

California

California Department of Insurance
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Summary of Important Regulations

MEWA Regulations	Yes ¹
TPA Regulations	Yes ²
Stop-Loss Regulations	No
UR Regulations	No

NAIC Model Laws or Regulations

<u>Name of Model Law/Regulation</u>	<u>Model/Similar</u>	<u>Related</u>
Health Insurance Reserves Model Regulation	Cal. Admin. Code tit. 10 §§ 2310 to 2315	Cal. Ins. Code § 997
Comprehensive Health Ins. Cost Containment Model Act	None	None
Standardized Health Claims Form Model Regulation	None	Cal. Health & Safety Code §§ 447.70 to 447.75
Small Employer Health Insurance Availability Model Law	None	Cal. Ins. Code §§ 10700 to 10749; Cal. Health & Safety Code §§ 1357 to 1357.17
Model Regulation To Eliminate Unfair Sex Discrimination	Cal. Admin. Code tit. 10 §§ 2560 to 2560.6	Cal. Ins. Code § 679.71
Health Information Privacy Model Law	None	None
Preferred Provider Arrangements Model Law	None	Cal. Ins. Code §§ 10133 to 10133.5,10180,742,10402 to 10402.1; Cal. Admin. Code tit. 10 §§ 2240 to 2240.4
Utilization Review Model Law	None	None
Managed Care Plan Network Adequacy Model Law	None	None
Third Party Administrator Law	Cal. Ins. Code §§ 1759.0 to 1759.10	None
Stop-loss Insurance Model Law California	None	None

NAIC Model Laws or Regulations

<u>Name of Model Law/Regulation</u>	<u>Model/Similar</u>	<u>Related</u>
Jurisdiction of Health Care Providers Model Law	Cal. Ins. Code § 740	None
Standard Group Health Model Law	None	Cal. Ins. Code §§ 10270 to 10277
Group Health Insurance Conversion Law	None	Cal. Ins. Code §§ 12670 to 12691
Group Coverage Discontinuance/ Replacement Model Regulation	None	Cal. Ins. Code §§ 10128 to 10128.4; 10133.56
Premium Rates and Renewability of Coverage-Small Groups	None	Cal. Ins. Code §§ 10700 to 10749; Bulletin No. 93-3A
Group Coordination of Benefits Model Law	Cal. Admin. Code tit. 10 §§ 2232.52 to 2232.59	None
Model Regulation for Certification of Health Plans	None	None
Off-Label Drug Use Model Law	None	Cal. Ins. Code § 10123.195
Group Health Mandatory Drug/ Alcohol Dependency Law	None	Cal. Ins. Code §§ 10123.6, 11512.14
Model Newborn Children's Law	None	Cal. Ins. Code § 10119
Health Examination Benefits Availability Law California	None	Cal. Ins. Code §§ 10123.5; 11512.14

NAIC Model Laws or Regulations

<u>Name of Model Law/Regulation</u>	<u>Model/Similar</u>	<u>Related</u>
Accident and Sickness Insurance Minimum Standards Model Law	None	Cal. Ins. Code §§ 10291.5;10600 to 10609
Agents and Brokers Licensing Model Law	None	Cal. Ins. Code §§ 1621 to 1758.5
MEWA Licensing Model Law	None	None
Managing General Agents Law	Cal. Ins. Code §§ 769.80 to 769.87	None
Health Maintenance Organization Model Law	None	Cal. Health & Safety Code §§ 1340 to 1399.64 §§ 1374.60 to 1374.71
Insurance Information and Privacy Protection Law	Cal. Ins. Code §§ 791.01 to 791.26	None
Unfair Trade Practices Law	Cal. Ins. Code §§ 780 to 790.10	Cal. Ins. Code § 750.1
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basics of Physical or Mental Impairment	Cal. Ins. Code § 10144; § 11512.19	None
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basics of Total or Partial Blindness	Cal. Ins. Code § 10145	None

NAIC Model Laws or Regulations

<u>Name of Model Law/Regulation</u>	<u>Model/Similar</u>	<u>Related</u>
Unfair Discrimination against Subjects of Domestic Abuse in Health Benefit Plans Model Law	None	Cal. Ins. Code §§ 10144.2 an 10144.3
Unfair Claims Settlement Practices Law	Cal. Ins. Code § 79.03	None
Improper Termination Practices Law	None	None
Employee Leasing Registration Model Law	None	None
Private Employer Workers' Compensation Group Self-Insurance Model Law	None	None
Public Employee Workers' Compensation Group Self-Insurance Model Law	None	None
Twenty Four Hour Coverage Pilot Project Model Law	None	None

State-Mandates

Benefits That Must Be Covered

- Breast reconstruction
- Cervical cancer screening
- Clinical trials, for cancer patients only
- Complications of pregnancy (only if maternity care is offered)
- Contraceptives
- Diabetic supplies, education
- Emergency services
- Formula for PKU
- Mammography screening
- Mental health, general
- Mental health, parity
- Minimum mastectomy stays
- Minimum maternity stays
- Off-label drug use
- Osteoporosis
- Prostate cancer screening
- Second medical and surgical opinion
- TMJ disorders
- Well-child care

Benefits That Must Be Offered

- Alcoholism treatment
- Blood lead screening
- Drug abuse treatment
- Home health care
- Infertility services and/or *in vitro* fertilization
- Maternity care
- Ortoties or prosthetics
- Prescription drugs if medically necessary

Persons Who Must Be Allowed Coverage

- Continuation/dependents/spouses
- Continuation/employees
- Conversion to non-group
- Handicapped dependents
- Newborns

Providers Who Must Be Covered

- Acupuncturists
- Chiropractors
- Dentists
- Marriage/Family Therapists
- Nurse Midwives
- Nurse Practitioners
- Nurse Psychiatric
- Occupational Therapists
- Optometrists
- Physical Therapists
- Podiatrists
- Professional Counselors
- Psychologists
- Social Workers
- Speech/Hearing Therapists

Coordination of Benefits

- | | |
|----------------------------|-----|
| • Birthday Rule? | Yes |
| • Divorced/Separated Rule? | Yes |
| • Joint Custody Rule? | No |
| • Active v. Inactive Rule? | Yes |
| • Longer v. Shorter Rule? | Yes |
| • Managed Care Rule? | No |
| • COBRA Rule? | No |
| • Preservation Rule? | Yes |

Continuation or Conversion

Required

Patient's Bill of Rights Legislation

Yes

High Risk Health Pool

Yes - premium caps at 125-137%

External Grievance System

Yes, for all health plans.

Basis for Filing Grievance

Investigational treatment appeals and medical necessity

Status of Decision of Grievance Panel

Binding

Prompt Payment of Health Claim Requirement

California

Yes. Insurers have 30 working days to pay claims and HMOs have 45 working days to pay claims.

Commentary

Physicians are prohibited from referring patients to laboratories, clinics, or other facilities in which they have an ownership interest.

A broker was assessed punitive damages in a breach of contract case for failing to provide health care coverage for a group after being told that a participant had AIDS or had tested positive for HIV. California law prohibits insurers from withdrawing or refusing coverage if a consumer tests positive for AIDS antibody. The employer was also ordered to pay continuation coverage premiums with the previous insurer.

The regulations require brokers for unlicensed companies to annually provide extensive documentation of the companies' financial stability and integrity before selling their policies. Unlicensed companies are prohibited from selling insurance unless an individual line of insurance is not available from a licensed company. Only specifically licensed surplus lines brokers are permitted to sell insurance from unlicensed companies. Brokers will be required to submit an annual financial statement, audited financial report, regulatory disclosure statements, and other records to prove the company is financially sound.

Specific Mandated Benefits

- Comprehensive preventive care of children, under such terms and conditions as may be agreed upon between the group policyholder and insurer, providing for physician and laboratory services for routine physical examinations and immunizations.
- Coverage for orthotic and prosthetic devices, or special footwear needed by persons who suffer from foot disfigurement (such as cerebral palsy, arthritis, polio, spina bifida, diabetes, or accidental or developmental disability), under such terms and conditions as may be agreed upon between the group policyholder and insurer.
- Coverage for prosthetic devices or reconstructive surgery incident to a mastectomy, subject to the deductible and coinsurance conditions applied to the mastectomy, if group disability or self-funded employee welfare benefit plan provides for a mastectomy.
- Coverage for a baseline mammogram for women 35-39 inclusive, a mammogram for women ages 40 to 49 inclusive, every two years or more frequently based on the woman's physician's recommendation, nurse practitioner, or certified nurse midwife, and a mammogram every year for women age 50 and over, if the group disability insurance policy or self-funded employee welfare benefit plan includes coverage for mastectomy and prosthetic devices and reconstructive surgery incident to the mastectomy.
- Mammography for screening or diagnostic purposes on the referral of the patient's physician, nurse practitioner, or certified nurse midwife, if mastectomy, prosthetic devices, and reconstructive surgery incident to mastectomy are also covered.
- Coverage for prenatal diagnosis of genetic or disorders of the fetus by diagnostic procedures in case of high-risk pregnancy, for every group disability insurance policy which offers maternity coverage.
- Sterilization operations or procedures that are not restricted or limited because of the covered individual's reason for the sterilization if sterilization is covered under the policy or plan.
- New California law now requires that health care service plans notify the provider or the patient as to why the claim was rejected. The law was changed from requiring the plan to provide specific *criteria* for the rejection to requiring the plan to provide the specific rationale.
- Acupuncture, under terms and conditions to be agreed on between the plan and the group contract holder.

- Coverage for treatment of infertility, except in vitro fertilization, under the terms and conditions as agreed on between the group subscriber and the plan.
- If the plan provides maternity benefits for a person covered continuously from conception, coverage for involuntary complications of pregnancy, which may not be excluded, reduced or limited, unless such provisions apply generally to all benefits paid under the policy. If a policy contains a maternity deductible, it must apply only to expenses resulting from normal and Cesarean section delivery. However, expenses from Cesarean section delivery in excess of the deductible must be treated as expenses for any other illness under the policy.
- An annual cervical cancer screening test, on the referral of the patient's physician, nurse practitioner, or certified nurse, midwife, if the policy covers treatment or surgery of cervical cancer.
- Nonprofit hospital service contracts providing for mastectomy must include coverage for prosthetic devices or reconstructive surgery incident to the mastectomy. Such coverage is subject to the deductible and coinsurance conditions which apply to the mastectomy, and all other terms and conditions applicable to other benefits. Nonprofit hospital service plans must offer group contract holders coverage for expenses incurred as a result of acupuncture treatment, under terms and conditions as agreed on between the nonprofit hospital service plan and group contract holder. HMOs providing group coverage for hospital, medical, or surgical expenses must offer the same infertility coverage according to terms and conditions agreed on between the group's subscriber and the plan, to group contract holders with at least 20 employees.

California prohibits the denial of coverage to, or otherwise discriminating against, an applicant or insured who is or has been a victim of domestic violence. California must cover all medically recognized cancer screening tests. California requires group health insurance contracts and health care plans that cover mastectomies and lymph node dissections also must cover all complications from a mastectomy, and the insured patient's hospital stay following a mastectomy. Also, group health service plans and group health insurance plans must provide coverage for prostate cancer screening.

California requires that health care plans use arbitration to settle disputes with enrollees. Also, California requires all health plans to provide a statement describing how participants may be limited to the choice of physician or other health care provider, the methodology of reimbursement, the payment methods made to contracting providers, and whether any incentives are included in the provider's contract.

MEWA Regulations

California has enacted its own MEWA statute patterned after the NAIC model.³ The MEWA statute specifically exempts any health care service plan which would otherwise be covered by the Knox-Keene Act of 1975.⁴ If the MEWA can demonstrate that is subject to the jurisdiction of federal government, it is exempted; otherwise, the state has jurisdiction of such plan.

Such MEWA, to be approved in California, must meet numerous requirements including:

1. Be nonprofit.
2. Sponsoring association must have at least 200 paid members and operated actively for at least 5 years.
3. MEWA must have been organized with at least 2,000 covered employees and 50 paid employer members for at least 5 years.

4. Benefits must be offered only to association members and only through licensed agents.
5. Meet certain financial requirements.
6. Maintain specific claim stop-loss insurance (attachment point no more than 5% of annual expected claims) and aggregate stop-loss insurance (attachment point no more than 125% of annual expected claims).
7. Either have its own facilities and personnel to administer the MEWA or contract with a licensed TPA to provide this service.

TPA Regulations

California adopted an administrator law in 1977.⁵ The California Penal Code has an unspecified felony punishment.

- Taxes and fees -- agent type fees, filing fees, and fingerprint fees are required.
- Forms -- registration application.
- Records -- five-year retention.
- Bond -- bond is not required.
- Items filed -- corporation papers (if California corporation), thumbnail of officers and directors, key employees and their functions, list of insurers used by the TPA, lead-in information to TPA's bank, statement of business operation.

A TPA license may be revoked or suspended in the same manner as that of an agent/broker and for the same reasons.

California does not specifically waive its TPA statute for ERISA plans; nor does it provide reciprocity with the TPA's home state or *de minimis* relief where extraterritorial issues may arise.

Stop-Loss Regulation

Attempts by California to impose restrictions on stop-loss in its health care reform legislation have been successfully challenged in court.⁶ California had attempted to apply state regulation of employee benefits by requiring insurance companies that provide stop-loss policies to self-funded plans to ensure that the underlying plans conformed to certain selected provision of the Small Group Reform Act (AB 1672). The court upheld ERISA preempted and that the order was unenforceable by the Insurance Commissioner solely against ERISA self-funded plans and dismissed the case. The court said that no ERISA self-funded plans, no employer or plan sponsor of a self-funded plan, or insurance carrier issuing, or seeking to issue, stop-loss coverage to self-funded plans, have any obligations to comply with the state law. The court further permanently enjoined the state from administering or enforcing any part of the state statute against self-funded plans, carriers, contract administrators, or employers. The Insurance Commissioner did reserve the right to exercise its authority to take administrative or legal action deemed necessary regarding certain stop-loss coverage issued to a specific ERISA plan to determine whether the arrangement is not preempted from the Insurance Code.

Stop-loss agreements must be filed with the state. Subrogation provision usually part of such agreements is not permitted. As part of its approval process. California requires that the specific exceed 5% of the expected claims and that the aggregate exceed 125% of expected claims.⁷

California

Utilization Review Regulations

Agency Responsible	Dept. of Corporations ⁸
Requirements	No licensure or certification requirements. Reviewers must have educational background to evaluate clinical issues. Applies only to HMOs.
Exemptions	N/A
Waivers	N/A

Miscellaneous

State Premium Taxes

Commercial insurers are taxed at 2.35%; Blue Cross and HMOs are not taxed.

Small Group Reform⁹

Health insurance carriers must make coverage available to any small employer that offers coverage to 100% of its eligible employees who work or reside in the service area, as long as the employer itself is physically located in the service area. A small employer plan is required to provide coverage for all of certain mandated basic health care services, including physician services, hospital inpatient services and ambulatory care services, diagnostic laboratory services, diagnostic and therapeutic radiologic services, home health services, including out-of-area coverage.

To be eligible, the employer must have employed from 5-50 within the statute. An eligible employee is one working full-time with a normal work week of 30 hours or more, and may be a sole proprietor or a partner in a partnership, but not a part-time, temporary, or substitute employee. For coverage to be made available to a small employer, a portion of the premium or benefits must be paid by the employer.

Continuation of Coverage and Conversion Requirements

California requires health care plans to allow continued coverage for at least 90 days to participants (including widows, widowers, divorced spouses and their dependents who were covered by the group policy upon termination) in certain instances when coverage is terminated. It does not apply if an employer's group plan is terminated. Eligibility ends when covered individuals:

- Permanently relocate outside California (except for dependent children).
- Remarry.
- Become eligible for comparable public or private medical benefits.
- Become eligible for another employer's group policy by becoming employed.

Conversion rights. California requires group health plans to allow participants whose coverage ends under the group plan to convert their coverage without evidence of insurability. The law allows exceptions for those :

- Whose coverage termination was for good cause.
- Who lost coverage for failure to pay premiums.
- Who are eligible for Medicare or other public benefits.

- Who were not covered for three months by the group plan before coverage termination.
- Who are covered for similar benefits under an individual policy.

Individuals must apply for the conversion coverage and pay the premium within 31 days of the loss of their group coverage. The law does not apply to self-funded plans. Employers are required within 15 days of group coverage termination.

Replacement insurance carriers are not required to reimburse prior carriers for payments made to totally disabled persons during the prior carrier's extension-of-benefits period mandated under California insurance statutes.

Managed Care

The Department of Insurance claims general regulatory authority to limit the size of the price differential between in-network and out-of-network providers on a case-by-case basis. No specific threshold has been set by the department.

Endnotes

¹ Cal. Ins. Code §§ 700, 703.5; 740-742.1; 1759-1759.10.

² Cal. Ins. Code §§ 1759.0-1759.10.

³ Cal. Ins. Code § 740; See also Ins. Dept. Bulletin 92-4.

⁴ Cal. Health and Safety Code § 1345(F).

⁵ Cal. Ins. Code § 1759.0 to 1759.10.

⁶ *Independent Administrators Association v. Garamendi*, __F.Supp.__(C.D.Cal. 1995).

⁷ Cal. Ins. Code § 742.24.

⁸ Cal. Health & Safety Code §§ 1270 *et seq.*

⁹ Cal. Ins. Code §§ 10700-100749; see also Ins. Dept. Bulletin 93-3(1993).