



DATE: October 28, 2010
TO: Our Valued Client Partners & Friends
FROM: HIB Account Team
RE: **LEGISLATIVE UPDATE 2010-22: California Health Care Legislation: 2010**

We are pleased to bring you our **Legislative Update 2010-22: California Health Care Legislation: 2010**. This update provides details of some of the laws passed in the California State Legislature; many of the new state laws mirror federal Health Care Reform. As always, please feel free to contact your HIB Account Team for assistance.

CALIFORNIA HEALTH CARE LEGISLATION: 2010

In 2010, the California State Legislature produced its own health care reform legislation which, for the most part, constitutes California's response to the new federal Health Care Reform Laws (HCR). Although the centerpiece legislation is the establishment of the rules and a mechanism for the California Health Benefit Exchange, there are other important developments:

- i [AB 1178](#): California failed to extend state tax relief on premiums paid for group health care coverage provided to adult dependents between age 24 and 26. Federal law provides a tax break; California will not.
- i California also established a high-risk pool for individuals with preexisting conditions, which prevented them from obtaining group health coverage for six months or longer. For details regarding this legislation, please refer to our Memorandum 2010-18.
- i California has enacted a number of other new laws in conformance (or near conformance) with federal Health Care Reform Laws.

The purpose of this Memorandum is to provide a very informal discussion of the California response to federal HCR and to identify some other health care initiatives enacted during the 2010 session of the California legislature.

THE CALIFORNIA HEALTH BENEFIT EXCHANGE

Although the Exchange begins its duties in 2014, California is the first and, perhaps, will be the model for other Exchanges throughout the country, when all is said and done, or undone. This new legislation gives us an overview of its potential structure.

1. **The California Health Benefit Exchange: An Overview.** In general, the Exchange will serve as a government-administered marketplace providing Californians with a choice of group and individual health insurance plans through a website that will provide detailed information about plans and offer a toll-free number to assist consumers in understanding their options, compare, and buy coverage. The Exchange will serve a consortium of individuals and small businesses (up to 100 employees) that will pool their buying power, in theory, to get health care coverage at lower prices. California's Health Benefits Exchange is likely to be the largest Exchange operated by a single state, with as many as 8.3 million residents expected to be eligible for coverage.
2. **Federal Subsidies.** In accordance with federal requirements, the California Exchange will offer health plans in five categories, ranging from catastrophic coverage to plans with extensive benefits. The Exchange also will provide resources to connect eligible Californians to federal subsidies for health coverage and access to coverage through government programs such as Medi-Cal. The program is expected to bring as much as \$10 billion in subsidies for California over a 10-year period.
3. **Oversight Board.** [AB 1602](#) and [SB 900](#) establish an independent, five-member board to oversee California's Exchange. Gov. Schwarzenegger will appoint two of the five members before the end of his term, and the legislature will appoint the remaining members. The Oversight board will be in charge of developing the



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framework for the insurance Exchange and defining how the Exchange will operate, the implementation of the Exchange, enrolling Californians, and selecting qualified health plans to participate. The Exchange is due to be in place by 2014, the deadline imposed by HCR.

OTHER APPROVED MAJOR HEALTH CARE REFORM BILLS

Gov. Schwarzenegger signed several additional health care-related reform bills, including: prohibiting insurers from denying coverage to children because of preexisting conditions; extending dependent coverage to age 26, preventing insurance companies from canceling coverage except in cases of fraud or misrepresentation, and a bill mandating at least 60 days written notice before insurers implement any changes to premium rates or coverage, and another requiring health plans to cover certain preventive services without imposing cost-sharing.

1. **Adult Dependent Coverage to Age 26.** [SB 1088](#) requires health insurers and health care service plans to cover dependents up to age 26 in accordance with the Federal Patient Protection and Affordable Care Act (PPACA), which requires a health insurance carrier or Knox-Keene plan issuing group or individual coverage that provides dependent coverage of children to continue to make that coverage available to an adult child until the child attains 26 years of age for plan years beginning on or after September 23, 2010. It also requires issuers to provide certain dependents who have lost or been denied coverage an opportunity to re-enroll.

Note: California failed to extend state tax relief on premiums paid for group health care coverage provided to adult dependents between age 24 and 26.

2. **Preexisting Condition Limitations on Children to Age 19 Abolished.** [AB 2244](#) prohibits insurers and health care service plans from denying coverage or non-renewing coverage for children up to age 19 with preexisting conditions. The bill also prescribes limits on the rates that may be imposed for coverage of a child depending on whether the child applies for coverage during an open enrollment period or is a late enrollee and would require plans and insurers to apply standard risk rates to child coverage. The bill prohibits a plan or carrier that does not comply or ceases to write new plan contracts or policies for children from offering new contracts or policies in the State of California for five (5) years. AB 2244 further authorizes the Department of Managed Health Care and the Department of Insurance to issue guidance for purposes of implementing these provisions. Except as noted, the main provisions of this bill parallel HCR.
3. **Rescissions.** [AB 2470](#) prohibits health insurers or health care service plans from canceling insurance once a policy is issued, unless there is fraud or intentional misrepresentation. Paralleling federal Health Care Reform Law, the Act gives an enrollee of a health care service plan or insurance policy a right to appeal a cancellation or nonrenewal and further prohibits a plan or insurer from engaging in post-claims underwriting and from rescinding an individual contract or policy for any reason, or canceling the contract or policy due to misrepresentation after 24 months following issuance of the contract or policy.

Notice Requirement: AB 2470 requires a plan or insurer to send a notice to the enrollee or subscriber or policyholder or insured at least 30 days prior to the effective date of the rescission containing specified information. AB 2470 further modifies the cancellation and nonrenewal appeal rights by requiring coverage under the plan or policy to continue pending the appeal. The Director of the Department of Managed Health Care and the Insurance Commissioner are authorized to issue guidance to health care service plans and health insurers on compliance. Once again, California follows the federal rules.

4. **Rate Approvals.** [SB 1163](#) requires independent actuaries to review and certify health insurers' rate filings to ensure that premium costs are calculated accurately and that all proposed rate hikes are posted on insurer and



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state websites. SB 1163 also requires health plans to provide an applicant to whom it denies coverage or enrollment or offers coverage at a rate higher than the standard rate or standard employee risk rate with the specific reason or reasons for that decision in writing. Both health insurers and health care service plans issuing individual or group policies or contracts are required that the reasons for a denial or a higher than standard rate be stated in clear, easily understandable language. SB 1163 also requires a 60 day notice of a change to the premium prior to the effective date of the change.

Once again, the Departments of Managed Care and Insurance must review all rate filings and issue guidance regarding compliance, require the departments to consult with each other regarding specified actions, and require the departments to post certain findings on their websites.

5. **Preventive Care.** [AB 2345](#) requires all health plans to cover certain preventive services with no cost-sharing, adopting the federal Health Care Reform rule. AB 2345 requires health care service plan contracts and health insurance policies issued, amended, renewed, or delivered on or after September 23, 2010, to comply with the provisions of PPACA regarding coverage of, and cost-sharing for, preventive services and any rules or regulations issued pursuant to those provisions to the extent required under federal law.

COMMENTARY

1. **Insured Plans Only.** It is important to note that the health care legislation in California applies only to insured group health plans and health care service plans (HMOs). These laws modify the California Insurance Code and the Health and Safety Code. These laws will not apply to self-funded plan or to stop loss policies (i.e., a liability policy not a health care policy). To the extent that there are differences between state and federal law, the state law will apply for California policies. Self-funded plans must follow the federal rules.
2. **Dental and Vision Plans.** Although, with minor exception, free-standing dental and vision plans are outside the scope of most federal HCR rules, some California insurers have interpreted SB 1088 to require insured dental and vision plans to allow age 24-26 year old adult dependents to re-enroll in dental and vision plans. We await official guidance on this issue.

UNRELATED HEALTH AND OTHER LAW CHANGES

The Legislature has passed and the Governor has signed additional pieces of legislation during the 2009-2010 session.

- i [AB 52](#) allows parents to voluntarily donate umbilical cord blood that could help treat cancer and other illnesses. AB 52 augments existing law.
- i [AB 328](#) allows certain transactions to be conducted electronically, including insurance transactions.
- i [AB 952](#) authorizes certain disclosures of medical information to an employee welfare benefit plan formed under the Taft-Hartley Act.
- i [AB 1541](#) extends from 30 days to 60 days the time period an individual or dependent who has lost or will lose Healthy Families Program coverage or no share-of-cost Medi-Cal coverage has to request enrollment in group coverage without being considered a late enrollee.
- i [AB 2541](#) provides additional tools for California to improve its HIV/AIDS surveillance activities and reporting of certain communicable diseases and apply for federal Ryan White CARE Act funds. AB 2541 removes the exemption from electronic reporting for HIV infections and requires health care providers and laboratories to



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report cases of HIV infection to the local health officer using patient names and set guidelines regarding such reports.

- i [SB 296](#) requires every health care service plan, including a specialized health care service plan, and health insurer that provides professional mental health services to issue an identification card to each enrollee.
- i [SB 1304](#) provides employees that donate life-saving bone marrow or organs with paid, protected leave from their employment.

We will keep you informed about the renewed activities of the California legislature once election day has passed.

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