The 9 Most Important New Health Insurance Laws From the 2015 California Legislative Session

Compiled by Bill Robinson, DCAHU Communications Chair
October 21, 2015 - E-Mail: BRPCIA@aol.com

[these new laws take effect on January 1, 2016 - unless otherwise noted]

AB 248 - (Hernandez) - Minimum Value Health Insurance for Large Groups
CAHU Posiiton: Oppose

Prohibits a non-grandfathered health plan or health insurer that offers, amends, or renews a large group health plan contract or health insurance policy from marketing, offering, amending, or renewing a large group plan contract or health insurance policy that provides a minimum value of less than 60%. Excludes from this prohibition a health plan offering a specialized health plan contract, or an insurer issuing a specialized health insurance policy. Excludes limited wraparound coverage,

States legislative intent in enacting this act to ensure that employees of large employers who are offered health coverage by their employers are offered coverage that meets or exceeds 60% minimum value, the minimum standard for comprehensive employer coverage under the federal ACA. This requirement applies if an employer purchases that health coverage from a health plan or health insurer regulated by the State of California.

Author's statement. According to the author, AB 248 creates a consistent baseline for health insurance requirements in the State of California. Large employers (50 full time employees or more) health insurance, unlike individual and small employer health insurance, are not required to provide EHBs. This has created a federal loophole so that large employers are not held to the same minimum benefits standards as small employers and individuals. The result has been some health insurers selling limited benefit or "skinny" health plans, such as prevention-only or indemnity insurance to large employers, primarily those with low-wage workers. Some of these so called skinny plans do not cover doctor visits, hospital stays, emergency rooms, prescription drugs, x-rays, hospice or other preventative care. This can leave workers vulnerable to thousands of dollars in medical bills when they get sick. We need to end this loophole that rewards bad behavior. If our small business community is required to provide comprehensive health insurance to its employees, large employers have no excuse to not offer the same. AB 248 protects the spirit of the ACA, and everyone's access to affordable and comprehensive health coverage.

AB 339 (Gordon) - Regulating High Cost of Outpatient Prescription Drugs
CAHU Posiiton: Oppose

Requires a non-grandfathered health plan or policy of health insurance offered, amended, or renewed ***on or after January 1, 2017*** to comply with the following, with respect to plans and policies that cover outpatient prescription drugs:

- Prohibit the formulary or formularies from discouraging the enrollment of individuals with health conditions and do not reduce the generosity of the benefit for enrollees or insureds with a particular condition in a manner that is not based on a clinical indication or reasonable medical management practices, consistent with federal law, as specified;

- Cover combination antiretroviral drug treatments that are medically necessary for the treatment of AIDS/HIV, that is a single-tablet drug regimen that is as effective as a multitablet regimen unless the health plan is able to demonstrate to the DMHC director, or insurer is able to demonstrate to the CDI Commissioner, consistent with clinical guidelines and peer-reviewed scientific and medical literature, that the multitablet regimen is clinically equally or more effective and more likely to result in adherence to a drug regimen;

- Limit the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for up to a 30 day supply to not more than $250, as specified, except for a product with actuarial value to bronze coverage, cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days to not more than $500. Requires for a federally defined high deductible health plan the limit to apply only after the enrollee's deductible has been satisfied for the year, and limits for non-grandfathered individual and small group products the annual outpatient drug deductible to not more than twice these caps;

- Use defined formulary tier groupings for nongrandfathered individual and small group plans only, if a plan contract or insurance policy maintains a drug formulary with a fourth tier, but does not require the use of a fourth tier, and prohibits this bill from being construed to limit a health plan or insurer from placing any drug in a lower tier;

- Ensure placement of prescription drugs on formulary tiers is clinically indicated, reasonable medical management practices;

- States that health plan or health insurer may utilize formulary, prior authorization, step therapy, or other reasonable medical management practices in the provision of outpatient prescription drug coverage, consistent with this bill;

- Sunset's the cost cap and tiering definitions on January 1, 2020;

- Requires, commencing January 1, 2017, a plan or insurer to maintain a pharmacy and therapeutics (P&T) committee responsible for developing, maintaining, and overseeing any drug formulary list, and establishes requirements associated with the P&T committee that are substantially similar to federal regulations;

- Requires, commencing January 1, 2017, a plan or insurer that provides essential health benefits to allow an enrollee or insured to access prescription drug benefits at an in-network retail pharmacy unless the prescription drug is subject to restricted distribution by the Food and Drug Administration, or requires special handling, as specified, or patient education, as specified. Permits the plan or insurer to charge an enrollee or insured different cost sharing but requires all cost sharing to count toward the plan's or policies' annual limitation on cost sharing;

- Authorizes a health insurer to impose prior authorization requirements consistent with this bill. Prohibits an insurer from requiring an insured to repeat step therapy when changing policies;

- Requires an insurer to provide coverage for the medically necessary dosage and quantity of the drug prescribed consistent with professionally recognized standards of practice.

Author's statement. According to the author, Californians with cancer, HIV/AIDS, hepatitis, multiple sclerosis, epilepsy, lupus, and other serious and chronic conditions need high cost specialty drugs, which can cost thousands of dollars. These Californians can often reach their out-of-pocket limit in the first month of the plan year with only one prescription drug. Many Californians would find it difficult to pay over $6,000 out-of-pocket for a single prescription drug, let alone in one month. Too many patients are forced to choose between paying for their life-saving drugs and paying for housing, child care, or food. In turn, failure to access prescription drugs leads to suffering, and even death, from illnesses that are treatable. AB 339 is designed to ensure consumer access to vital medications and builds on existing California law and recent federal guidance to provide basic consumer protections that take the patient out of the middle of the negotiations between health plans and pharmaceutical manufacturers. This bill benefits patients by reducing cost barriers to those who depend on life-saving prescription drugs and implements and improves upon concepts from federal guidance in order to ensure that the anti-discrimination provisions of the Affordable Care Act (ACA) remain intact.

Drug discrimination. Jacobs and Summer describe in a 2015 New England Journal of Medicine perspectives piece that there is evidence that insurers are resorting to tactics to dissuade high-cost patients from enrolling. A formal complaint on this point was submitted to the Department of Health and Human Services in May 2014 that insurers in the federal exchange had structured their drug formularies to discourage people with HIV infection from selecting their plans. These insurers categorized all HIV drugs, including generics, in the tier with the highest cost sharing. Insurers have historically used tiered formularies to encourage enrollees to select generic or preferred brand-name drugs instead of higher-cost alternatives. Jacobs and Summer write that "adverse tiering" is not to influence enrollees' drug utilization but rather to deter certain people from enrolling in the first place. Findings of a recently published California HealthCare Foundation study indicate products used to treat complex chronic conditions, especially those for autoimmune disorders like rheumatoid arthritis, were disproportionately placed on the specialty tier in Covered California plans compared to the selected employer plans.

AB 375 (Nazarian) - Step Therapy Prescription Drugs
CAHU Position: Neutral

Requires DMHC and CDI to jointly develop a uniform prior authorization form that health plans and insurers must accept when prescribing providers seek authorization for prescription drug benefits. Permits an exception to a health plan or insurer's step therapy process to be submitted in the same manner as a request for prior authorization for prescription drugs. Requires those requests to be treated in the same manner, and responded to by the plan or insurer in the same manner, as a prior authorization request.

Author's statement. According to the author, AB 374 does not prohibit step therapy protocols. Rather, this bill establishes an exception process that creates a balance between a provider's professional judgment and health plan and insurer's business practice. This bill recognizes that the health plan/insurer must not have complete and ultimate control on the medications a patient is permitted to try. Plans utilize step therapy to reduce their costs. This process forces patients to "fail first" on several alternative medications, before they are permitted to obtain the appropriate medication. Anecdotal data shows that plans may require a patient to try up to five different medications before receiving the one prescribed by their physician. Also, the duration of this protocol is left up to the health plan and has been known to last up to 90 days. Step therapy is based solely on cost and does not take into consideration patients' unique needs. The use of step therapy can exacerbate patient's condition, causing irreversible deterioration or damage to patients, such as limiting their daily functions and ability to remain a productive member of the workforce and society.

AB 387 (M cCarty) - CDI Approval of LTCi Policies
CAHU Position: Support

This law extends the period of time for the Insurance Commissioner to review disability insurance policies Incvluding LTCi policies) from 30 to 120 days. Requires the IC to request that a multistate regulatory support organization commission a study comparing California insurance standards with those developed by the IIPRC and that the study be completed by January 1, 2017.

Insurers must file forms for disability insurance. If the IC notifies the insurer that the form does not comply with required standards, the insurer must fix the form and get approval before issuing policies. If the IC affirmatively approves the form, or 30 days passes without notice, the insurer may issue policies under that form. Traditionally, the statute has been read so that the IC would have discretion to review a policy or not. The California Court of Appeal in the case Ellena v. Department of Insurance (2014) held that the IC has a mandatory duty to review each disability insurance policy. That opinion has created a substantial new workload in the California Department of Insurance's (CDI) policy review process. This bill addresses the additional workload by extending the review period to 120 days.

According to the author, this bill codifies an agreement between CDI and the disability insurance industry and clarifies what constitutes "acceptance" of a new disability insurance policy by CDI. CDI explains that providing standards to expedite the policy approval process coupled with increasing the amount of time provided to review and approve policies may help to improve the process and reduce confusion for consumers and industry.

AB 1163 (Rodriguez) - Health Care Service Plans and Health Insurers: Notice of Contract Changes to Agents & Brokers
CAHU Posiiton: Support & SPONSOR

Prohibits a material change made by a plan or insurer to the terms and conditions of a contract with a solicitor, agent or broker from becoming effective until the plan or insurer has provided at least 45 days of written or electronic notice indicating the change to the contract. Defines "material" as a provision in a contract affecting commissions, bonuses, and incentives paid to the solicitor, agent or broker, right of survivorship, indemnification of the solicitor, agent or broker by the health plan or errors and omissions coverage requirements for the solicitor, agent or broker. Exempts from the notice requirement a change to the contract that is mutually agreed upon by the plan or insurer and the solicitor, agent or broker, or a change required by state or federal law.

Author's statement. According to the author, AB 1163 was introduced in response to the recent action of a health insurance carrier that made material changes to their agreement with licensed health insurance agents with only 48 hours of notice before the substantive changes took effect. This action, combined with other recent actions that changed agent agreements since the advent of the Affordable Care Act, have made licensed agents aware of agent vulnerability to health plan and carrier actions as they seek to add or shed market share. AB 1163 levels the playing field and provides for a fair and reasonable notice to licensed agents when their contract is materially changed.

AB 1305 (Bonia) - Limitations on Cost Sharing for Family Health Plan Coverage
CAHU Position: Neutral as Amended

Prohibits coverage purchased for a family that has a **maximum out-of-pocket limit** for each individual covered by the plan or policy from having an individual limit that is greater than the maximum out-of-pocket limit for coverage purchased for an individual. Prohibits coverage purchased for a family that includes a **deductible** for each individual covered by the plan or policy from having an individual deductible that is greater than the deductible for coverage purchased for an individual. Includes an exception for the deductible for an HDHP. Implements these provisions in the large group market on contracts and policies issued, amended, or renewed on or after January 1, 2017. (Takes effect in small group market on January 1, 2016)

Author's statement. According to the author, this bill prohibits a health plan or insurer from imposing a higher deductible and limit on out-of-pocket costs on an individual simply because the individual is a member of a family. Health plans and insurance policies often include a deductible amount, as well as limits on the amount out-of-pocket costs a person or family may incur in a year. The author states that some family plans and policies include deductibles and out-of-pocket limits for individuals in the plan or policy, so when a family member gets sick, he or she only has to reach the individual deductible or cost-sharing limit in order for coverage to kick-in.

However, other plans and insurers do not include these individual deductibles and out-of-pocket cost limits within a family plan or policy, which means that families with one member who has more expensive health care needs would have to reach the family limits before coverage kicks in. Under this structure, families with one member with high health care costs are forced to pay thousands of dollars in out-of-pocket expenses simply because they are in a family plan. This bill creates parity between what consumers pay in individual and family plans by embedding individual deductibles and out-of-pocket limits in family plans, and ensures consumers are not unfairly charged for doing what is right by getting family coverage.

SB 125 (Hernandez) - Open Enrollment Periods for Health Care Coverage
CAHU Position: Support ***- Took effect June 17, 2015 -***

1) This bill extends the sunset date of the California Health Benefit Review Program (CHBRP) to June 30, 2017 and makes changes to its analyses and timelines.

2) Requires health plans and insurers to provide annual open enrollment periods for plan or policy years beginning on or after January 1, 2016, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive- consistent with revised federal policy enforcing the ACA. Also revises, for plan years commencing on or after January 1, 2016, the definition of small employer to require the use of a full-time equivalent (FTE) employee counting method for determining the size of the employer, specifically whether the employer is a small employer.

SB 137 (Hernandez) - Health Plan Provider Directories
CAHU Position: Support

1) Requires by December 31, 2016, DMHC and CDI to develop uniform provider directory standards to permit consistency and the development of multi plan directories to determine the plan a physician or other provider is available through. Requires by July 31, 2016, or no later than 12 months after the date that provider directory standards are developed by DMHC and CDI, a plan or insurer to use the standards for each product offered by the plan or insurer.

2) Requires a health plan or insurer to make available a provider directory or directories that provide information on contracting providers, including those that accept new patients, as specified. Prohibits a provider directory from including information on a provider that does not have a current contract with the plan or insurer.

3) Requires a plan or insurer to provide the directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, enrollees, potential enrollees, the regulators, and other state or federal agencies can easily identify which providers participate in which networks for which products.

4) Requires the provider directory or directories to be available on the plan's or insurer's Internet Web site and available without any requirement that a member of the public or potential enrollee indicate intent to obtain coverage from the plan or insurer, without demonstrating coverage with the plan or insurer, providing a policy number, providing any other identifying information, or creating or accessing an account, and accessible through a clearly identifiable link or tab.

5) Requires searches by name, practice address, National Provider Identifier number, California license, facility or identification number, product, tier, provider language, medical group or independent practice association, hospital or clinic, as appropriate.

6) Requires the plan or insurer to update the provider directory or directories, at least weekly, with any change to contracting providers, as specified.

7) Requires the provider directory or directories to include both an email address and a telephone number for members of the public and providers to notify the plan if the provider directory information appears to be inaccurate.

8) Requires plans or insurers to ensure processes are in place to allow providers to promptly verify or submit changes to demographic information and participation status that at a minimum, include an online interface for providers to submit verification or changes electronically and to allow providers to receive an acknowledgement of receipt from the plan or insurer.

Author's statement. According to the author, Californians shopping for health insurance must have confidence in provider directory information in order to make coverage decisions, especially when health insurance coverage is required by government for most of the population. For too long, Californians have been unable to rely on information provided by health insurance carriers and health care providers about which carriers their existing health care providers are contracted with, and if a provider is taking new patients. California's provider directory law also needs to be updated to reflect technological advancements away from paper-based directories. Federal and state health insurance regulations have established requirements on different segments of health insurance carriers, but uniform standards are necessary to ensure consistency among carriers, markets and programs. This bill would establish uniform provider directory standards and require weekly updates of online directories.

SB 546 (Leno) Large Group Health Plan Disclosure Mandate
CAHU Position: Oppose

This bill establishes weighted average rate increase disclosure requirements for a health plan's or insurer's aggregated large group market products and requires the Department of Managed Health Care and the California Department of Insurance to conduct a public meeting regarding large group rate changes for each plan or insurer that offers coverage in the large group market between November 1, 2016, and March 1, 2017, and annually thereafter.

This bill also creates a notice to employers 60 days prior to renewal about the rate increase relative to rate increases negotiated by the California Health Benefit Exchange and CalPERS, and whether the rate change includes any portion of the excise tax paid by the plan.

Requires health plans and insurers to include in a notice required 60 days before contract renewal whether the rate proposed is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange, the amount that a rate change is greater than the average rate increase negotiated by CalPERS, and whether the rate change includes any portion of the excise tax paid by the plan.

Establishes large group rate filing requirements including that health plans and health insurers report the weighted average rate increase for all large group benefit designs during the 12 months period ending January 1 of the following calendar year.

Author's statement. According to the author, the rising cost of health care is a major concern for large purchasers in California, and the lack of transparency in pricing for the large group market has contributed to uncontrolled cost increases for large employers and union trusts. According to the 2014 California Employer Health Benefits Survey, health premiums in California rose by 185% since 2002, more than five times the state's overall inflation rate. In addition, one in four California employers reported that they reduced benefits or increased employee cost sharing in the last year because of the rising cost of health care.

SB 1163 (Leno, Chapter 661, Statutes of 2010) requires health plans and insurers to provide regulators and consumers with critical data and information documenting the true drivers of premium increases in the individual and small group markets. Since its enactment in 2011, SB 1163 has saved California consumers over $300 million. However, the same protections have not been implemented for large employers and their employees. SB 546 extends the similar transparency and reporting from SB 1163 to the large group market.