The 13 Most Important New Health Insurance Laws From the 2018 California Legislative Session

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[these new laws take effect on January 1, 2019 - unless otherwise noted]

AB 1751 - (Low) - Controlled Substances & CURES Database
CAHU Position: Support

Existing law establishes CURES for the electronic monitoring of and the electronic transmission of Schedule II, III and IV controlled substance prescription information to the CA Department of Justice (DOJ) no more than seven days from the time prescriptions are dispensed. States that the purpose of CURES is to assist law enforcement and regulatory agencies in controlling diversion and abuse of Schedule II, III and IV controlled substances and for statistical analysis, education and research.

CURES currently only contains information related to prescriptions dispensed within California. This means that when a health practitioner consults a patient's prescription history prior to writing a new prescription, information relating to prescriptions written in other states are not reflected in the activity report. For true "doctor shoppers," traveling across state lines to secure prescriptions of opioids is not uncommon. This is especially true in communities located near California's borders.

This bill requires the CA DOJ, no later than July 1, 2020, to adopt regulations regarding the access and use of the information within CURES. Requires DOJ to consult with all stakeholders identified during the rulemaking process. Requires the regulations to address:
a)The process for approving, denying, and disapproving individuals or entities seeking access to information in CURES.
b)The purposes for which a health care practitioner may access information in CURES.
c)The conditions under which a warrant, subpoena, or court order is required for a law enforcement agency to obtain information from CURES as part of a criminal investigation.
d)The process by which information in CURES may be provided for educational, peer review, statistical, or research purposes.
2)Authorizes DOJ to enter into an agreement with an entity operating an interstate data share hub for purposes of participating in interjurisdictional information sharing between prescription drug monitoring programs across state lines.
3)Requires any agreement entered into by DOJ for purposes of interstate data sharing to ensure that all access to data within CURES, and handling of CURES data, complies with California law and meets the same patient privacy and data security standards employed and required for direct access of CURES.

AB 1753 - (Low) - Controlled Substances & CURES Database
CAHU Position: Support

Under the DOJ's Security Prescription Printers Program, all paper prescriptions of any Schedule II through V controlled substance must use special tamper-resistant forms obtained from manufacturers approved by the DOJ. The author notes that "One of the stated challenges to requiring standardized serialization of prescription pads is that the number of approved security printers that are each individually manufacturing pads throughout the state without significant restriction or coordination. Approximately 43 security printers are currently approved by the DOJ and operating throughout the state.

This bill: 1) Authorizes DOJ, in order to facilitate the standardization of all prescription forms and the serialization of prescription forms with unique identifiers, to cease issuing new approvals of security printers to the extent necessary to achieve these purposes. 2) Authorizes DOJ, pursuant to regulation, to reduce the number of currently approved security printers to no fewer than three vendors. 3) Requires DOJ to ensure that any reduction or limitation of approved security printers does not impact the ability of vendors to meet demand for prescription forms.

According to the author, "Allowing the DOJ to cap the number of approved security printers and reduce the list to no fewer than three will provide for a more manageable amount of coordination between manufacturers. This will allow for prescription pads to be tracked by law enforcement when lost or stolen, and for serialized pads to be linked to CURES. The tighter regulation could also arguably make it easier for law enforcement to identify counterfeit or fraudulent prescription pads sold on the street."

AB 2088 - (Santiago) - Patient Records: Adding an Addendum
CAHU Position: Support

According to the author, current law allows minors to consent to medical treatment under certain circumstances and gives them the right to inspect their treatment records, but only authorizes adult patients, not minors, to add their own brief statements to those records when they believe those records are incomplete or inaccurate. This bill simply authorizes minors who already have the right of inspection to add their own, short statement to their records.

AB 2472 - (Wood) - Heath Care Coverage in California
CAHU Position: Watch

Existing law establishes the Council on Health Care Delivery Systems (council), as of January 1, 2019, as an independent body to develop a plan that includes options for advancing progress toward achieving a health care delivery system that provides coverage and access through a unified financing system for all Californians. Authorizes the California Health and Human Services agency to staff the council.

This bill requires the council to prepare an analysis and evaluation (feasibility analysis) to determine the feasibility of a public health insurance plan option to increase competition and choice for health care consumers. Requires, at a minimum, the feasibility analysis to include:
a)An actuarial and economic analysis of a public health insurance plan;
b)A plan to expand the participation of public health plans, including state licensed county organized health systems (COHS) and local health plans;
c)A state developed public health insurance plan;
d)A list of necessary federal waivers for a state developed public health insurance plan;
e)A discussion of potential funding and state costs for a public health insurance plan; and,
f)An analysis of the extent to which a new public health insurance plan option could address the underlying factors that limit health plan choices in some regions.

This bill also requires the council, in developing the feasibility analysis, to consult with key stakeholders, including but not limited to, consumer advocates, health care providers, and health plans (including, but not limited to, COHS' and local health plans).

This bill also requires the council to submit the feasibility analysis to the Legislature and the Governor on or before October 1, 2021, and update the health committees of the Senate and Assembly on or before January 1, 2020, and every six months thereafter.

According to the author, although the Affordable Care Act (ACA) has greatly reduced the number of uninsured in California, premiums continue to rise for many consumers. Policymakers have an obligation to find ways to make healthcare more affordable and accessible to consumers. One proposed solution to the problem of limited health plan competition in the individual market is the establishment of a public option as an alternative to existing private plans. However, among other considerations, the structure, financing, and governance of a public option need to be evaluated. This bill requires the council to conduct an analysis and evaluation of a public health insurance plan option and determine if this public option is possible to implement in California.

AB 2487 - (McCarty) - Continuing Education for Physicians & Surgeons for Opiate-Dependent Patient Treatment & Management
CAHU Position: Support

Existing law requires all physicians and surgeons to complete a mandatory CE course in the subjects of pain management and the treatment of terminally ill and dying patients. As an alternative, this bill authorizes a physician and surgeon to complete a one-time CE course of 12 credit hours in the subjects of treatment and management of opiate-dependent patients, including eight hours of training in buprenorphine treatment, or other similar medicinal treatment, for opioid use disorders as an alternative to the required CE course on pain management and the treatment of terminally ill and dying patients.

According to the author, "Congress passed the Drug Addiction Treatment Act of 2000 (DATA-2000) which allowed physicians to prescribe medication to treat the growing opioid epidemic. One of the flaws with DATA-2000 is that it restricts who can prescribe certain Medical Assisted Treatment (MAT) drugs and the number of patients a physician can treat with through MAT. After receiving the minimum of 8 hour training they must apply through the Drug Enforcement Administration to receive what is known as an "X-waiver" that gives folks the opportunity to prescribe buprenorphine. The problem with current law is that because of the specific requirements placed on physicians, there are not enough physicians with an "X- waiver". Further, those who have such waiver are limited on the amount of patients they can see.

AB 2499 - (Arambula) - Health Care Coverage - Medical Loss Ratios
CAHU Position: Neutral

This bill as originally written would have increased the minimum Medical Loss Ratio (MLR) percentages by 5% for individual, small group and large group health plans. This would have been disastrous for agents, consumers and employers, but this approach was ultimately rejected by the CA Legislature due to intensive lobbying efforts by CAHU and its allies in Sacramento. Now the bill only requires MLRs to be consistent with federal law and any rules or regulations issued as in effect on January 1, 2017. This is another example of CAHU's ongoing, successful efforts to protect agents, and consumers from harmful healthcare legislation.

AB 2789 - (Wood) - Health Care Practioners - Prescriptions & Electronic Data Transmission
CAHU Position: Support ***Takes Effect 1-1-2022***

This bill requires, on and after January 1, 2022, a health care practitioner authorized to issue a prescription to have the capability to issue an e-prescription to transmit that e-prescription to a pharmacy selected by the patient. On and after January 1, 2022, requires a pharmacy, pharmacist, or other practitioner authorized to dispense or furnish a prescription to have the capability to receive an e-prescription. The bill allows for a few reasonable exceptions to be made.

AB 2863 - (Nazarian) - Health Care Coverage - Prescription Co-Pays
CAHU Position: Support

This bill requires a pharmacy to inform a customer whether the retail price for a prescription drug is lower than the applicable cost-sharing amount for the prescription drug. Provides that the maximum amount a health plan or health insurer may require an enrollee to pay at the point of sale for a covered prescription medication is the lesser of the applicable cost-sharing amount or the retail price.

This bill prohibits a health plan or health insurer from requiring a pharmacist or pharmacy to charge or collect from an enrollee a cost-sharing amount that exceeds the total retail price for a prescription drug. And it provides that the payment rendered shall constitute the applicable cost sharing and shall apply to the deductible and/or the maximum out-of-pocket limit in the same manner as if the enrollee had purchased the prescription drug by paying the cost-sharing amount.

SB 910 - (Hernandez) - Short-Term Health Insurance
CAHU Position: Oppose Unless Amended

This bill prohibits a health insurer, commencing January 1, 2019, from issuing, amending, selling, renewing, or offering a policy of short-term limited duration health insurance in California. It defines "short-term limited duration health insurance" as health insurance coverage provided pursuant to a health insurance policy that has an expiration date that is less than 12 months after the original effective date of the coverage.

California has been enacting policies to rid the individual and small group markets of "junk insurance" even before the ACA. With the ACA's reforms that ensure guaranteed issue of products, prevent underwriting, and require inclusion of essential health benefits, there are limited instances where it is appropriate to allow these noncompliant products to remain in the market.

While CAHU agrees with the intention of ensuring that California consumers are enrolled in comprehensive coverage, this bill will likely result in a number of unintended consequences. Up until now, short-term limited duration policies could be purchased outside of the open and special enrollment periods, and are at times a consumer's only option. For example, under SB 910, if an enrollee's coverage is dropped due to failure to pay their premiums, they would be forced to go without any coverage until the next open enrollment period which may be months away. This is because coverage that is lost due to failure to pay is not a qualifying event for special enrollment periods.

SB 910 removes a critical tool for coverage and leaves affected individuals with no option other than to utilize costly emergency services should any medical need arise. CAHU requested amendments to SB 910 to reach a comprehensive solution to make plans available in limited instances to those who are otherwise prohibited from purchasing comprehensive coverage, limited in duration until the next open enrollment and nonrenewable. These suggested amendments would help achieve the desired policy goal of market stabilization without jeopardizing the health and financial security of those who find themselves locked out of comprehensive coverage options. But the legislature rejected our amendments.

SB 1008 - (Skinner) - Dental Insurance Medical Loss Ratios
CAHU Position: Neutral ***Takes Effect 1-1-2021***

This bill requires for plan and policy years on and after January 1, 2021, or 12 months after regulations are adopted, a health plan or health insurer that issues, sells, renews, or offers a contract or health insurance policy that covers dental services in California, in addition to other applicable disclosure requirements, to utilize a uniform benefits and coverage disclosure matrix, to be developed by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI), and in consultation with stakeholders, as specified.

It changes the annual medical loss ratio (MLR) report filing requirement on specialized dental plans or insurers to be filed with DMHC or CDI from September 30 each year to July 31 of each year, and requires DMHC or CDI to post plan's or insurer's MLR annual report on their Internet Websites within 45 days after receiving the report.

According to the author, this bill addresses these problems by providing greater transparency for dental insurance, ensuring that patients understand the benefits offered by a dental plan.

However, as first introduced, this bill would have created a 70-75% dental loss ratio requirement on dental plans, which would cause added financial and administrative burdens, benefit shifting, increased consumer costs and drive competition out of the dental care marketplace all together (aka: killing dental insurance products). But it has now become just an informational bill, thanks to CAHU's successful lobbying efforts.

SB 1121 - (Dodd) - California Consumer Privacy Act of 2018
CAHU Position: Support ***Takes Effect 1-1-2020***

This bill amends the recently enacted California Consumer Privacy Act of 2018. In response to growing concerns about the privacy and safety of consumers' data, proponents of the Act, a statewide ballot initiative began collecting signatures in order to qualify it for the November 2018 election. The goal was to empower consumers to find out what information businesses were collecting on them and give them the choice to tell businesses to stop selling their personal information.

In response, AB 375 (Chau, Chapter 55, Statutes of 2018) was introduced and signed into law, creating the Act. It integrated many of the elements of the ballot initiative to provide consumers certain rights over their information, with certain exceptions. Consumers were provided significantly more control over their information and given a modified enforcement mechanism to protect those rights. It made its operation contingent on the withdrawal of the initiative measure above, which subsequently took place. The Act delayed its operation until January 1, 2020.

In the rushed process to put together the bill, AB 375 included a number of issues that require attention. In a coalition, CAHU SUPPORTS SB 1121, which amends the California Consumer Privacy Act (CCPA), to address a number of drafting errors and fix aspects of the law that would be unworkable and would result in negative, unintended consequences after swift passage this past June.

SB 1121 makes three crucial clarifications to the CCPA's HIPAA exemption. First, SB 1121 ensures that life-saving clinical trials can continue in California. Second, SB 1121 specifies that the HIPAA exemption also covers HIPAA-defined "business associates," which are already subject to all HIPAA privacy and security obligations. For example, third party administrators, (TPAs) are "business associates" that contract with health plans and insurers to adjudicate claims. If TPAs are not exempted from the CCPA, insured individuals could ask that TPAs delete personal information they collect – which would preclude claims from being processed and prevent providers from getting paid.

Finally, SB 1121 largely exempts hospitals and doctors from complying with CCPA. Otherwise, if a consumer could request their information be deleted, hospitals and doctors would be required to collect all information about an individual, review each piece to determine what is protected by HIPAA (and not subject to the CCPA) and what is not protected by HIPAA (and must be deleted). This massive administrative burden would greatly increase the cost of healthcare with no corresponding benefit to the patient.

SB 1248 - (Gaines) - California Partnership for Long-Term-Care Program
CAHU Position: Support

The author states that Partnership standards, adopted in 1993, have not kept up with market trends and the policies have grown too expensive for its target population. This bill gives middle-income consumers more affordable options and greater access to Partnership policies. This bill permits the Department of Health Care Services (DHCS) to certify a California Partnership for Long-Term Care policy with a reduced per diem benefit of at least $100 per day for a nursing facility, residential care facility, and home care and community-based services, if the policy provides a lifetime maximum benefit of not less than $73,000.

It permits an insurer to offer a Partnership policy with these reduced benefits only if the insurer also offers the applicant policy benefits that provide at least a lifetime maximum benefit that, at the time of purchase, is equivalent in dollars to at least 365 times 70% of the average daily private pay rate for a nursing facility and a nursing facility per diem benefit of no less than 70% of the average daily private pay rate for a nursing facility.

It requires a LTC insurer or agent, at the time of application to provide:
a)An illustration of the differences in benefits between the Partnership policies described this bill; and,
b)A description of the available lower-cost Partnership options and the advantages and disadvantages of each option, including the differences between lower and higher minimum benefits, lower and higher inflation protection options, the types of services covered, and how these options compare to the anticipated costs of home, community-based, and institutional care.

It deletes the requirement that every Partnership LTC policy, certificate, or rider that purports to provides home and community-based services provide residential care facility and assisted living facility benefits, deletes the definitions of those two phrases, and instead requires such a policy provide the benefit of "care in a residential facility." It requires a Partnership policy, certificate, or rider to be called a "Home Care, Community-Based Services, and Residential Care Facility" only policy, certificate, or rider, instead of a "Home and Community-Based Services.

SB 1375- (Hernandez) - Small Employer Group Health Insurance
CAHU Position: Neutral

This bill prohibits employer group health benefit plans from being issued, marketed, or sold to a sole proprietorship or partnership without employees. This bill requires only individual health benefit plans to be sold to any entity without employees. This bill revises the definition of "eligible employee" for purposes of all small employer health plan contracts and health insurance policies to exclude sole proprietors or their spouses, and partners or their spouses.

This bill revises, for plan years on or after January 1, 2019, the definition of eligible employee for purposes of all small employer health plan contracts and health insurance policies to exclude sole proprietors or their spouses, and partners, or their spouses.

It prohibits employer group health benefit plans from being issued, marketed, or sold to a sole proprietorship or partnership without employees directly or indirectly through any arrangement. Requires only individual health benefit plans to be sold to any entity without employees.

Author's statement. According to the author, federal and state law developed in response to major insolvencies of MEWAs of which Association Health Plans (AHPs) are, have protected Californians since the mid 1990's. As part of the Trump Administration's continued assault on the ACA, the federal Department of Labor (DOL) has finalized new rules to broaden access to AHPs by expanding eligibility and exempting them from ACA requirements.

If these policy changes are allowed to be implemented it will result in increases in premiums in the individual and small group market and increase the number of uninsured Californians. While these finalized federal rules would not preempt California law, this bill is necessary to make California law consistent and clear that ACA rules apply even if individuals or small employers join together in an association.
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And among some very bad proposed health care bills this year, there was **AB 3087 (Kalra)**. It would have created a **California Health Care Cost, Quality and Equity Commission.** This commission would set the amounts to be accepted as payment by ALL health plans, hospitals and providers! CAHU's position is that the issues of health care affordability, quality, transparency and access are critical and need to be addressed without harmful cuts to services and decreased access to care that this bill would have caused. CAHU's intensive lobbying efforts in Sacramento helped to kill this bad bill!

Another very bad proposed bill was **SB 562 (Lara and Atkins) - The Healthy California Act (a Single Payer Bill).** It would eliminate all private health insurance, Medicare, Medi-Cal, Long Term Care, Covered California, and the valuable services of all insurance agents and advisors. Its cost would be 2-1/2 times the current total California State Budget - $400 Billion for just the first year! Again, CAHU's lobbying efforts, along with many allies, helped to kill this bill in the Assembly Rules Committee. HOWEVER, we expect this bill to reappear in the 2019 Legislative Session, so this battle is not over. Therefore, CAHU urges its members to continue to strongly support CAHU-PAC in its continuing efforts to protect the role of agents and brokers and also to protect consumers from a costly, ineffective single payer health care system in California.