The 7 Most Important New Health Insurance Laws From the 2016 California Legislative Session

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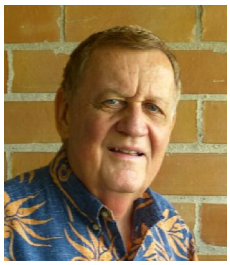

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[these new laws take effect on January 1, 2017 - unless otherwise noted]

AB 72 - (Bonta) - Prohibits Balance Billing by Out-of-Network Providers For Care At An In-Network Facility
CAHU Position: Support *Takes Effect on July 1, 2017.*

This bill's purpose is one which CAHU has been working tirelessly to get passed for several years, and finally this year we have succeeded! Establishes a payment rate to Out-of-Network Providers, which is the greater of the average of a health care service plan (health plan) or health insurer's contracted rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services; and an independent dispute resolution process (IDRP) for claims and claim disputes related to covered services provided at a contracted health facility by a noncontracting individual health care professional for health plan contracts and health policies issued, amended, or renewed on or after July 1, 2017. Limits enrollee and insured cost sharing for these covered services to no more than the cost sharing required had the services been provided by a contracting health professional.

Permits a noncontracting individual health professional to bill or collect from the enrollee or insured with out-of-network coverage, the out-of-network cost sharing, if applicable, only when the enrollee or insured consents in writing and that written consent satisfies all the following criteria:

a) At least 24 hours in advance of care, the enrollee or insured consents in writing to receive services from the identified noncontracting individual health professional;

b) The consent is obtained by the noncontracting individual health professional in a document that is separate from the document used to obtain the consent for any other part of the care or procedure, and not obtained by the facility or its representative, at the same time as admission or at any time when the enrollee or insured is being prepared for surgery or any other procedure;

c) At the time of consent, a written estimate of the enrollee or insured's total out-of-pocket cost of care is provided and based on the noncontracting individual health professional's billed charges, and prohibits the noncontracting individual health professional from attempting to collect more than the estimate amount without receiving separate written consent from the enrollee or insured or authorized representative unless circumstances arise during the delivery of services that was unforeseen at the time the estimate was given that would require the provider to change the estimate;

d) The consent must advise the enrollee or insured that he or she may elect to seek care from a contracted provider or may contact the health plan or health insurer in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs;

e) The consent and estimate will be provided to the enrollee or insured in the language spoken by the enrollee or insured if the language is a Medi-Cal threshold language as defined in existing law; and,

f) The consent will also advise the enrollee or insured that any costs incurred as a result of the out-of-network benefit will be in addition to in-network cost sharing amount and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

According to the authors, this bill protects patients from surprise medical bills when they follow the rules of their health plan by going to an in-network hospital, lab, imaging center, or other health care facility. Patients would only be responsible for their in-network cost sharing and would be prohibited from getting outrageous out-of-network bills from doctors they did not choose. Surprise medical bills wreak havoc on people's finances and their ability to pay for basic necessities. This bill also provides certainty for doctors and insurers and keeps our health care costs under control. Insurers must reimburse doctors a fair rate for their services, and doctors are assured a minimum payment in statute.

AB 1823 - (Bonilla) - Establishes for Privately Funded California Cancer Trials Program To Be Overseen by University of California CAHU Position: Support

This bill requests the University of California (UC) to create a Board of Trustees of the California Cancer Clinical Trials Program which must meet several specific qualifying parameters for the 5 members of this Board of Trustees. It would provide grants to increase patient access to eligible cancer clinical trials in underserved or disadvantaged communities, as specified. Allows the UC to decline to establish or participate in, and to terminate, the program, as specified.

According to the author, this bill will help remedy the problem of low participation in trials, especially for under-represented communities, by creating a grant program administered by the UC aimed at breaking down barriers to trial participation. The opportunity to assess and evaluate innovative treatments with participation from women and under-represented individuals allows researchers to properly test the effects of medication resulting in the opportunity to develop robust treatments that meet the varying genetic make-up of women and men of diverse racial/ethnic groups. Unfortunately, there is currently no support for patients who want to access trials. Some of the barriers to patient participation in trials include the following: lack of awareness of the available trials, mistrust of research and the medical system, loss of income, transportation, and lodging costs. This bill will create the CCTP, which will grant money to nonprofits and research institutes focused on breaking down the barriers to trial participation.

According to the National Cancer Institute, the largest sponsor of cancer clinical trials at 3,000 sites, over 30,000 patients are enrolled in trials annually. It is estimated that only about 3-5% of the 10.1 million adults with cancer in the U.S. participate in trials, however. A 2011 study published in the journal Annals of Surgery, based on data from the California Cancer Registry, found that less than one percent of cancer patients in California enroll in trials. Black patients, those older than 65, those with early stage cancer or with gastrointestinal or lung cancers were less likely to enroll than average.

AB 1899 - Calderon) - Permits Certain CDI Agent License Exams to Also Be Given In Spanish
CAHU Position - Support

This bill requires that as of January 1, 2018, and until January 1, 2024, the California Department of Insurance (CDI) to provide the license examinations for life, life-only, and accident and health licensees in Spanish.

ARGUMENTS IN SUPPORT: Several insurance trade associations state that the option to have the examination administered in Spanish will decrease potential miscommunication, increase agent understanding of their duties and obligations, and allow California to keep pace with the needs of its multilingual and multicultural insurance consumers.

ARGUMENTS IN OPPOSITION: CDI argues that permitting an agent to sell products and policies in English although they took and passed the Spanish examination does not provide adequate protection for the agent or the consumer. CDI explains that there is no evidence that simply passing an examination in Spanish prevents miscommunication or potential fraud during the sales process.

AB 2366 - Nazarian) - Exempts LTCi Insurers From Certain Requirements In Current Law
CAHU Position - Support

Exempts insurers that offer a policy that combines both life and long-term care (LTC) coverages from the requirement to offer the new policy to their existing long-term care policy holders and clarifies the requirements for when LTC policy holders must be offered a new policy. The Senate amendments clarify that an insurer must still offer existing LTC policyholders any new policy that adds coverage for new LTC services or providers.

According to the author, the requirement to offer new LTC products to existing policyholders hinders the ability of companies to make new products available for consumers, creates a compliance debacle for new hybrid products, and can be extremely confusing or misleading to existing policyholders. This bill offers a simple solution to ensure that insurance consumers are offered the latest innovative insurance products, while protecting existing policyholders from being forced to review and contemplate a potentially inappropriate replacement product. This modest change in the law will assist in the development of new innovative LTC products, and protect many existing policyholders from being needlessly confused by an updated offer every time a new LTC product is developed.

SB 908 - Hernandez - New Required CDI & DMHC Notices When Rate Increases for Individual & Small Group Policies Are Deemed Unreasonable Or Not Justified CAHU Position: Neutral As Amended

This bill requires notification to individuals and small groups when DMHC or CDI has determined the health plan or health insurance policy rate is unreasonable or not justified. It requires rate information to be filed 120 days, prior to implementing a rate change in the grandfathered individual or small group market. Requires all required rate information for nongrandfathered individual health plan contracts and insurance policies on the earlier of 100 days before the first day of the applicable open enrollment period, or the date specified in the federal guidance issued pursuant to federal regulations. It also requires the DMHC or CDI to determine reasonableness no later than 60 days following receipt of all information required to make a determination. Requires regulators to issue a determination that the rate increase is unreasonable or not justified no later than 15 days before the first day of the applicable open enrollment period.

All of these notices are also to be provided to the agents of such policies so they may best assist their clients in a timely fashion.

SB 1091 - Liu - Alternative Plan of Care For LTCi Policies
CAHU Position: Support

This bill establishes minimum standards for alternate plans of care as provided in long-term care insurance (LTCI) policies and requires insurers to provide written notice when they deny a request for treatment for an alternate plan of care.

This bill defines "alternate plan of care" to mean means a plan of care developed by a licensed health care practitioner that includes a specification of long-term care services required by an insured that are not specifically defined as covered services under the policy. It requires alternate plans of care to be freely agreed to by the insured, insurers, and licensed health care practitioner.

It provides that maximum benefit available under the contract shall not change based on an insured utilizing an alternate plan of care, but provides that the maximum benefit will be reduced by the amount of any benefits paid under an alternate plan of care. Provides that coverage for services under an alternate plan of care shall be in addition to, not in lieu of, covered services and permits the insured to switch to covered services as a matter of right, and back to an alternate plan of care if there is agreement by the licensed health care practitioner and the insurer.

It declares that the bill should not be construed to require an insurer to include an alternate plan of care in its contracts.

Background: Long-term care services prescribed by an authorized licensed professional, such as a medical doctor, are listed in a "plan of care." Some LTCI policies contain provisions that explicitly govern "alternate plan of care," that is a plan of care that includes services not covered in the policy. The insurer will pay for these services if the insurer, the insured, and the overseeing health care professional agree to the alternate plan of care. For example, some insurers will pay for durable medical equipment or modifications to the home, not otherwise covered, if the modifications allow the insured to stay in their own home rather instead of facility care. Existing law does not explicitly define or address alternate plans of care. This bill codifies existing practices and requires insurers to provide a written explanation to the insured within 60 days once it determines that an agreement cannot be reached.

SB 1234 - (De Leon) - Establishes “California Secure Choice Retirement Savings Program” (SCRSP)
CAHU Position: Neutral

A previous SB 1234 (De Leon, Chapter 734, Statutes of 2012) created the initial statutory framework for SCRSP and required the Board to perform a market analysis and feasibility study to determine if SCRSP could be implemented and to publish its findings and bring a recommendation to the Legislature for approval. That feasibility study has been completed and reported to the State Legislature, resulting in this new SB 1234.

The key findings in the report are the following:
1) About 6.8 million workers are potentially eligible for the SCRSP.
2) Likely participation rates (70-90%) are sufficiently high to enable the SCRSP to achieve broad coverage well above the minimum threshold for financial sustainability.
3) Eligible participants in California are equally comfortable with a 3% or 5% contribution rate. The vast majority of likely participants are also comfortable with auto-escalation in 1% increments up to 10%.

4) To start, the SCRSP should offer a default investment option consisting of a diversified portfolio with long-term growth potential and the choice to opt into a low-risk investment.
5) Given its inherent portability, the SCRSP should have a lower incidence of rollovers and cash-outs than employer-sponsored 401(k) plans, which often force workers with low balances to close their accounts. At the same time, pre-retirement withdrawals are likely to be higher for the Program given eligible workers' income profile.
6) The SCRSP launch should include a concerted public education campaign focused on workers and small businesses.

This bill requires that contract administrators and consultants discharge their duties as fiduciaries with respect to the program. It states that the Board shall design and implement SCRSP subject to its authority and fiduciary duty; requires, for up to three years following initial implementation, that the Board shall establish managed accounts invested in US treasuries, myRAs, or similar investments; requires that myRA contributions and returns be administered in accordance with federal requirements; and eliminates language limiting the Board's options as to which asset categories it may consider.

This bill requires the Board, during the three year period following implementation, to develop and implement an investment policy and establish policies and procedures designed to meet investment objectives in a prudent manner, minimizing participant fees and maximizing returns, as specified; allows the Board to include a range of risk and return opportunities; allows the Board to develop investment options that address risk-sharing and smoothing of market losses and gains and include the creation of a reserve fund, pursuant to legislative approval;

It requires the Board to collaborate with and evaluate the role of insurance and financial advisors in assisting and providing guidance for eligible employers and employees.

It specifies the Board's duties to provide information and appropriate forms to employers and employees and clarifies that the program is not sponsored by the employer and that the employer is not responsible or liable of the plan.

It changes the timeframes around implementation requirements for employers to the following and allows the Board to extend the timelines if it deems necessary:
a) Beginning 12 months after opening of enrollment, employers of 100 or more employees must have an arrangement to allow employees to participate in the SCRSP.
b) Beginning 24 months after opening of enrollment, employers of 50 or more employees must have an arrangement to allow employees to participate in the SCRSP.
c) Beginning 36 months after opening of enrollment, employers of five or more employees must have an arrangement to allow employees to participate in SCRSP.

Allows the Board to implement annual automatic escalation of employee contributions subject to the following limitations:
a) Contributions subject to automatic escalation cannot exceed 8 percent.
b) Automatic escalation cannot amount to more than 1 % annually.
c) An employee may opt out of automatic escalation and set his or her contribution rate at a level determined by the employee.

It also allows the Board, unless otherwise specified by the employee, to set the initial employee contribution into the SCRSP between 2% and 5% and clearly states that employers always retain the right to provide their own employer-sponsored retirement plans in lieu of SCRSP.

Background: Social Security is the foundation of retirement income for the vast majority of retirees in California, but these payments alone-today averaging $1,328 per month-are simply not enough to sustain workers in retirement.

On February 24, 2016, AARP and Small Business Majority released an opinion poll that revealed that two-thirds of small business owners in California support the creation of a state retirement savings program that would help small businesses and their employees save for retirement. In addition, nearly three-fourths (73%) of the respondents expressed the belief that offering such a program would give their business a competitive edge.

Overall, the lack of retirement savings impacts all Californians, as seniors without sufficient retirement income will need to rely on government assistance for housing, health care and other basic necessities. The California Secure Choice Program will provide participants with a professionally-managed, lifelong retirement savings system that offers them the opportunity to build their assets and achieve financial stability when they can no longer work.