
VETO

Bill No: SB 1156
Author: Leyva (D)
Amended: 8/24/18
Vote: 21

SENATE HEALTH COMMITTEE: 8-0, 4/18/18

AYES: Hernandez, Nguyen, Leyva, Mitchell, Monning, Newman, Nielsen, Pan
NO VOTE RECORDED: Roth

SENATE APPROPRIATIONS COMMITTEE: 6-0, 5/25/18

AYES: Lara, Beall, Bradford, Hill, Nielsen, Wiener
NO VOTE RECORDED: Bates

SENATE FLOOR: 34-1, 5/30/18

AYES: Allen, Atkins, Beall, Berryhill, Bradford, Cannella, Dodd, Fuller,
Galgiani, Glazer, Hernandez, Hertzberg, Hill, Hueso, Jackson, Lara, Leyva,
McGuire, Mitchell, Monning, Moorlach, Newman, Nguyen, Nielsen, Pan,
Portantino, Roth, Skinner, Stern, Stone, Vidak, Wieckowski, Wiener, Wilk
NOES: Anderson
NO VOTE RECORDED: Bates, De León, Gaines, Morrell

SENATE FLOOR: 26-8, 8/30/18

AYES: Allen, Atkins, Beall, Bradford, Cannella, De León, Dodd, Galgiani,
Hernandez, Hertzberg, Hill, Hueso, Jackson, Lara, Leyva, McGuire, Mitchell,
Monning, Nguyen, Pan, Portantino, Skinner, Stern, Wieckowski, Wiener, Wilk
NOES: Anderson, Bates, Chang, Gaines, Moorlach, Morrell, Nielsen, Stone
NO VOTE RECORDED: Berryhill, Delgado, Fuller, Glazer, Roth, Vidak

ASSEMBLY FLOOR: 50-21, 8/29/18 - See last page for vote

SUBJECT: Health care service plans and health insurance: 3rd-party payments

SOURCE: Author

DIGEST: This bill establishes requirements for any financially interested entity making third-party premium payments for health plan enrollees or insureds.

ANALYSIS: Existing law establishes the Department of Managed Health Care (DMHC) to regulate health plans and the California Department of Insurance (CDI) to regulate health insurance. A health plan or insurer is referred to as “issuer”. [HSC §1340, et seq. and IC §106, et seq.]

This bill:

- 1) Requires an issuer to accept premium payment from the following third-party entities without the need for the entity to seek a determination from DMHC or CDI as described in 5) below:
 - a) A Ryan White HIV/AIDS Program;
 - b) An Indian Tribe, tribal organization, or urban Indian organization;
 - c) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf; and,
 - d) Any member of the individual’s family, defined for purposes of this bill to include the individual’s spouse, domestic partner, child, parent, grandparent and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.
- 2) Requires any financially interested entity that is not specified in 1) above that is making third-party premium payments, to comply with all of the following requirements:
 - a) Provide assistance for a full plan or policy year and notify the recipient prior to any open enrollment periods, if applicable, if financial assistance will be discontinued;
 - b) Require an entity that provides coverage for an enrollee with end state renal disease (ESRD) to agree not to condition assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device;
 - c) Inform an applicant of financial assistance, and requires the entity to inform a recipient annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable;

- d) Agree not to steer, direct, or advise the patient into or away from a specific coverage option or health insurance plan; and,
 - e) Agree that financial assistance is not conditioned on the use of a specific facility or health care provider.
- 3) Requires an entity described in 2) above to comply prior to making a payment with the following:
- a) Provide annually a statement to the issuer that it complies with 2) above; and,
 - b) Disclose to the issuer, prior to making the initial payment, the name of the enrollee or insured.
- 4) Limits reimbursement for covered services to the amount of reimbursement of covered services governed by the terms and conditions of the enrollee or insureds contract or the Medicare reimbursement rate, whichever is lower. Prohibits balance billing the enrollee or insured except for applicable cost sharing or coinsurance.
- 5) Allows a claim submitted by a noncontracting financially interested provider to be considered an incomplete claim and contested by the issuer.
- 6) Requires the issuer to be entitled to recover 120% of the difference between any payment made to a provider and the payment to which the provider would have been entitled, including interest on that difference if the issuer discovers that a financially interested entity fails to provide required disclosures.
- 7) Requires the issuer to notify the regulator of the amount by which the provider was overpaid and remit to the regulator any amount exceeding the difference between the payment made and the payment to which the provider would have been entitled, including interest on that difference.
- 8) Defines “financially interested” as any entity or provider that is a provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment; or an entity that receives the majority of its funding from one or more financially interested providers of health care service, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

Comments

- 1) *Author's statement.* According to the author, health insurance rates in California are driven up every year when providers seek profit by exploiting loopholes created by the Affordable Care Act (ACA). Financially-interested providers who steer patients away from Medicare and Medi-Cal by directly or indirectly paying their commercial insurance premiums raise prices for Californians who purchase their own insurance, businesses purchasing insurance on behalf of their employees, and state/local governments purchasing insurance on behalf of their employees. Financially-interested providers steering patients onto commercial insurance plans can also expose patients to unnecessary coverage disruptions, higher out-of-pocket costs, and other harms. SB 1156 regulates financially-interested third parties that boost their own profits by directly or indirectly purchasing health insurance for vulnerable patients. SB 1156 requires financially-interested providers or provider-funded entities to disclose that relationship to regulators and comply with disclosure requirements, including showing that patients are not otherwise eligible for Medicare or Medi-Cal. This bill sets an alternative payment rate tied to the lower of Medicare rates or contracted rates for financially-interested providers when the requirements are not met.
- 2) *Dialysis centers.* On December 14, 2016, Centers for Medicare and Medicaid Services (CMS) issued an interim final rule that would have implemented new requirements for Medicare-certified dialysis facilities that make payments of premiums on behalf of their patients for individual market health plans. The federal Department of Health and Human Services (HHS) had become concerned about the inappropriate steering of individuals eligible for or entitled to Medicare or Medicaid into individual market plans by providers and suppliers because of significantly higher reimbursement. One insurance company indicated that commercial coverage could pay more than ten times more than public coverage (\$4,000 per treatment rather than \$300 per treatment). A preliminary injunction was issued by a judge in the U.S. District in Eastern Texas to block implementation of the rule. The plaintiffs successfully argued that HHS/CMS violated the Administrative Procedures Act and the Medicare Act because the rule was unlawfully promulgated without notice and comment, and the rule's disclosure requirements were arbitrary, capricious, and contrary to law.
- 3) *Support in concept.* Anthem Blue Cross writes that from 2014-2016, Anthem saw a significant spike of ESRD active members in the individual marketplace. The on-Exchange ESRD incidence rate in 2016 was over three times as high as

in 2014, and for non-Exchange ESRD members in 2016 was nearly three times the rate in 2014. At the same time the ESRD incidence rate for Anthem's Medicaid members remained relatively flat. Anthem indicates that they do not accept payments from third-party payors other than those required by law or those made by a family member or legal guardian on behalf of an applicant or member. Anthem believes this bill relies on self-reporting from bad actors and does not include a process for registering third-party payers and verifying the information that is self-reported. Also, Anthem questions how would the requirement that an entity pay a full year's worth of premiums be enforced.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Assembly Appropriations Committee:

- 1) Costs to the DMHC to oversee and enforce the new disclosure requirements of approximately \$140,000-\$200,000 for the first three years and \$65,000 annually thereafter (Managed Care Fund).
- 2) Costs to the CDI to oversee and enforce the new disclosure requirements of approximately \$200,000 for the first year-and-a-half, and \$90,000 annually thereafter (Insurance Fund).
- 3) Potential, likely minor, GF revenues, as this bill is likely to discourage non-compliance with its requirements.
- 4) To the extent this bill restricts or removes the incentive for third-party payments to maintain commercial insurance or Medicare wraparound insurance plans, this bill could result in unknown, potentially significant Medi-Cal costs associated with higher enrollment than under the status quo. The effect of this bill's restriction, as it pertains to how many patients would continue to be able to maintain their coverage via third-party payments, is unknown. Medi-Cal costs could exceed \$1 million for increased enrollment if patients seek Medi-Cal coverage due to the unavailability of premium assistance to maintain commercial coverage (GF/federal).

SUPPORT: (Verified 10/3/18)

America's Health Insurance Plans

Association of California Life and Health Insurance Companies

Blue Shield of California

California Association of Health Plans

California Association of Health Underwriters

California Labor Federation

California Rural Legal Assistance Foundation
California School Employees Association
County Behavioral Health Directors Association of California
Health Access California
Health Net
Kaiser Permanente
Latino Coalition for a Healthy California
SEIU California

OPPOSITION: (Verified 10/3/18)

American Academy of Pediatrics
American Kidney Fund
California Dialysis Council
California Hepatitis C Task Force
California Hospital Association
California Medical Association
California State Association of Electrical Workers
California State Pipe Trades Council
Chronic Disease Coalition
DaVita
Dialysis Patient Citizens
Fresenius Medical Care North America
Patient Services Incorporated
Renal Support Network
US Renal Care
Western States Council of Sheet Metal Workers

ARGUMENTS IN SUPPORT: The California Labor Federation writes that steering patients onto commercial insurance plans can hurt patients who may now have higher out-of-pocket costs than if they stayed on public programs and can expose them to disruptions in coverage. The practice also shifts costs onto commercial plans, driving up health care spending and increasing premiums for Californians already struggling with rising costs. This bill will protect legitimate groups that help Californians afford health coverage. Blue Shield of California writes that a foundational tenet of the ACA is that no person can be turned down for coverage because of a preexisting condition. This fundamental provision is now being used for financial gain by some providers. Over the past four years, Blue Shield has seen the creation of a cottage industry by bad actors who have figured out how to manipulate the market for financial gain, driving up the cost of coverage and unduly putting consumers at risk. Blue Shield indicates that

providers identify patients who are otherwise Medicare or Med-Cal eligible, and pay the premiums for commercial coverage so they can receive higher reimbursement rates. They either do this directly or indirectly, through financial interested third parties and/or charities. While the biggest abuses are occurring in the dialysis industry, Blue Shield is seeing this market manipulation in substance use treatment, fertility treatment and others.

The SEIU California writes that this practice has been most common among substance use disorder treatment facilities and outpatient dialysis clinics – two types of providers serving particularly vulnerable patients. Unscrupulous treatment facilities aggressively bill insurance companies for care including daily drug tests and detox monitoring and patients are kicked out of the facility as soon as their insurance rehab benefit is exhausted, and the premium payments for insurance are cut off.

ARGUMENTS IN OPPOSITION: The California Dialysis Council (CDC) believes this bill will harm patients and cause patients to spend down their financial resources and will result in more ESRD patients on Medi-Cal increasing state costs. CDC writes that dialysis providers are required to educate patients on available community resources, including AKF, and that patients weigh numerous factors when determining what coverage best suits their individual circumstances. In California, where Medigap coverage is not guaranteed for ESRD patients under 65, the 20% uncapped co-insurance requirement under Medicare can make Medicare less attractive than private coverage. For financially needy patients, premiums for such coverage may be difficult to afford without charitable premium support from organizations like AKF. Dialysis Patient Citizens (DPC) writes that dialysis patients prefer private insurance because the actuarial value is often higher 88.9 to 91.8% compared to Medicare's 80%. DPC also believes if a patient can lose coverage when his or her chronic kidney disease progresses to ESRD it will create a perverse financial incentive for the insurer not to take all possible measures to preserve the patient's kidney function. The California Hospital Association (CHA) is concerned that this bill would undermine programs that pay for health insurance for patients who cannot afford it, but who do not qualify for Medicare, Medi-Cal or Covered California. CHA understands that some restrictions on the current practice of third-party payments may be called for. However, the restrictions and conditions currently proposed would be extraordinarily burdensome and costly to the health care system and would not improve care.

GOVERNOR'S VETO MESSAGE:

I am returning Senate Bill 1156 without my signature.

This bill attempts to prohibit the questionable practice of financially interested entities providing premium assistance payments to patients for the purpose of obtaining higher fees for medical services.

I believe, however, that this bill goes too far as it would permit health plans and insurers to refuse premium assistance payments and to choose which patients they will cover. I encourage all stakeholders to continue to work together to find a more narrowly tailored solution that ensures patients' access to coverage.

ASSEMBLY FLOOR: 50-21, 8/29/18

AYES: Aguiar-Curry, Berman, Bloom, Bonta, Burke, Caballero, Calderon, Carrillo, Cervantes, Chau, Chiu, Chu, Cooley, Cooper, Dahle, Eggman, Friedman, Gabriel, Cristina Garcia, Eduardo Garcia, Gloria, Gonzalez Fletcher, Grayson, Holden, Irwin, Jones-Sawyer, Kalra, Levine, Limón, Low, Mayes, McCarty, Mullin, Muratsuchi, Nazarian, O'Donnell, Quirk, Reyes, Rivas, Rodriguez, Rubio, Salas, Santiago, Steinorth, Mark Stone, Thurmond, Ting, Weber, Wood, Rendon

NOES: Acosta, Travis Allen, Baker, Bigelow, Brough, Chávez, Chen, Choi, Cunningham, Fong, Frazier, Gray, Harper, Kiley, Lackey, Medina, Melendez, Obernolte, Quirk-Silva, Voepel, Waldron

NO VOTE RECORDED: Arambula, Daly, Flora, Gallagher, Gipson, Kamlager-Dove, Maienschein, Mathis, Patterson

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
10/9/18 10:57:35

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