SB 743 (see companion bill AB 784)

This bill requires defined network plans, such as health maintenance organizations, and certain preferred provider plans and self-insured governmental plans that cover benefits or services provided in either an emergency department of a hospital or independent freestanding emergency department to cover emergency medical services without requiring a prior authorization determination and without regard to whether the health care provider providing the emergency medical services is a participating provider or facility. If the emergency medical services for which coverage is required are provided by a nonparticipating provider, the plan must 1) not impose a prior authorization requirement or other limitation that is more restrictive than if the service was provided by a participating provider; 2) not impose cost sharing on an enrollee that is greater than the cost sharing required if the service was provided by a participating provider; 3) calculate the cost-sharing amount to be equal to the amount that would have been charged if the service was provided by a participating provider; 4) provide, within 30 days of the provider's or facility's bill, an initial payment or denial notice to the provider or facility and then pay a total amount to the provider or facility that is equal to the amount by which the provider's or facility's rate exceeds the amount it received in cost sharing from the enrollee; and 5) count any cost-sharing payment made by the enrollee for the emergency medical services toward any in-network deductible or out-of-pocket maximum as if the cost-sharing payment was made for services provided by a participating provider or facility. The provider or facility may not bill or hold liable an enrollee of the plan for any amount for the emergency medical service that is more than the cost-sharing amount that is calculated as described in the bill for the emergency medical service.

AB 784 (see companion bill SB 743)

This bill requires defined network plans, such as health maintenance organizations, and certain preferred provider plans and self-insured governmental plans that cover benefits or services provided in either an emergency department of a hospital or independent freestanding emergency department to cover emergency medical services without requiring a prior authorization determination and without

regard to whether the health care provider providing the emergency medical services is a participating provider or facility. If the emergency medical services for which coverage is required are provided by a nonparticipating provider, the plan must 1) not impose a prior authorization requirement or other limitation that is more restrictive than if the service was provided by a participating provider; 2) not impose cost sharing on an enrollee that is greater than the cost sharing required if the service was provided by a participating provider; 3) calculate the cost-sharing amount to be equal to the amount that would have been charged if the service was provided by a participating provider; 4) provide, within 30 days of the provider's or facility's bill, an initial payment or denial notice to the provider or facility and then pay a total amount to the provider or facility that is equal to the amount by which the provider's or facility's rate exceeds the amount it received in cost sharing from the enrollee; and 5) count any cost-sharing payment made by the enrollee for the emergency medical services toward any in-network deductible or out-of-pocket maximum as if the cost-sharing payment was made for services provided by a participating provider or facility. The provider or facility may not bill or hold liable an enrollee of the plan for any amount for the emergency medical service that is more than the cost-sharing amount that is calculated as described in the bill for the emergency medical service.

AB 789

This bill requires a defined network plan or preferred provider plan to make available a current directory of health care providers in the plan's network of providers to anyone considering enrollment in the plan and to the plan's enrollees at least annually. Defined network plans and preferred provider plans are types of managed care organizations that provide health care benefits to their enrollees. The bill requires the plan to maintain a current provider directory on its website, to ensure that the directory on the site is updated at least quarterly, and to ensure that the public may view the provider directory on the site without creating or accessing an account or entering a policy or contract number. A plan is also required by the bill to provide information in each electronic and print directory on providers for each of the plan's covered services, to prominently indicate in each electronic and print directory which providers are accepting new patients at the time the directory is updated, and to accommodate with each electronic and print directory the

communication needs of persons with disabilities and persons with limited English proficiency.

AB 773 (see companion bill SB 737)

Regulation of pharmacy benefit managers, fiduciary and disclosure requirements on pharmacy benefit managers, and application of prescription drug payments to health insurance cost-sharing requirements.

AB 338 (see companion bill SB 328)

Price transparency in hospitals and providing a penalty. This bill creates several requirements for hospitals to provide cost information
for certain items and services provided by the hospital. Under the bill, each hospital must make publicly available a digital file in a machine-readable format that contains a list of standard charges for certain items and services provided by the hospital and a consumer-friendly list of standard charges for certain shoppable services. “Standard charge” is defined to mean the regular rate established by the hospital for an item or service provided to a specific group of paying patients and includes certain price information, including the gross charge, the payor-specific negotiated charge, and the discounted cash price. “Shoppable service” is defined to mean a service that may be scheduled by a health care consumer in advance. If the Department of Health Services determines that a hospital is not in compliance with any of the price transparency requirements specified in the bill, the bill requires DHS to take certain actions, including providing a written notice to the hospital, requesting a corrective action plan from the hospital, or imposing a penalty. The bill establishes escalating penalties for violations of the hospital price transparency requirements specified in the bill based on the hospital’s bed count, from $600 for each day in which a hospital with 30 beds or fewer violates the hospital price transparency requirements under the bill up to $10,000 for each day in which a hospital with greater than 550 beds violates the hospital price transparency

requirements under the bill.

SB 328 (see companion bill AB 338)

Price transparency in hospitals and providing a penalty. This bill creates several requirements for hospitals to provide cost information
for certain items and services provided by the hospital. Under the bill, each hospital must make publicly available a digital file in a machine-readable format that contains a list of standard charges for certain items and services provided by the hospital and a consumer-friendly list of standard charges for certain shoppable services. “Standard charge” is defined to mean the regular rate established by the hospital for an item or service provided to a specific group of paying patients and includes certain price information, including the gross charge, the payor-specific negotiated charge, and the discounted cash price. “Shoppable service” is defined to mean a service that may be scheduled by a health care consumer in advance. If the Department of Health Services determines that a hospital is not in compliance with any of the price transparency requirements specified in the bill, the bill requires DHS to take certain actions, including providing a written notice to the hospital, requesting a corrective action plan from the hospital, or imposing a penalty. The bill establishes escalating penalties for violations of the hospital price transparency requirements specified in the bill based on the hospital’s bed count, from $600 for each day in which a hospital with 30 beds or fewer violates the hospital price transparency requirements under the bill up to $10,000 for each day in which a hospital with greater than 550 beds violates the hospital price transparency requirements under the bill.

SB 718 (see companion bill AB 747)

Creating a Prescription Drug Affordability Review Board, funding for an office of prescription drug affordability, crediting certain amounts to the general program operations account of the office of the commissioner of insurance, granting rulemaking authority, and making an

appropriation.

SB 574 (see companion bill AB 584)

Cost-sharing cap on insulin. This bill prohibits every health insurance policy and governmental self-insured health plan that cover insulin and impose cost sharing on prescription drugs from imposing cost sharing on insulin in an amount that exceeds $35 for a one-month supply. The bill’s cost-sharing limitation on insulin supersedes the specification that the exclusions, limitations, deductibles, and coinsurance are the same as for other coverage.

AB 584 (see companion bill SB 574)

Cost-sharing cap on insulin. This bill prohibits every health insurance policy and governmental self-insured health plan that cover insulin and impose cost sharing on prescription drugs from imposing cost sharing on insulin in an amount that exceeds $35 for a one-month supply. The bill’s cost-sharing limitation on insulin supersedes the specification that the exclusions, limitations, deductibles, and coinsurance are the same as for other coverage.

AB 103 (see companion bill SB 100)

Application of prescription drug payments to health insurance cost-sharing requirements. Health insurance policies and plans often apply deductibles and out-of-pocket maximum amounts to the benefits covered by the policy or plan. A deductible is an amount that an enrollee in a policy or plan must pay out of pocket before attaining the full benefits of the policy or plan. An out-of-pocket maximum amount is a limit specified by a policy or plan on the amount that an enrollee pays, and, once that limit is reached, the policy or plan covers the benefit entirely. This bill generally requires health insurance policies that offer prescription drug benefits, self-insured health

plans, and pharmacy benefit managers acting on behalf of policies or plans to apply amounts paid by or on behalf of an individual covered under the policy or plan for brand name prescription drugs to any cost-sharing requirement or to any calculation of an out-of-pocket maximum amount of the policy or plan. Health insurance policies are referred to in the bill as disability insurance policies.