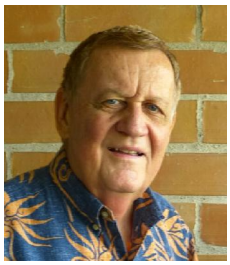
The 5 Most Important New Health Insurance Laws From the 2017 California Legislative Session



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[these new laws take effect on January 1, 2018 - unless otherwise noted]

AB 156 - (Wood) - Individual Market Enrollment Periods
CAHU Position: Support

With respect to individual health benefit plans offered outside of the Exchange, and also individual health benefit plans offered through the Exchange, a health insurer shall provide an initial open enrollment period from for policy years beginning on or after January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year.

Sets the open enrollment period for policy years beginning on or after January 1, 2019 outside of Covered California at October 15 to January 15; and inside Covered California at November 1, to December 15 of the preceding calendar year. Also establishes new special enrollment periods with respect to individual health benefit plans offered through Covered California for policy years beginning on or after January 1, 2019, from October 15 to October 31 of the preceding calendar year and from December 16 of the preceding calendar year, to January 15 of the benefit year.

Consistent with the federal rules, the market outside of Covered California requires a health plan or insurer in the individual market to allow an individual to purchase health insurance coverage during the same annual open enrollment period required of Covered California. The net effect of this bill is that individuals will be able to enroll in individual market coverage either through Covered California or outside of Covered California for a 90-day period that begins on October 15 of the preceding year through January 15 of the benefit year.....for policy years beginning on or after January 1, 2019.

This bill brings California law into compliance with the federal market stabilization rule and also maintain our current three month long annual open enrollment period. This consistency will help to boost enrollment in the individual market, hopefully among healthy enrollees, which will improve the market risk mix and keep overall premiums down.

AB 265 - Wood) - Prohibition On Price Discounts On Certain Drugs
CAHU Position: Support

This bill prohibits prescription drug manufacturers from offering a discount, repayment, product voucher, or other reduction in an individuals out-of-pocket expenses associated with insurance coverage, including, but not limited to, a copayment, coinsurance, or deductible, for a prescription drug if a lower cost generic or an over-the-counter drug are available at a lower cost. This bill applies to patients in self-insured plans as well as those regulated by the Department of Insurance and the Department of Managed Health Care. This bill exempts branded drugs from the coupon prohibition for three months after a generic equivalent is approved by the US Food and Drug Administration. Also this bill does not prohibit drug companies from offering patient assistance programs that are solely funded by a drug company.

According to the author, in recent years there has been a proliferation of coupons offered by drug manufacturers that sound great, but two recent studies show that most of these coupons are a classic bait and switch. When drug companies offer a coupon for the brand-name version of a generically equivalent drug, patients often stay with the more expensive brand-name drug, despite increases in prices year after year, even though a low-cost generic equivalent is available. The author emphasizes that the problem this bill aims to address is the use of coupons for drugs that have unnecessarily high prices sometimes costing tens of thousands of dollars over the course of a patients treatment when lower cost generic alternatives are available. Encouraging patients to use a much higher priced drug than is necessary means higher health care premiums for all.

SB 17 - (Hernandez) - Transparency of Prescription Drug Costs
CAHU Position: Support

1) Requires drug manufacturers to notify specified state purchasers, health plans, and health insurers, in writing at least 60 days prior to the planned effective date, if it is increasing the wholesale acquisition cost (WAC) of a prescription drug by specified amounts. Requires a prescription drug manufacturer with a WAC of more than forty dollars for a course of therapy to provide notification, in writing at least 60 days prior to the planned effective date of the WAC increase, to each purchaser, if the increase in the WAC of a prescription drug is more than 16%, including the proposed increase and the cumulative increases that occurred within the previous two years prior to the current year.

Requires drug manufacturers to notify the Office of Statewide Health Planning and Development (OSHPD) within three days of commercial availability if it is introducing a new prescription drug to market at a WAC that exceeds the Medicare Part D specialty drug threshold. Requires drug manufacturers to provide specified information to OSHPD related to the drug's price.

2) Requires OSHPD to post information on its Internet Web site on a quarterly basis for price increases and within 60 days of receipt from a manufacturer; and on a quarterly basis for new drugs. Requires OSHPD to post information in a manner that identifies the information on a per-drug basis, and not be aggregated in a manner that would not allow identification of the drug.

3) Requires health plans to report to DMHC and insurers to report to CDI on an annual basis, rate information through existing group and individual rate review processes, beginning October 1, 2018, the following information about all covered drugs, including generic, brand name, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use:
a) The 25 most frequently prescribed drugs;
b) The 25 most costly drugs by total annual spending; and,
c) The 25 drugs with the highest year-over-year increase in total annual spending.

4) Requires DMHC and CDI to compile the data in 1) above into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums.
5) Requires DMHC and CDI to publish on its Internet Web site the report in 2) above by January 1 of each year, beginning on January 1, 2019.
6) Requires the information provided to DMHC and CDI, except for the report in 2) above, to remain confidential and protected from public disclosure.

7) Requires health plans and insurers, beginning October 1, 2018, to annually report, as part of the existing large group rate review process, the following information:
a) Enrollee cost sharing, including cost sharing for prescription drugs as a factor affecting base rate described in existing law;
b) For covered prescription drugs, including generic drugs, excluding specialty generic drugs, brand name drugs excluding specialty drugs, and brand name and generic specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following:
i) The percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs;
ii) The year-over-year increase, as a percentage, in total spending for each category of prescription drugs;
iii) The year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium;
iv) The specialty tier formulary list.

8) Requires the California Research Bureau, by January 1, 2022, to report to the Legislature on this bill's implementation, including, but limited to, this bill's effectiveness in addressing the following goals:
a) Promoting transparency in pharmaceutical pricing for the state and other payers;
b) Enhancing understanding about pharmaceutical spending trends; and,
c) Assisting the state and other payers in management of pharmaceutical drug costs.

According to the author, transparency-focused policies in this state have led to rules requiring hospitals in California to provide information on pricing for common surgeries, health plans to submit detailed data regarding premium changes, and doctors to report more information to the federal government. But somehow, drug makers have been granted an exception to this forward-thinking trend. This bill will bring prescription drugs in line with the rest of the health care sector by shining a light on drugs that are having the greatest impact on our health care dollar.

A study published in the Journal of the American Medical Association (JAMA) in August 2016 reported that the primary reason for increasing drug spending is the high price of branded products protected by market exclusivity provisions granted by the U.S. Patent and Trademark Office and the FDA. The JAMA article reported that although brand-name drugs comprise only 10% of all dispensed prescriptions in the U.S., they account for 72% of drug spending. The JAMA article also stated that high prices have historically been limited to brand-name drugs that treat rare conditions, however, drugs that treat conditions affecting millions of individuals in the U.S. now also have high costs, for example many of the new oncology drugs. The JAMA article also stated that although brand-name drugs account for the greatest increase in prescription drug expenditures, another area that has captured the attention of the public and of policy makers is the sharp increase in the costs of some older generic drugs.

SB 133 - (Hernandez) - **Continuity of Care for Patients**
CAHU Position: Watch

Requires a health plan or insurer to, at the request of a newly covered enrollee or insured under an individual health care service plan contract or health insurance policy, to arrange for the completion of covered services as set forth in existing law by a nonparticipating provider if the newly covered enrollee's or insured's prior coverage was terminated, as specified, which includes when a health benefit plan is withdrawn from any portion of a market. Covered services include: an acute condition, as specified, for the duration of the condition; a serious chronic condiiton for a period of time not to exceed 12 months from the contract termination; a terminal illness for the duration of the terminal illness-not to exceed 12 months from the date of coverage for the new enrollee; care of a newborn child between birth and 36 months, for a period not to exceed 12 months from the date of coverage for the new enrollee; performance of a surgery or other procedure that has been recommended and documented to occue within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

Requires a notice as to the process by which an enrollee or insured may request completion of covered services to be provided to be part of, accompany, or be sent simultaneously with any termination of coverage notice sent in the circumstances described above. Compensates, unless otherwise agreed to by the provider and the health plan, the services at rates and methods similar to those used by the plan or provider group for currently contracting providers who are not capitated and who are practicing in the same or similar geographic area. Neither the plan nor the provider group is required to continue the services if the provider does not accept the payment rates.

According to the author, while California has laws to require continuity of care in specified situations for patients covered in the group market, those rules are different when it comes to individual market coverage. This bill will provide an individual with individual market coverage who loses his or her access to a product through no fault of his or her own and who has an existing qualifying condition, to obtain completion of covered services if the provider is willing and the plan and provider are able to agree on payment terms. This bill is a common sense measure that will give a person who has coverage in the individual market some peace of mind that his or her treatment may not have to be disrupted when a carrier leaves the individual market or a product is removed and new coverage is not available that includes the patients existing provider.

SB 788 (Lara) - Insurance Licensing Requirements
CAHU Position: Support *Takes Effect on 7-1-2018*

Existing law requires CDI to obtain a SSN from an individual producer licensee or applicant at the time of issuance or renewal of a license. Permits, beginning on July 1, 2018, individuals to provide a SSN or an ITIN when applying for or renewing specified types of licenses, including an insurance producer license (agents and brokers). This bill allows an individual to submit an ITIN and makes conforming changes to ensure that a licensee complies with tax laws. An ITIN is a tax processing identification number issued by the Internal Revenue Service that is only available for taxpayers who are ineligible to receive a SSN due to immigration status or other factors. ITINs do not provide work authorization.

Although this bill impacts several types of licenses at CDI, it primarily impacts applicants for an agents and brokers license (overwhelming the most frequently issued licenses issued by CDI). According to a report by the Little Hoover Commission, there are about 390,000 agent/broker licensees.