

# California Legislative Update

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Western Claim Conference  
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# Today's Agenda

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- An overview of 2008
- What may be on the horizon for 2009
  - Mandated benefits
  - Rescission
  - Rate approvals
  - And more
- The impact of the budget & the deficit
- Questions

# Mandated Benefits: 2008

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- One Bill Passed
- AB 1894 - HIV Testing - Chapter 631
  - Applies to HMOs & health insurers
  - Applies to individual & group contracts & policies
  - Effective January 1, 2009
  - The mandate: the plans must provide testing for human immunodeficiency virus (HIV) regardless of whether the testing is related to a primary diagnosis

# Mandated Benefits – Vetoed Bills

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- AB 16 - Human Papillomavirus Vaccination – Vetoed
  - Plans (individual & group) would have covered a human papillomavirus vaccination (effective 1/1/2009)
- AB 30 - Phenylketonuria: Metabolism Error – Vetoed
  - Plans (individual & group) would have covered the testing & treatment of inborn errors of metabolism, including formulas and special food products (effective 1/1/09)
- AB 54 – Acupuncture – Vetoed
  - Plans (group) would have been required to cover (rather than just offer) coverage for acupuncture, on terms & conditions agreed to with the group policyholder (not a public entity) (effective 1/1/09)
- AB 368 – Hearing Aids – Vetoed
  - Plans (individual & group) would have offered coverage for hearing aids, up to \$1,000, to all covered persons under 18 (effective 1/1/09)

# Mandated Benefits – Vetoed Bills

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- AB 1887 – Mental Health Services – Vetoed
  - Plans (individual & group) would have covered the diagnosis and treatment of a mental illness of a person of any age; coverage would be for any mental disorder defined in the Diagnostic and Statistical Manual IV (“DSM IV”), including substance abuse (effective 1/1/09)
- AB 1962 – Maternity Services – Vetoed
  - Health insurance policies (individual & group) would have covered maternity services (effective 1/1/09)
- SB 1198 – Durable Medical Equipment – Vetoed
  - Plans (group) would have offered coverage for durable medical equipment & services on terms & conditions agreed to with the group contract/policyholder (effective 1/1/09)
- SB 1634 – Cleft Palates – Vetoed
  - Plans (individual & group) would have covered orthodontic services deemed necessary for medical reasons for cleft palate procedures (effective 7/1/09)

# Mandated Benefits - Stalled

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- AB 841 – Mammographies – Stalled
  - Plans (individual & group) would have covered mammographies for screening & diagnostic purposes upon referral (somewhat broader coverage than existing law) (effective 7/1/09)
- AB 1774 – Gynecological Cancer Screening Tests – Stalled
  - Plans (individual & group) would have covered any test necessary for the screening & diagnosis of gynecological cancers, consistent with national standards (effective 1/1/09)
- AB 2174 – Amino Acid Based Elemental Formulas – Stalled
  - Plans (individual & group) would have covered these formulas for the diagnosis & treatment of eosinophilic gastrointestinal disorders & short bowel syndrome (effective 1/1/09)
- AB 2234 – Breast Cancer Screening/Diagnosis – Stalled
  - Plans (individual & group) would have covered tests necessary for screening & diagnosis of breast cancer (not limited to mammography) (effective 1/1/09)

# Dependents & Dental Coverage

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- SB 1168 – Dependent Children – Chapter 390
  - If an HMO or health insurance policy covers children 18 & over who are enrolled full-time at a secondary or postsecondary school then,
    - If the student takes a medical leave of absence, coverage shall not terminate for 12 months
    - A medical certification shall be provided
- SB 1387 – Dental Coverage: Provider Overpayments – Chapter 403
  - Specifies what must be included in a notice of overpayment sent by a plan to a dentist
  - If the payment is uncontested, the dentist will be liable for 10% interest if the money is not returned in 30 working days

# Long-Term Care Insurance

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- AB 2137 – Long-Term Care: Rescission – Chapter 227
  - Changes existing law to require insurers to maintain records of all rescissions, including those voluntarily initiated by the insured
  - Specifies the type of information that must be provided to the DOI
  - Authorizes the DOI to make the information public
- SB 1216 – Long-Term Care: Interest – Chapter 171
  - Interest will accrue, starting on the date due, at 10% per year for claims accepted on 12/1/08 and then not paid

# Rescission & Underwriting

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- AB 2569 – Rescission – Chapter 604
  - Individual plans can only rescind the coverage of the person whose information led to the rescission, not others who may be covered under the contract or policy; a new individual contract or policy must be offered instead (at an appropriate rate)
  - Producers have a “duty to assist the applicant in providing answers to health questions accurately and completely”
  - Producers who assist applicants must sign an attestation on the application (applies to all contracts/policies)
  - A penalty of \$10,000 could be imposed for willfully making a false attestation

# Rescission & Underwriting

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- AB 1150 – Underwriting Practices – Chapter 188
  - HMOs & insurers cannot compensate someone based on the number of contracts or policies the person has caused or recommended to be rescinded, canceled, or limited, or the resulting cost savings
  - Cannot set performance goals, quotas, or compensation based on the number of rescissions or related cost savings
- AB 1945 – Individual Health Coverage – Vetoed
  - Regulators would prepare standard health questions
  - Individual applications would be approved prior to use as of 1/1/10
  - Medical underwriting would have to be completed prior to policy/contract issuance
  - Limitations would be placed on the ability to rescind

# Providers

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- AB 1203 – HMOs: Post-Stabilization Care – Chapter 603
  - Non-contracting hospital cannot balance bill a patient, unless the patient agrees or the hospital cannot obtain contact information for the HMO
  - HMO must provide 24-hour access so that non-contracting hospitals can obtain post-stabilization authorizations
- SB 1553 – HMOs: Mental Health – Chapter 722
  - HMOs cannot base decisions to deny provider authorization requests or reimbursements on whether mental health services were sought voluntarily or involuntarily

# Providers - Vetoed

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- AB 1155 – Provider Payments – Vetoed
  - This bill would have increased the penalties the DMHC could charge an HMO that engaged in an “unfair payment pattern” by failing to timely pay providers—plus pay the claim with interest
- AB 2220 – Emergency Room Physician Contracts – Vetoed
  - For contract negotiations between ER doctors & HMOs, either party would be able, once, to invoke mandatory mediation, costs to be shared equally
- AB 2861 – ER Services: Psychiatric Emergency – Vetoed
  - Authorizes the admission or transfer of a patient to a psychiatric ward within a general acute care hospital, if authorized by the treating doctor
  - The provider must notify the HMO
- SB 981 – Noncontracting Physician Claims – Vetoed
  - ER physicians cannot balance bill patients

# SB 28 – Cell Phones

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- July 1, 2008: Cannot talk on the phone while driving unless the phone is operated hands free
- January 1, 2009: Cannot write, send, or read a text-based message while driving
- \$20/first offense, \$50/subsequent offenses
- You can read, select, or enter a phone number or name for the purpose of making or receiving a call



# What's on the Horizon for 2009?

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- Piecemeal approach to reform, the sequel
- Numerous mandated benefit bills
  - CalChamber: Could cost employers, individuals, & state public employee benefit systems \$394M ([www.chbrp.org](http://www.chbrp.org))
- Rating, underwriting, & rescission
- The budget, the deficit, the governor

# Mandated Benefits

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- AB 244 – Mental Health Services
  - Mental health parity by HMOs & insurers would be extended to all mental illnesses defined in the Diagnostic and Statistical Manual IV; applies to individual & group policies & contracts
- AB 214 - Durable Medical Equipment
  - HMOs & insurers must cover durable medical equipment; applies to individual & group policies & contracts
- AB 163 - Amino Acid-Based Elemental Formulas
  - HMOs & insurers must cover the use of amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic gastrointestinal disorders when ordered by physician; applies to individual & group policies & contracts

# Mandated Benefits

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- SB 161 – Cancer Treatment
  - HMOs & insurers that cover chemotherapy treatment to must cover a prescribed, orally administered cancer medication on a basis no less favorable than intravenously administered or injected cancer medications; applies to individual & group policies & contracts
- SB 158 - Human Papillomavirus Vaccination
  - HMOs & insurers that cover cervical cancer must cover HPV vaccine; applies to individual & group policies & contracts
- AB 56 - Mammographies
  - Effective 7/1/10, expands coverage mandate by not limiting frequency of tests by age; applies to individual & group policies & contracts (& self-funded plans)

# Mandated Benefits

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- AB 98 - Maternity Services
  - Insurers must cover maternity services effective 1/1/10; applies to individual and group policies
- AB 259 - Certified Nurse-Midwives
  - Expands existing law to allow a woman to seek obstetrical and gynecological services from a certified nurse-midwife; applies to insurers & HMOs
- AB 513 - Breast-Feeding
  - HMOs & insurers must provide coverage for lactation consultation with an international board certified lactation consultant and for the rental of breast pumps; applies to individual and group policies and contracts

# Additional Mandates

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- SB 529 - FDA Approved Treatment
  - This bill would require a health care service plan contract or a health insurance policy that provides coverage of a health condition to also provide coverage for any federal Food and Drug Administration approved treatment of that condition, including medications
- SB 630 - Reconstructive Surgery
  - Expands existing requirement to cover reconstructive surgery in certain circumstances to include dental or orthodontic services that are medically necessary to provide or complete reconstructive surgery for cleft palate procedures; applies to individual & group policies and contracts
- SB 296 – Mental Health Services
  - HMOs & insurers must direct that mental health services be provided in a manner that coordinates benefits between all mental health care providers and general physical health care providers; must create a website & issue an ID card

# Universal Health Coverage & Reform

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- SB 810 - Single-Payer Health Care Coverage
  - A state plan covers all California residents
- SB 92 – Health Care Reform
  - Extensive bill expanding insurers are eligible to offer policies in this state, re-defining associations for purposes of AB 1672, permitting sales of policies without mandated benefits to low income individuals, & modifying medical necessity processes
- SB 316 – Health Care Coverage: Benefits
  - HMOs & insurers must expend on health care benefits no less than 85% of premiums with respect to contracts or policies issued on or after 1/1/13
    - Vetoed similar measure in 2008
- SB 786 – Individual Choice Categories
  - Establishing standards for individual policies & contracts: by 9/1/10, the DMHC & DOI must develop a system to categorize all HMO contracts & insurance policies offered to individuals into 6 coverage choice categories that meet specified requirements

# Rescission

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- AB 2 – Individual Health Care Coverage
  - Regulators establish health history forms
  - Must complete medical underwriting before issuing policy or contract
  - Cannot rescind if you do not follow all the medical underwriting requirements
  - Cannot rescind unless there was material misrepresentation or omission in the information submitted by the applicant that would have prevented the contract from being entered into & you can show it was intentional
- AB 108 – Individual Health Care Coverage
  - Insurer and HMO cannot rescind for any reason after 18 months

# Rating & Underwriting

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- AB 730 - Unlawful Postclaims Underwriting
  - Increases the penalties for unlawful postclaims underwriting by insurers
- AB 1218 – Rate Approval
  - HMOs & insurers must get regulatory approval for increase in the amount of the premium, copayment, coinsurance obligation, deductible, and other charges
- AB 119 & SB 54 – Health Care Coverage: Pricing
  - HMOs & insurers cannot charge a different premium based on sex, even if actuarially supported

# Claim Information

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- AB 562 - Report of Claim Information
  - HMOs and health insurers that receive a written request for claim information from a plan, plan administrator, or plan sponsor must provide the information within 30 days
    - Includes aggregate paid claims experience by month (including medical, dental, and pharmacy benefits), and capitation costs or payments
    - Premiums paid by month
    - Covered employees by month plus their tier
    - Total dollar amount of pending claims
    - Includes a separate description of claims over \$20,000
  - Cannot disclose if protected by state or federal law

# Provider Contracting

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- SB 196 - Provider Contracts
  - Contracts between providers and HMOs or insurers cannot restrict the ability of the HMO/insurer to furnish information on the cost of procedures or health care quality
- AB 1201 - Immunizations for Children: Reimbursement of Physicians
  - HMOs & insurers must reimburse immunizations in an amount not less than the actual cost of acquiring the vaccine plus the cost of administration of the vaccine
  - No co-pays or deductibles and no dollar limit
- AB 896 - Provider Reimbursement Rates
  - Provider rates of payment for services under certain government programs must be the same as those for Medi-Cal, except for hospital interim rates of payment, which are 90% of Medi-Cal hospital inpatient rates of payment until 1/1/10; AB 896 would extend indefinitely the provisions that would expire on 1/1/10

# Rx and Privacy

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- AB 1144 - Health Care Coverage: Prescriptions
  - Step therapy: HMOs & insurers must provide written reports to the regulators whenever it has required an enrollee/insured to use certain pain medications prior to providing access to a pain medication supported by an FDA approved indication or to a pain medication prescribed by the enrollee's or insured's provider
- SB 238 - Prescription Drugs
  - When medically indicated, insurers & HMOs must provide coverage for 90-day supplies of medications
  - For certain conditions, pharmacies will be allowed to mail information to patients
- AB 952 - Health Information: Disclosure: Taft-Hartley Plans
  - Allows authorized disclosures by an HMO or insurer

# Life Insurance

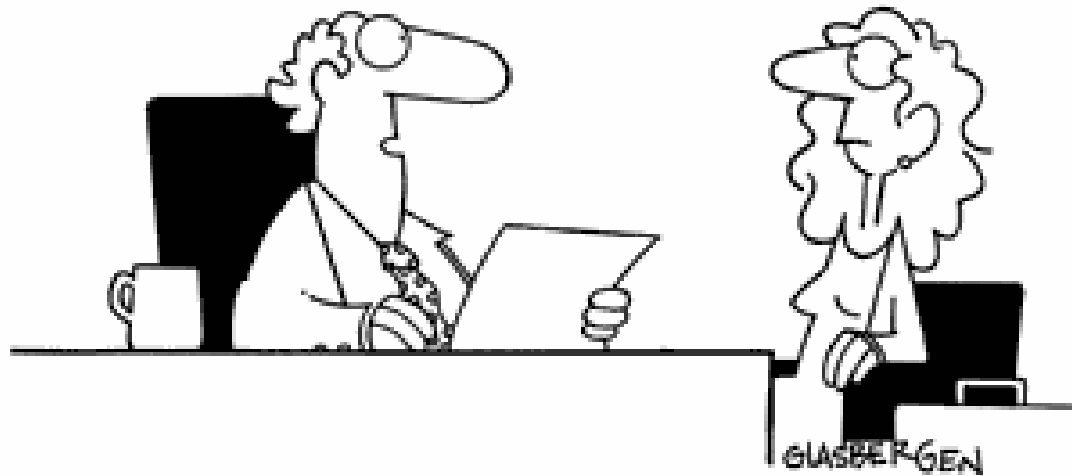
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- SB 98 - Life Insurance: Contracts and Viatical Settlements
  - Viatical settlements will be re-defined as life settlements
  - Would require special licensure to sell
  - Requires certain disclosures
- SB 397 – Life Insurance
  - Amends the notice requirements when life policies are sold to seniors for funeral or burial expenses
  - Policies with a face value of \$15,000 or less can be returned within 60 days

# Dental Coverage

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- AB 684 - Claim Reimbursement: Late Payments: Dental Services
  - Under existing law, HMOs and health insurers are required to reimburse uncontested claims no later than 30 or 45 working days after receipt of the claim, and if a claim is not reimbursed within that time period, interest will accrue at the rate of 15% per annum, for health care service plans, and 10% per annum, for health insurers
  - AB 684 would provide that, for dental service contracts, the interest rate for uncontested claims would accrue at 20% and 25% if they are not reimbursed within 60 or 90 working days, respectively, after receipt
  
- AB 745 - Self-Funded Dental Benefit Plans
  - An administrator providing administrative services for a self-funded dental benefit plan must include language in EOBs and other forms explaining that the plan is governed by ERISA



*"We encourage our employees to sweeten their  
coffee with toothpaste instead of sugar.  
That's our dental plan."*

# Medicare Supplement

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- AB 1543 - Medicare Supplement Coverage: Medicare Advantage
  - Among other changes, conforms laws relating to Medicare supplement coverage to GINA and the Medicare Improvements for Patients and Providers Act of 2008
  - Conforms law on Medicare Advantage policies relating to underwriting, beneficiary improvements, increased access for low-income beneficiaries, and modified prescription drug benefits and physician services
  - Sponsored by DOI to give it authority to bring law up-to-date

# Emergency Services

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- AB 235 - Emergency Services and Care
  - Emergency services would include admissions or transfers to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital within the care and treatment of this condition
  - Adds a definition of “psychiatric emergency medical condition”
  - To ensure that hospitals are reimbursed for emergency care that is treated with an inpatient admission

# Dependents

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## ■ AB 29 – Dependents: Limiting Age

- A group policy or contract cannot have a limiting age less than 27 years of age
- No employer is required to pay the cost of coverage for dependents who are at least 23 years of age, but less than 27 years of age
  - Instead, subscribers and insureds can elect to contribute the premium
- Does not apply to contracts subject to collective bargaining that are effective prior to 1/1/10; but it shall apply to any contract subject to collective bargaining issued on or after 1/1/10

# Continuation Coverage

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- SB 727 – Cal-COBRA
  - HMOs & insurers must offer continuation coverage to active employees whose employer terminates the plan and does not provide a successor plan; coverage would be for not less than 18 months, unless the employee is terminated for cause
- SB 796 – Continuation Coverage
  - Deletes the requirement that a person has to exhaust COBRA or Cal-COBRA in order to be eligible for an individual HIPAA policy

# The Stimulus Bill: Cal-COBRA

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- AB 23: Amends Cal-COBRA
  - Effective: May 12, 2009
- Provides for second election period
- Insurers must provide a notice to QBs who had a QE between 9/1/08 and 12/31/09
  - Specifies what must be included in notice, such as notice of subsidy, election form, & option to enroll in different coverage
  - Notice provided within 14 days of effective date
- Insurer not required to amend EOC
- 60 days to elect Cal-COBRA
- May request verification of involuntary termination from employer

# Questions

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