The 14 Most Important New Health Insurance Laws From the 2019 California Legislative Session

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[these new laws take effect on January 1, 2020 - unless otherwise noted]

AB 5 - (Gonzalez) - Worker Status: Employees & Independent Contractors
CAHU Position: Support

This bill codifies and expands the recent decision in *Dynamex Operations West v. Superior Court* (2018) 4 Cal. 5th 903.

1) Provides that, for the purposes of the Labor Code and Unemployment Insurance Code and the IWC's wage orders, where a definition for employee is not provided a person providing labor or services for remuneration must be considered an employee *unless* the hiring entity demonstrates that all of the following conditions are satisfied:

a) The person is free from the control and direction of the hiring entity in connection with the performance of the work, both under the contract for the performance of the work and in fact.

b) The person performs work that is outside the usual course of the hiring entity's business.

c) The person is customarily engaged in an independently established trade, occupation, or business of the same nature as that involved in the work performed.

2) Provides that, if a court of law rules that the three-part test above cannot be applied to a particular context based on grounds other than an express exception to employment status as provided in this bill, then the determination of employee or independent contractor status in that context shall instead be governed by the California Supreme Court's decision in *S. G. Borello & Sons, Inc. v. Department of Industrial Relations* (1989) 48 Cal.3d 341 (Borello).

3) Provides that, for the following occupations, the applicable test for determining if an individual is an employee or an independent contractor is the predecessor test to *Dynamex* developed by the California Supreme Court in *Borello* or relevant statute:

a) **Licensed insurance brokers**.

b) Licensed physicians and surgeons, dentists, podiatrists, psychologists, lawyers, architects, engineers, private investigators, veterinarians, and accountants, provided that the medical fields listed above are not covered by a collective bargaining agreement.

c) Registered securities broker-dealers, investment advisors, or their agents and advisors.

d) A direct salesperson, provided that the salesperson's compensation is based on actual sales, rather than wholesale purchases or referrals.

e) Commercial fisherman, except as per the provision of unemployment insurance benefits. This provision will become inoperative on January 1, 2023.

f) Real estate licensees and repossession agents, as provided under existing licensure provisions in the Business and Professions Code.

Provides that the *Borello* employment test governs professional contracts if the contracting entity can demonstrate all of the following:

a) The individual maintains a business location, which may include the individual's residence, that is separate from the hiring entity. Nothing prevents an individual from choosing to perform services at the location of the hiring entity.

b) If work is performed more than six months after the effective date of this section, the individual has a business license, in addition to any required professional licenses or permits for the individual to practice in their profession.

c) The individual has the ability to set or negotiate their own rates for services performed.

d) Outside of project completion dates and reasonable business hours, the individual has the ability to set their own hours.

e) The individual is customarily engaged in the same type of work performed under contract with another hiring entity or holds themselves out to other potential customers for the same work.

f) The individual customarily and regularly exercises discretion and independent judgment in the performance of the services.

Provides that an individual contracting for professional services can do so as a sole proprietor or other business entity.

[This is a lengthy, complex & important new law. For more details, go to-
http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201920200AB5
and click on- "09/09/19- Senate Floor Analyses"]

AB 290 - (Wood) - Health Care Service Plans & Health Insurance: Third-Party Payments
CAHU Position: Watch - *Not Effective Until 7-1-2020*

Requires a financially interested entity that is making third-party premium payments to comply with specified provisions, including agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug or device; and, agree not to steer, direct, or advise the patient into or away from a specific coverage program option, health care service plan contract or health insurance policy.

Prohibits a financially interested entity from making a third-party premium payment unless the entity annually provides a statement to the health plan/insurer that it meets the requirements set forth in 3) above; and, discloses to the health plan/insurer, prior to making the initial payment, the name of the enrollee/insured for each health plan contract/insurance policy on whose behalf a third-party premium payment was made.

Requires, commencing January 1, 2022, reimbursement for covered services to a financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment to1 a health plan or insurer on behalf of an enrollee/insured to be determined by the following:

- For a contracted provider payment for covered services reimbursement is governed by the higher of the Medicare reimbursement rate or the rate determined through the independent dispute resolution process
- Requires for a noncontracted provider payment for covered services reimbursement is governed by the terms and conditions of the health plan contract/health insurance policy or the rate determined through the IDRP, whichever is lower.

Requires cost-sharing to be based on the amount paid by the plan or insurer under this bill, if the contract or policy imposes coinsurance. Prohibits enrollees/insureds from being billed or reimbursement from being sought, except for cost-sharing pursuant to the terms and conditions of the contract/policy.

According to the author, this bill provides certain parameters on a practice where companies that provide certain types of care, donate money to a nonprofit that, in turn, pays for a patient's private coverage even though they qualify for coverage under Medicare or Medi-Cal, in order to receive a higher reimbursement rate. This bill will still allow providers, like dialysis companies, to donate to nonprofit organizations if they want to help provide premium assistance to patients, but it will not allow them to leverage those donations into higher reimbursement rates than they might otherwise receive through Medicare.

AB 414 - (Bonta) - Creation of New CA Individual Health Care Coverage Mandate
CAHU Position: Watch

This bill enacts several changes to maintain the positive effect of the ACA on health insurance rates in California (SB 78, Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2019) including to:

a) Establish a program within Covered California to provide state subsidies to assist individuals with incomes under 600 percent of the federal poverty level afford health insurance.

b) Require California residents, using the definition for resident used in the Personal Income Tax Law, to ensure that they and any of their dependents has Minimum Essential Coverage (MEC) for each month beginning on January 1, 2020, also known as the "Minimum Essential Coverage Individual Mandate."

c) Impose a penalty on individuals who fail to maintain MEC, known as the "Individual Shared Responsibility Penalty," almost identical to the penalty in federal law. The penalty must be included as part of the individual's tax return filed with the Franchise Tax Board (FTB), and applies for any month in which an individual or their dependent fails to maintain MEC.

According to the author, in order to keep healthcare affordable, enrollment by healthy individuals is necessary to spread the risk in an insurance market place. According to Covered California, the federal decision to zero out the individual mandate penalty had a chilling effect on new consumers signing up for the 2019 coverage year. The repeal of the penalty payment is projected to result in 150,000 to 450,000 additional Californians without health coverage by 2020. The recent budget proposal in SB 78 recognizes this concern and includes a state individual mandate penalty to provide immediate relief to Californians and to prevent further destabilization of the insurance market. This bill ensures we have the data to inform the Legislature as relates to the individual mandate, including the number of individuals paying the penalty, the total amount of state penalty imposed, and the number of exemptions applied.

AB 528 - (Low) - Controlled Substances: CURES Database
CAHU Position: Support - *[Not Effective Until 1-1-2021 and 7-1-2012]*

Changes the required timeframe in which pharmacists are required to report dispensed prescriptions to the state's prescription drug monitoring program (PDMP), Controlled Substance Utilization Review and Evaluation System (CURES), from seven days to the following working day; authorizes physicians and surgeons who are licensed by the Medical Board of California (MBC) but do not possess a federal Drug Enforcement Agency (DEA) registration to register for access to CURES; requires pharmacists to report Schedule V drugs to CURES; expands the authority for a prescriber's licensed delegate to retrieve data from CURES on behalf of that prescriber.

CURES database. CURES is the state's PDMP, allowing health professionals, regulators, and law enforcement to conduct web-based searches of the system to inform prescribing practices and support investigations. Every dispenser of controlled substances and every health practitioner authorized by the DEA to prescribe controlled substances is required to obtain a login for access to CURES. For each dispensed Schedule II, III, or IV drug, pharmacists are required to report basic information about the patient and their prescription within 7 days (current law). This information is then made available to other system users in a variety of possible contexts. For example, physicians may query a patient's prescription history prior to writing a new prescription; pharmacists can check the system before agreeing to fill a prescription for a controlled substance; regulators may review a licensee's prescribing practices as part of a disciplinary investigation; and law enforcement can incorporate a search of the system into a potential criminal case of drug diversion.

AB 651 - Grayson) - Air Ambulance Services
CAHU Position: Support

This bill:
1) Requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2020 to limit the enrollee or insured payment for covered services provided by a noncontracted air ambulance service provider to no more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracted air ambulance provider. Refers to this as the in-network cost-sharing amount.
2) Prohibits an enrollee or insured from owing the noncontracting provider more than the in-network cost-sharing amount for the services that are the subject of this bill, and requires, at the time of payment, the plan or insurer to inform the enrollee or insured and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee or insured.
3) Requires the following:
a) Any cost-sharing paid by the enrollee or insured for the services to count toward the annual out-of-pocket expenses limit, as specified.
b) Cost-sharing for these services to be counted toward any deductible in the same manner as cost sharing attributed to a contracted provider.
c) The cost-sharing paid by the enrollee or insured to satisfy the enrollee's or insured's obligation to pay cost-sharing for the health service.

According to the author, this bill will increase Medi-Cal reimbursement rates for emergency air ambulance providers. Without passage of this legislation in 2019, reimbursement will revert to 1993 levels. This bill will re-base the Medi-Cal rate for air ambulance providers to the rural Medicare level, which will bring air ambulance providers closer to actual costs. This bill will adjust for the loss of the supplemental Emergency Medical Air Transportation Act (EMATA) funds that expire at the end of this year. In addition, this bill will institute a prohibition on balance billing by air ambulance providers for patients who are insured in California. This bill will allow plans and providers to continue to negotiate in good faith, while requiring the patient only remain responsible for ordinary out-of-pocket expenses.

AB 731 - Kalra) - Health Care Coverage: HMO Rate Review
CAHU Position: Oppose - *[Not Effective Until 7-1-2020]*

This bill: 1) Requires health plans and insurers to notify the contract holder if a large group contract or policy rate has been determined unreasonable by DMHC or CDI.
2) Requires, beginning July 1, 2020, for large group products that are either experience rated, in whole or blended, or community rated, a plan/insurer to file specified information 120 days before any change in the methodology, factors, or assumptions that would affect the rates paid by a large group.
3) Deletes exemptions in existing law for a health plan/policy that exclusively contracts with no more than two medical groups to arrange for professional services from specified reporting requirements and alternative applicable disclosure requirements.
4) Requires a large group plan or insurer to disclose the same information as required in existing law for each

individual and small group rate filings.
5) Requires nongrandfathered individual, small and large group plans and insurers to disclose by geographic region, integrated care management fees or other similar fees, as well as reclassification of services from one benefit category to another, such as from inpatient to outpatient; and, aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories.
6) Requires, in addition to 5) above, variation in trend, by geographic region, if plan or insurer serves more than one geographic region; and, information by benefit category that demonstrates the price paid compared to the price paid by Medicare for the same service.
7) Requires any individual, small, or large group plan that fails to file specified information for each benefit category to also disclose specified information for individual, grandfathered group, and nongrandfathered group contracts and policies by market and geographic regions.
8) Makes failure to provide the information required in existing law and this bill, as specified, an unjustified rate.
9) Allows a large group contract holder to apply for a review of a rate change, if the contractholder has more than 2,000 total enrollees; or, the plan failed to provide information specified in this bill and existing law.
10) Makes contracted rates between a health plan or health insurer, and a large group, confidential information exempt from disclosure under the California Public Records Act.

AB 824 - (Wood) - Preserving Access to Affordable Generic Drugs
CAHU Position: Support

This bill presumes a patent infringement claim settlement between a brand drug maker and a generic or biosimilar biologic (biosimilar) drug maker to be anticompetitive and subject to a civil penalty, as specified, if the generic or biosimilar drug maker receives anything of value from the brand drug maker in exchange for limiting or foregoing entry into the market unless that presumption can be rebutted with specified evidence.

Author's statement. According to the author, pay-for-delay agreements where brand companies pay generic manufacturers not to produce lower priced generics after the patent has run out hurt consumers twice – once by delaying the introduction of an equivalent generic drug that is almost always cheaper than the brand name and second by stifling additional competition because we know that when multiple manufacturers of generic drugs compete with each other, prices can be up to 90% less than what the brand name drug cost originally. This bill makes California the first state to tackle pay-for-delay agreements and preserves consumer access to affordable drugs by prohibiting brand name and generic drug manufacturers from entering into these types of agreements by making them presumptively anticompetitive.

AB 929 - (Rivas & Luz) - Cov ered California: Data Collection
CAHU Position: Oppose

This bill requires a Covered California qualified health plan to report on cost reduction efforts, quality improvements, or disparity reductions. This bill requires Covered California to post annually on its Web site plan-specific data and information on cost reduction efforts, quality improvements, and disparity reductions in a manner that protects the personal information of enrollees.

According to the author, the process to eliminating health disparities and inequities starts with high quality data. This bill ensures Covered California has the authority to collect the data it needs to fully evaluate how a health plan is delivering care and to publish that data by health plan. In doing so, this bill helps to provide more information to the public and to patients so that patients are more educated about the best plan options for their health care needs. This bill allows for the disaggregation of critical data in order to gather information about sub-populations and reveal trends and patterns in racial and ethnic health disparities and inequities that can be masked by larger, aggregated data.

AB 1309 - (Bauer-Kahan) - Individual Health Care Coverage: Enrollment Periods
CAHU Position: Support

This bill: 1) Revises the annual open enrollment period for individual health benefit plans offered outside of Covered California, for policy years beginning on or after January 1, 2020, from November 1 of the preceding calendar year to January 31 of the benefit year, inclusive.
2) Establishes a special enrollment period for individual health benefit plans offered through Covered California, for policy years after January 1, 2020, from December 16 of the preceding calendar year, to January 31 of the benefit year, inclusive. Requires an application for a health benefit plan submitted during this special enrollment period to be treated the same as an application submitted during the annual open enrollment period.
3) Makes the effective date of coverage for plan selection made from December 16 to January 31, inclusive, February 1 of the benefit year for individual health benefit plans offered outside and through Covered California.

AB1803 - (Committee on Health) - Pharmacy Claims for Prescription Drugs Sold For Retail Price
CAHU Position: Support - *[Took Effect 7-12-2019]*

This bill delays for one year a provision in existing pharmacy law that requires a pharmacy claim to be submitted to a health plan or health insurer in the same manner as if a customer purchased the prescription drug by paying the cost-sharing instead of the retail price of the prescription drug.

According to the author, this bill will delay implementation by one year of a requirement for pharmacies to submit claims to the patient's health plan or insurance company when a patient pays a lower point of sale cost compared to the copayment, in compliance with AB 315 (Wood, Chapter 905, Statutes of 2018) and AB 2863 (Nazarian, Chapter 771, Statutes of 2018). Both bills enacted similar provisions that require a pharmacy, in the event that the copay of a particular patient's prescription is more than the point of sale price, to submit the claim for the lesser amount to the health plan or insurer to apply to the deductible and/or out of pocket max. The one-year delay will give pharmacies more time to develop mechanisms to comply with the law.

SB 129 - (Pan) - Health Care Plan Reporting
CAHU Position: Watch

This bill expands annual health care service plans (health plans) and health insurers reporting requirements to include products sold inside and outside of the California Health Benefit Exchange (the Exchange or Covered California) and any other business lines. Requires a multiple employer welfare arrangement (MEWA) or a health plan or insurer that provides coverage through a MEWA to report specified data to the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).

According to the author, since the enactment of the ACA, the health care coverage market has undergone major transformation. California's uninsured rate has been dramatically reduced as millions have gained coverage in Medi-Cal, and the individual and small group markets. Policy shifts, litigation, industry innovations, the economy and other factors can have positive or negative impacts on enrollment trends. Beginning in 2013, California has tracked enrollment in different types of health care coverage products and business lines. This information has helped policymakers and others monitor trends over time. This bill is necessary to update the annual health plan and insurer enrollment reporting requirement to capture additional business lines and ensure the data is available from DMHC and CDI by a certain time every year.

SB 260 - Hurtado) - Automatic Health Care Coverage Enrollment in Covered California Plans
CAHU Position: Watch - *[Effective before or by 7-1-2020]*

Requires the California Health Benefit Exchange (the Exchange or Covered California) to enroll an individual in the lowest cost silver plan or another plan, as specified, upon receiving the individual's electronic account from a county, or upon receiving information from another insurance affordability program, as specified. Requires plan enrollment to occur before the termination date of coverage through the insurance affordability program and implementation no later than July 1, 2021.

According to the Author, this bill would help consumers keep health insurance coverage and avoid coverage gaps when they undergo different life events that cause them to lose health coverage. Everyday Californians may face gaps in coverage because they lose or change jobs, get divorced or become widowed, turn age 26, and undergo other life changes that trigger a loss of insurance coverage. As long as Californians change their insurance whenever they change jobs, move from Medi-Cal to Covered California people will continue to experience gaps in coverage. This bill would make it easier for Californians to maintain health coverage when faced with life transitions that impact their coverage.

SB 407 (monning) - Medicare Supplement Coverage
CAHU Position: Watch

This bill would exclude outpatient prescription drug benefits as a new or innovative benefit. The bill, commencing July 1, 2020, would require the portion of the premium attributed to the new or innovative benefits to be identified as a separate line item on the payment invoice or bill. The bill would require the Department of Managed Health Care and the Department of Insurance to collaborate with specified individuals and entities, including consumer group representatives, to develop and implement various policies and procedures related to the new requirements, such as standardizing the new or innovative benefits approved for sale.

Extends the annual open enrollment period to a minimum of 60 days to purchase a Medicare supplement contract or policy, and requires a health care service plan (health plan) or health insurer to notify an enrollee or policyholder of specified rights on any notice related to a benefit modification or premium adjustment.

According to the Author, recently insurers, citing broad regulatory language, have begun adding non-medical "innovative benefits" to the most popular Medigap package in an attempt to distinguish their product from others in the marketplace. While these benefits, vision, dental and hearing, do provide some additional coverage, the inclusion of these non-standard benefits inside the standard Medigap benefit package complicates the ability of consumers to make meaningful comparisons between numerous additional non-medical benefits of striking complexity and variation offered by various insurers. This bill sets consumer-focused standards, which will protect and allow seniors to comprehend all aspects of an innovative plan they may pursue.

SB 639 - (Mitchell) - Medical Service: Credit or Loan
CAHU Position: Support - *[Not Effective Until 7-1-2020]*

Establishes, effective July 1, 2020, limits on the types of medical credit cards healthcare providers may sign patients up for and additional procedures and disclosures for doing so.

1) Limits healthcare providers' ability to facilitate deferred interest credit for their patients.
2) Requires treatment plans to show medically-appropriate alternatives covered by Medi-Cal, as specified, and required providers to follow Medi-Cal rules to secure those services.
3) Requires patients, rather than health care providers, to fill out applications for credit.
4) Prohibits providers, except veterinarians, from having patients apply for medical credit in the treatment area unless the patient agrees.
5) Prohibits medical credit cards from being charged more than 30 days before treatment.
6) Simplifies the text of notices provided to patients before they can be offered medical credit.

Medical credit cards are private-label credit cards that are offered for use in healthcare settings. Typically, the cards are accepted through a network of participating healthcare providers (such as dental offices or veterinary clinics) that have contractual relationships with a card company. In many of these networks, providers are allowed, and sometimes expected, to offer the opportunity for patients to apply for, and if they qualify, use the credit card to pay for healthcare services.

Because some healthcare costs are not covered by insurance or health benefit plans, some services may be too expensive to pay out of pocket. As a result, medical credit cards may provide patients and other consumers of healthcare an additional option for financing services. Further, medical credit cards can be used to pay for elective services, such as dental and orthodontic procedures, eye correction surgery, audiology care, cosmetic procedures, and hair removal or restoration, as well as for veterinary services. Some medical credit cards also may be used to pay for insurance copayments and deductibles or to finance medical care for people who do not have health insurance.

Because patients may not understand how medical credit cards or deferred interest products work, state law regulates the way health care providers may arrange or establish medical credit cards for their patients. According to the author, there are many cases where patients are unprepared to pay for the interest charges added to their accounts at the end of a deferred interest promotional period. This bill seeks to reduce the situations in which a patient is asked to agree to services and pay for those services by signing up for a new financial product that the patient may not fully understand.

According to the Author, "While medical credit cards resemble other credit cards, there is a very important difference to consider; medical credit cards are solicited and offered by medical providers, not by banks or creditors. Marketing a credit card to consumers when they most vulnerable, such as when they are in pain or when awaiting to receiving treatment, blurs the patient's understanding of the loan or credit offered because the medical provider is acting as both the advisor and solicitor to that patient."

"Third-party financing may have a place when patients need services that they cannot immediately pay for, but more protections need to exist in order to ensure that consumers are not preyed upon. Products with 'gotcha' clauses like deferred interest have no place in a medical practice. Consumers should not feel pressured into applying for these products and need to have a better understanding of what they are signing up for."