines brokers selling personal lines insurance products, such as homeowners' and umbrella insurance, to immediately bind coverage with an applicant, under specified circumstances. Sunsets January 1, 2008.

AB 2962 (Pavley) Chapter 605, Statutes of 2004

Provides that, if a total loss structure has not been rebuilt by the time of policy renewal, the insurer shall charge a renewal rate that reflects the change in risk to the property since the total loss occurred, prohibits an insurer from canceling coverage while the destroyed structure is rebuilt, except for specified reasons, and requires the insurer to offer to renew the policy at least once in certain circumstances. Applies to both homeowners and earthquake insurance coverage. This bill also defines actual cash value as: (1) in a case of total loss to the structure, the policy limit or the fair market value of the structure, whichever is less; or, (2) in a case of a partial loss to the structure, or loss to its contents, the amount it would cost the insured to repair, rebuild, or replace the thing lost or injured, less a fair and reasonable deduction for physical depreciation, as specified, based upon its condition at the time of the injury or the policy limit, whichever is less.

BILLS NOT SENT TO THE GOVERNOR

SB 667 (Soto) Held in Senate Rules Committee

Would have prohibited an insurer issuing certain forms of property insurance from ceasing to offer any particular line of coverage without obtaining the prior approval of the commissioner.

SB 691 (Escutia) Held in Assembly Insurance Committee

Would have defined credit history and generally prohibited its use in the offer or pricing of homeowners insurance.

SB 1474 (Escutia) Held in Assembly Insurance Committee

Would have prohibited an insurer from refusing to issue a residential property policy, renew a policy, base a surcharge or disallow a credit on the basis of certain claims. Specified that the following claims could not be considered in an adverse action: a) claims resulting from a loss due to natural causes; b) claims that are filed but are not paid or payable under the policy; c) claims resulting from fire losses in which the property of the applicant or insured was not the inception point of the fire; or d) claims for which the exposure to loss has been mitigated through the removal of the hazard, the repair of the damage or defect, or other changes to the property or loss-causing condition that eliminated the exposure that caused the loss.

AB 2444 (Dutton) Held in Senate Insurance Committee

Would have required the California Fair Access to Insurance Requirements Plan to provide an annual report to the Legislature on policies in force for insuring qualified property and probable maximum losses in very high fire hazard severity zones.

LIFE AND DISABILITY

BILLS SIGNED INTO LAW

SB 620 (Scott) Chapter 547, Statutes of 2003

Prohibits certain types of advertising and sales practices when marketing annuity products to seniors, increases training required of insurance representatives, and prohibits the recommendation of annuities to seniors under certain circumstances in order to reduce the possibility of expensive "churning" of investments.

SB 1088 (Scott) Chapter 381, Statutes of 2004

Allows a "grants and annuities society" (charity) to hold up to 50% of its investments backing charitable gift annuities in common stocks rather than the previous limit of 10%.

SB 1872 (Denham) Chapter 123, Statutes of 2004

Would allow the University of California to restrict employees to UC-selected annuities when investing through UC's 403 (b) retirement plan.

AB 226 (Vargas) Chapter 328, Statutes of 2003

Modifies the definition of "insurable interest" so that insurers could not issue corporate-owned life insurance policies on non-exempt employees, as defined. Would apply retroactively to such policies currently held by employers, except that it would allow fully-paid policies to continue in force under certain conditions.

AB 284 (Chavez) Chapter 381, Statutes of 2003

Creates an index-based interest rate for deferred annuity products, sets a single percentage of 87% for purposes of calculating the net considerations of all deferred annuities, and sets a flat fee of $50 per contract as the annual fee.

AB 1083 (Cogdill) Chapter 115, Statutes of 2003

Prohibits an insurer from issuing a policy to an applicant that insures the life of the applicant's spouse unless the spouse has signed the policy application or has otherwise been notified in advance of the issuance of the policy.

AB 1600 (Nakano) Chapter 166, Statutes of 2003

Extends the period of time that life and disability insurers must maintain records relating to the activities of their agents, authorizes the State Insurance Commissioner (IC) to collect and report data relating to life and disability insurance, and establishes civil penalties for failure to comply with the IC's request for information.

AB 2129 (Chavez) Chapter 803, Statutes of 2004

Technical clean-up to ensure consistent use of the term "owner" rather than "insured" in the provisions governing the 30-day right to cancel individual life insurance and individual annuity contracts, as specified.

AB 2316 (Chan) Chapter 835, Statutes of 2004

Creates a Life and Annuity Consumer Protection Program, including a fund exclusively dedicated to protecting consumers of life insurance and annuity products in the state. Levies a $1 dollar fee against new individual life insurance and annuity products worth $15,000 or more to fund the program. Sunsets these provisions effective January 1, 2010.

AB 2384 (Nakano) Chapter 601, Statutes of 2004

Requires all life and annuity contract forms be filed with the Department of Insurance prior to being issued, and also provides that an insurer who fails to pay under a disability insurance that contains a death benefit, accidental death insurance, and credit life insurance within 30 days of death, shall also pay interest on the death proceeds left on deposit, as already required of life insurance policies. Double-joins section 4.5 of this bill with AB 1910 (Harman) and makes the enactment of that section contingent upon certain conditions.

BILLS NOT SENT TO THE GOVERNOR

SB 273 (Soto) Held in Senate Rules Committee

Would have exempted the University of California from certain restrictions on the ability of a state department or agency to negotiate life or disability insurance or an annuity, or to require that that insurance or annuity be placed through particular agents, brokers or companies.

SB 1286 (Scott) Held in Assembly Insurance Committee

Would have required insurance agents who work inside banks to disclose to customers whether they are employed by the bank or whether they have a contractual relationship with the bank.

AB 1868 (Vargas) Held in Senate Insurance Committee

Would have allowed a disability income insurance policy to contain provisions for a rehabilitation program with mandatory physical or vocational rehabilitation as a condition of receiving payable benefits under the policy; would have allowed the insurer to require specified medical care as a condition of receiving payable benefits; and would have allowed a disability income insurance policy to provide for additional disability income if the insured was unable to perform at least two activities of daily living, as defined.

LICENSING

BILLS SIGNED INTO LAW

AB 700 (Diaz) Chapter 47, Statutes of 2004

Allows insurers who are licensed to transact credit insurance in other states to also be eligible to issue financial guaranty insurance in California.

AB 2520 (Vargas) Chapter 428, Statutes of 2004

Requires self-service storage facilities and their franchisees that sell insurance in connection with, and incidental to, self-service storage rental agreements to obtain a license to do so from the Insurance Commissioner, requires such licensees to provide training to their employees, allows the facility to collect the monthly storage fee and insurance premium in one check, and imposes other specified duties.

AB 2557 (Koretz) Chapter 279, Statutes of 2004

Increases penalties for unlicensed insurance agents, augments background information reporting requirements for insurance license applicants and licensees, and allows the Insurance Commissioner to take action against providers of continuing education who fail to achieve the Commissioner's standards.

BILLS NOT SENT TO THE GOVERNOR

AB 2639 (Cox) Held in Senate Insurance Committee

Would have authorized the Insurance Commissioner to restrict, rather than suspend or revoke, an underwritten title company's license or certificate of authority.

LONG-TERM CARE

BILLS SIGNED INTO LAW

SB 200 (Murray) Chapter 408, Statutes of 2003

Prohibits, until January 1, 2008, long-term care insurers from using genetic testing to determine insurability or for underwriting purposes.

MISCELLANEOUS

BILLS SIGNED INTO LAW

SB 1495 (Machado) Chapter 160, Statutes of 2004

Requires an insurer to reimburse an insured for any fees charged to the insured due to a late payment or lapse of coverage that was the result of fraud committed by an agent or broker, under specified conditions.

AB 652 (Leno) Chapter 4, Statutes of 2003

Permits California-domiciled mutual insurance companies, and reciprocal exchanges, to issue surplus notes or to incur loans on terms acceptable to the financial markets, and under appropriate regulatory control of the Department of Insurance.

AB 943 (Chavez) Chapter 392, Statutes of 2003

Makes several technical changes to statutory mortgage insurance company accounting practices to conform to laws in other states. Specifically, this bill: (1) allows mortgage insurance companies to transfer, with permission of the Insurance Commissioner, funds from the contingency reserve to the unassigned surplus; (2) gives the IC authority to approve or deny these transfers; and, (3) requires contributions to the contingency reserve to be quarterly rather than annual.

AB 1005 (Dutra) Chapter 440, Statutes of 2003

Allows a title insurer, underwritten title company or controlled escrow company to offer a reduced rate to the public upon filing the rate with the Department of Insurance and displaying the rate publicly; clarifies that rate reductions authorized under the statute remain under the authority of the Insurance Commissioner; and specifies that five years from the effective date of

this bill, and within existing resources, the DOI shall review the reduced rates authorized by this section to determine if they are inadequate or if they increase the possibility of title insurers becoming insolvent. This review shall be in addition to any other authorized by statute.

AB 1953 (Vargas) Chapter 600, Statutes of 2004

Substantially increases fines for acting as an unlicensed public adjuster and places additional limitations on the solicitation practices of public adjusters after disasters.

AB 2147 (Kehoe) Chapter 777, Statutes of 2004

Requires insurers who write wrap-up insurance policies to report workers' compensation information on both contractors and subcontractors to the rating agencies and to the contractor.

AB 2866 (Frommer) Chapter 281, Statutes of 2004

Requires the posting of specified fraud information on the Department of Insurance Web site for each person convicted of fraud.

ACR 74 (Steinberg) Res. Chapter 97, Statutes of 2003

States the position of the Legislature that Holocaust related funds obtained by the International Commission on Holocaust Era Insurance Claims be disbursed to, or on behalf of, Holocaust survivors living in poverty, in order to meet their basic needs, including food, shelter, and medical care, thereby allowing them to live out the remainder of their lives in comfort and dignity. Also requests that the California Insurance Commissioner utilize his seat on the commission to implement the intent of the Legislature.

AJR 44 (Koretz) Res. Chapter 145, Statutes of 2004

Urges the California Attorney General and the Insurance Commissioner to investigate any feasible alternatives to enacting a state law that would increase the likelihood that insurance companies would pay Holocaust era life insurance claims, and calls upon the U.S. Congress to pass legislation requiring insurance companies to disclose Holocaust era policy information.

BILLS VETOED

SB 673 (Florez)

As passed by the committee, SB 673 would have required the prior approval of rates used by mortgage guarantee insurers. The bill was ultimately amended to deal with a transportation issue in Fresno County, and was vetoed by the Governor.

AB 1297 (Frommer)

As reported to the committee, the bill would have redefined an "agent" for purposes of the insurance code. As reported out of the committee and sent to the Governor, the bill banned insurance to indemnify tax evaders against losses incurred when the IRS disallows their tax evasion schemes.

BILLS NOT SENT TO THE GOVERNOR

SB 344 (Speier) Held in Senate Insurance Committee

Would have permitted mortgage guarantee companies to offer a form of insurance that would satisfy a lender's interest upon refinancing or for purposes of a second mortgage, and as an alternative to title insurance, and would have permitted title insurers to offer the same coverage.

SB 354 (Speier) Sent to conference committee on workers' compensation

Would have made significant changes to the workers' compensation system, and to the insurance fraud statutes, including but not limited to: 1) setting reasonable caps on chiropractic and physical therapy treatments to avoid abusive care; 2) barring referrals to surgical centers by physicians who own the centers; 3) permitting employers to use health insurance to treat occupational injuries; 4) establishing a system of independent medical review for purposes of rapidly resolving disputes about the medical necessity of recommended care for injured workers; 5) increasing penalties for all types of insurance fraud. A form of independent medical review was ultimately adopted in legislation passed during this session, as was a cap on chiropractic and physical therapy visits, and a ban on self-referral except under specified circumstances (SB 228, Alarcon). Many of the insurance fraud provisions of this bill were ultimately incorporated into SB x4 2 (Speier) or AB 227 (Vargas) and signed into law.

SB 396 (Florez) Held in Senate Insurance Committee

Would have provided that an insurer is liable for a loss caused by the intentional commission of securities fraud by the insured.

SB 1675 (Johnson) Held in Senate Insurance Committee

Would have provided that certain prohibitions on cancellation of commercial insurance currently applicable to policies in force for 60 or more days instead apply to policies in force 65 or more days.

SB 1896 (Burton) Held in Senate Insurance Committee

Was introduced as a technical amendment to the code establishing the California Earthquake Authority, but not further amended to create substantive changes to the code.

AB 1962 (Cox) Held in Senate Insurance Committee

Would have allowed underwritten title companies to be domestic limited liability companies.

Informational Hearings 2003-2004

The committee held nine informational hearings regarding a mix of health, privacy, homeowners, and workers' compensation insurance issues, as noted below:

12/03/02: Medical Insurance and Consumer Financial Privacy

The committee examined the recently-enacted Health Insurance Portability and Accountability Act of 1996 (HIPAA), taking testimony from the Office of HIPAA Implementation (OHI) and stakeholders. Key issues examined included 1) whether HIPAA preempted state law; 2) whether the HIPAA privacy rule weakened California consumer protections; and 3) how California law regarding medical privacy should be clarified and strengthened.

The committee also examined a financial privacy issue: how much money is made in the selling and sharing of private consumer information by financial institutions? Although the committee requested the testimony of 10 financial institutions on this point, all 10 declined to participate in the hearing. The chair made a formal invitation to financial institutions to participate in a follow-up hearing. Testimony was taken from James Clark of the California Bankers Association; Evan Hendricks, editor and publisher of Privacy Times; and Mike DeCastro, a direct marketing consultant for Imagination, Inc. Mr. DeCastro testified that the direct marketing industry, entirely based on personal information, is worth $700 billion nationally. In 2002, according to Mr. DeCastro, the financial industry was estimated to have spent $24.4 billion in advertising expenditures. The net revenue to the financial services industry of direct marketing is almost $4 billion per year. Mr. DeCastro testified that by the hearing date in 2002, Californians' personal data was worth $468 million ($937 million gross) to the financial services industry.

12/04/02: Haunted Houses: Does making a claim make a home uninsurable?

The committee took testimony from Insurance Commissioner Harry Low, homeowners, agents, and insurers. Homeowners reported being uninsurable if they made inquiries about coverage or made a claim. In effect, their records were haunted by ordinary inquiries or minor claims. Consumer advocates noted that an inquiry or claim regarding one home could render all homes owned by the homeowner uninsurable. Homes with problems that had been fixed were also deemed uninsurable by some insurers—haunted by erroneous or misleading records kept in industry databases. At this hearing, Allstate Insurance Company conceded that it was using credit scoring in the rating and underwriting of homeowners policies. It subsequently agreed with the Insurance Commissioner that it would no longer use credit scoring. Other carriers denied using credit scoring in California. The committee subsequently informed the Department of Insurance about allegations of credit scoring in the underwriting of insurance by several other carriers. The department put an end to credit scoring at all companies that were reported, and additionally issued advisories to the insurance industry reminding carriers that the use of credit scoring in the rating and underwriting of homeowners and auto insurance is not permissible in California. From this hearing, SB 64 (Speier) was authored in 2003 and defeated in the

Assembly Insurance Committee. The bill, essentially, would have required an offer of homeowners coverage to any home that was insurable. SB 1474 (Escutia), a similar measure, was also authored and defeated in the Assembly Insurance Committee. SB 64 was subsequently amended (and signed into law) to permit the mediation of disputed claims arising out of the 2003 firestorms in Southern California.

1/15/03: Consumer Financial Privacy

A follow-up hearing to the medical and financial privacy hearing of December 3, 2002, at which 10 invited financial institutions had declined to testify. Five of the originally-invited institutions agreed to testify at the January 15th hearing: Cendant, Citigroup, Progressive Insurance, Providian, and Wells Fargo. Five again declined to testify: Bank of America, Capital One, Household, MBNA, and Merrill Lynch. The committee also heard testimony from Ed Mierzwinski of the California Public Interest Research Group, Washington, D.C., office. The purpose of the hearing was to examine the companies' financial privacy practices, their rationale, and their impact on consumers. Financial institutions discussed their corporate structures, their practices in sharing and using personal information, and how different laws, including federal and European laws, affect those practices. Mr. Mierzwinski testified in part on national privacy legislation and laws.

2/27/03: "Financial Planning or Fleecing of Seniors?": Insurance Products and Investments

Financial planning by the elderly is more important than ever as the costs of medical care not otherwise covered by Medicare, and long-term care, increase. This hearing examined the ways in which seniors are misled when buying insurance products during the financial planning process. "Medi-Cal planning," a process of shielding assets from recovery after the death of the Medi-Cal patient, was also discussed. A deputy district attorney and several experts on scams targeted at seniors testified about unscrupulous planners and insurance agents who misrepresented a variety of insurance products, notably annuities, as very secure investments, only to deliver losses to the investor. During the past five years, the California Department of Insurance has received approximately 2,500 complaints and inquiries that pertain to annuity products. DOI figures indicate that 25% of the complaints have involved senior citizens. However, cases involving seniors probably make up a much higher percentage of the complaints because the DOI does not always identify the age of the complainant and victims do not always disclose their age. SB 1088 (Scott-annuities), SB 1273 (Scott-twisting), and SB 1286 (Scott-banks and disclosure during insurance sales) were introduced as a result of these hearings. All three bills passed out of the committee and two were signed by the Governor. SB 1286 failed passage in the Assembly.

11/20/03: After The Fire-- Insurance Questions and Answers

On November 20, 2003, the Senate Insurance Committee convened in San Bernardino City Council chambers to meet with homeowners, insurers and Department of Insurance personnel. A firestorm of historic proportions had recently swept through Southern California. During the hearing, the Chair was able to get the insurance companies to agree that they would extend alternative living expense money for at least one year to all policyholders. The Chair was also

able to obtain agreement that no policyholder would be required to rebuild within 180 days of the fire in order to obtain replacement cost under the policy. Many companies issued policies that required homeowners to rebuild within 180 days of a loss in order to obtain full value under their homeowners policies (aka "replacement cost"). Southern California Automobile Club noted that its policies offer "guaranteed replacement cost" and therefore its policyholders were probably not underinsured. Other carriers asserted that their insureds largely had adequate coverage because "extended coverage" of anywhere from 20%+ under their policies would cover most major losses. Subsequent investigation by the committee and widespread reports about under-insurance cast doubt on these assertions. (The committee scheduled hearings in November 2004 in San Diego in order to examine the extent of the under-insurance problem, and to determine if statutory changes are necessary.) Policyholders reported tremendous mental anguish over having to provide a personal property inventory in order to claim full coverage under the personal property loss provisions of their homeowners' policies.

5/20/04: State Compensation Insurance Fund vs. Insurance Commissioner: Can California Win? (And Other Issues)

This hearing examined the impact of a lawsuit originally filed by the State Compensation Insurance Fund (SCIF), against the Department of Insurance, in opposition to the applicability of risk-based capital standards (RBC) to SCIF. The Chair and Vice-Chair of the committee met privately with both SCIF and the Insurance Commissioner prior to the hearing to urge settlement, and to note that a hearing would be held absent settlement. Settlement did not happen, and the Chair subsequently called both SCIF and the Insurance Commissioner to the hearing to examine the impact of the lawsuit upon the workers' compensation market. Generally speaking, the hearing demonstrated to the satisfaction of the members of the committee present that the suit was not beneficial to California. SCIF acknowledged that the Insurance Commissioner had regulatory authority over SCIF, but asserted that the Legislature never intended RBC standards to apply to SCIF. Generally speaking, SCIF indicated that it was important to keep its independence from the Insurance Commissioner. The Insurance Commissioner generally stated that he was willing to settle the suit and had made an attempt to do so. Testimony also demonstrated that SCIF and the Insurance Commissioner tended to blame each other for the inability of SCIF to reduce its rates faster. The hearing may lead to legislation in the 2005-06 session.

6/30/2004: Oversight of the Department of Managed Health Care (DMHC)

The committee held a hearing to oversee the structure, budget, and regulatory actions of the DMHC as a part of its regular oversight of departments within its jurisdiction. The committee heard testimony from the department's newly-appointed director, Ms. Lucinda "Cindy" Ehnes on the current priorities and future plans of the DMHC; it also heard from staff in several department units regarding specific staffing and budgeting questions. The chair made the following suggestions:

1. The DMHC should consider publishing an advisory rate for non-contracted provider reimbursements as the Insurance Commissioner does for workers' compensation rates.

2. A law may be needed to require plans to identify which doctors are accepting new patients, and to report the information to the department.

3. The power of the director of the DMHC to waive certain provisions of the Knox-Keene Act may need further examination by the Legislature.

4. The department should do a review of the lack of plan compliance with osteoporosis screening.

5. Regarding its approval of the Anthem-Wellpoint merger, the department should be careful to ensure that the prices of conversion health insurance products offered to California enrollees are affordable.

6. The chair questioned whether the Office of the Patient Advocate should be independent of the DMHC or whether it should be folded into the HMO Help Center. The chair also questioned the need for an HMO guide if most enrollees obtain their insurance through employers that have human resources departments.

7. In general, the chair was concerned that the department is not devoting enough of its resources to enforcing the Knox-Keene Act and its accompanying regulations.

07/09/04: Blue Cross-Anthem Merger Hearing with Assembly Select Committee to Investigate the Merger of California Health Insurance Providers

The two committees took testimony from the DMHC, the Department of Insurance, Blue Cross and opponents of the merger of WellPoint (Blue Cross' parent) with Anthem. The level of executive compensation, questions about coverage that would be available to small businesses post-merger, the rationale for the proposed merger, and Blue Cross' record of provider relations were discussed. Ultimately, the DMHC approved the application from WellPoint for a material modification to its existing license, and the Department of Insurance rejected the application before it. WellPoint has sued the Insurance Commissioner arguing that he has exceeded his authority in rejecting the application.

11/15/04: Up In Smoke: Can More Be Done to Help Fire Survivors Settle Their Claims?

The committee took testimony in El Cajon (San Diego County) before 250 survivors of the 2003 firestorms. At the opening of the hearing, the committee was able to announce that one company (Allied) was willing to continue paying alternative living expense money through the end of 2004, and would probably be paying homeowners for debris removal performed by volunteers. These agreements were achieved due to intervention by the committee. Key complaints from dozens of witnesses who spoke before the committee during the evening were: a) Some carriers refused to modify their contracts so that fire survivors could obtain additional living expense money for more than one year; b) Some carriers required lengthy, detailed inventory lists from homeowners – an agonizing process of cataloging losses of possessions accumulated over decades; c) Many homeowners were simply underinsured and were not aware of it, despite repeated assurances from agents or companies that they had all the insurance needed to rebuild

should they lose their home. The committee also offered to help settle disputes between insurers and homeowners. Thirteen requests were received on the night of the hearing, and one dispute was settled that same evening. The committee's staff was instructed to contact homeowners and companies in order to move the process of settlement forward in these individual cases.