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LEGISLATION EFFECTIVE IN 2018

Diana Livingston

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In the first year of the California State Legislature's two year 2017-2018 session, several major bills impacting the health care community became law and will be valid as of 2018 (January 1 or July 1, depending on the legislation); these bills will be addressed below, in Part One of a two-part series on issues to watch in 2018. Several other pieces of legislation that would affect health care in the state were introduced and are still pending in various committees in the State Assembly and Senate, which will be addressed in Part Two.

Legislation Taking Effect in 2018

- Senate Bill 17 – Prescription Drug Costs:
  - Health care plans must file prescription drug cost information as a part of their standard rate filing procedures with the Department of Managed Health Care (DMHC) or Department of Insurance (DOI), which will show the impact of prescription drug pricing on health insurance premiums. DMHC and DOI will publish public reports with the drug pricing information and its effect on insurance premiums on January 1 of each year. [1]

    Additionally, should a prescription drug manufacturer increase the price of most drugs by 16 percent or more, it would be required to report any such change to specified purchasers, including health plans and state agencies, at least 60 days prior to the planned increase.[2] Prescription drug manufacturers will have to explain the reasons behind price increases to the Office of Statewide Health Planning and Development (OSHPD) beginning in 2019.

    The bill is intended to keep prescription drug prices in check and allow greater transparency in the methods used to determine health insurance premiums.

- Senate Bill 133 – Continuity of Care:
  - The ongoing uncertainty over the future of the Affordable Care Act (ACA) at the national level prompted the introduction of this bill, which was designed to ensure that patients impacted by insurers leaving the individual market would be able to maintain care.[3]

    Should an insurer terminate a provider contract, the insurer would have to cover services an enrollee continued to receive from that provider for a number of health conditions, including an acute medical condition, a serious chronic condition (for 12 months after the insurer-physician contract termination or 12 months from the effective date of new coverage), a pregnancy, a terminal illness (for as long as the illness lasts), the care of a newborn child to age 36 months, and/or a surgery the insurer had previously authorized. A health plan may require a provider to agree in writing to the terms of their previous contractual agreements and the provider would be compensated at comparable rates to other providers in the same field and similar geographic area.[4]

For more information about this article contact:

Diana Livingston
Health Care Research Analyst
dlivingston@dsrhealthlaw.com

There are similar provisions for non-participating providers (as opposed to providers whose contracts have been canceled, above) who, at the time of a new enrollee's contract effectuation, were providing care for said enrollee affected by one of the conditions listed above. The new enrollee's previous insurer had to have left the market, as might happen if the ACA is overturned or eroded.

- Senate Bill 171 and Assembly Bill 205 – Medi-Cal Managed Care Plans "Mega-Reg":
  - SB 171 and AB 205 are companion bills, introduced to ensure California's compliance with the final rule released by the Centers for Medicare and Medicaid Services (CMS) in May 2016.[5] The rule is commonly known as the "Medicaid Mega-Reg." SB 171 contains provisions for an 85-15 medical loss ratio (MLR) for Medi-Cal managed care plans as well as public hospital funding. AB 205 sets new network adequacy standards for 15 new specialties in Medi-Cal managed care plans.
  - SB 171: Beginning in 2019, this bill will mandate the 85 percent MLR required by federal regulations. Health plans will report their MLRs each year and beginning with contract periods on or after July 1, 2023, plans will pay remittance to the state if they do not meet the required ratio (the nonfederal portion of any remittance funds would go into the Medically Underserved Account for Physicians).[6]

    In compliance with the federal Medicaid Mega-Reg, SB 171 requires the Department of Health Care Services (DHCS), which implements California's Medicaid program, to develop a direct payment methodology by which Medi-Cal managed care plans will increase contract services payments to public hospital systems. Payments would be determined based on a public hospital's class, which DHCS will determine. Managed care plans that do not comply with the new payment requirements will be penalized by decreasing the number of enrollees they are assigned by as much as 25 percent. DHCS, in correlation with the public hospitals and managed care plans, will establish performance-based incentive program payments, which will reward public hospitals that "advance at least one goal identified in the state's Medicaid quality strategy."[7]
  - AB 205: This legislation retools existing practices around the Medi-Cal managed care appeals process for enrollees who have received an adverse benefit determination is upheld or the enrollee has exhausted that plan's internal appeals process. Beginning on January 1, 2018, Medi-Cal managed care plan enrollees would have 120 days to file such an appeal with the State Department of Social Services (SDSS), as opposed to the 90-day limit that has been enforced until that point. For enrollees who qualify for expedited hearings, managed care plans would have three business days from the date of notice to provide SDSS with the relevant case file, after which SDSS would be required to issue a decision within three business days.[8]

    To ensure network adequacy standards mandated by the federal Medicaid Mega-Reg, beginning with contract periods starting on or after July 1, 2018, AB 205 will require DHCS to enforce new network adequacy standards regarding time, distance, and appointment time for Medi-Cal managed care plans. Exceptions can be made if a plan can demonstrate that it has a sufficient structure in place to meet network adequacy requirements or that it has exhausted all reasonable options to create a provider network that would meet these new time and distance requirements. The bill also encourages the use of telemedicine and/or telehealth technologies in meeting these requirements. Managed care plans must provide DHCS annual reports to show their compliance with the time and distance standards DHCS creates. Of note for health plans, there is a sunset clause in this legislation of January 1, 2022, at which point the regulations created by AB 205 presumably will be reevaluated.[9]

    Lastly, AB 205 imposes specific time periods when Medi-Cal managed care plans must notify enrollees of adverse benefit determinations. If an enrollee appeals the adverse benefit determination, a managed care plan will be required to resolve said appeal through its internal process within 30 calendar days from the day the plan receives notice of the appeal or 72 hours after notice of an appeal for an expedited case.

- Assembly Bill 1048 – Pain Management and Schedule II Drug Prescriptions:
  - This bill was created in response to the ongoing opioid crisis in this country.[10] In an attempt to stem the tide of opioid overdoses, AB 1048 will allow partial prescription fills of Schedule II controlled substances and, beginning on January

1, 2019, will mandate that health plans prorate the cost of these types of fills for enrollees. Per the legislation, either a patient or a provider can request a partial fill.[11]

[1] *Senator Edward Hernandez, "SB 17 Health Care: Prescription Drug Costs," October 9, 2017.*

[2] *April Dembosky, "California Governor Signs Law to Make Drug Pricing More Transparent," National Public Radio News, October 10, 2017, https://www.npr.org/sections/health-shots/2017/10/10/556896668/california-governor-signs-law-to-make-drug-pricing-more-transparent.*

[3] *Melanie Manson, "Two Measures to Boost Obamacare in California Signed into Law by Gov. Jerry Brown," Los Angeles Times, October 4, 2017, http://www.latimes.com/politics/essential/la-pol-ca-essential-politics-updates-gov-brown-signs-two-measures-to-aid-1507155294-htmlstory.html.*

[4] *Senator Edward Hernandez, "SB 133 Health Care Coverage: Continuity of Care," October 4, 2017.*

[5] *Centers for Medicare and Medicaid Services, HHS, 81 FR 27497, May 6, 2016.*

[6] *Senator Edward Hernandez, "SB 171 Medi-Cal: Medi-Cal Managed Care Plans," October 13, 2017.*

[7] *Ibid., p. 4.*

[8] *Assemblymember Jim Wood, "AB 205 Medi-Cal: Medi-Cal Managed Care Plans," October 13, 2017.*

[9] *Ibid.*

[10] *James L. Madara, MD, "American Medical Association Support for Assembly Bill 1048, An Act in Support of Partially Filling Schedule II Opioid Prescriptions," American Medical Association, June 22, 2017.*

[11] *Assemblymember Joaquin Arambula, "AB 1048, Health Care: Pain Management and Schedule II Drug Prescriptions," October 9, 2017.*