DSR HEALTH LAW

LEGISLATION TO WATCH IN 2018 (PART 2 OF 2)

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FEBRUARY 15, 2018

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- Senate Bill 538 – Health Care Market Fairness Act of 2017:
  - Designed to protect patients and health insurers from unfair contracting practices common with dominant provider systems (e.g., Dignity and Sutter), this bill would essentially serve as an antitrust act against hospital groups. The legislation acknowledges that the dramatic increase in hospital consolidations in recent years has reshaped the health care landscape, particularly when it comes to rate negotiations between hospital groups and health insurers, resulting in increased insurance premiums. It goes on to assert that because the large hospital groups described in this bill "tend to lessen competition, increase prices, and reduce the affordability and availability of insurance coverage, and for the protection of other important state interests," they have behaved in an unfair manner that runs counter to public interest and threatens the validity of their contracts under state law.[1]

    The legislation would update the California Insurance Code, section 10133.57 to add guidelines around what contracts between hospitals (or hospital affiliates) and health insurers can and cannot contain.[2] The bill enumerates the following provisions that hospitals or any hospital affiliate and health insurers may not include in contractual agreements:

    1. Set payment rates or other terms for nonparticipating affiliates of the hospital.
    2. Require the health insurer to contract with any one or more of the hospital's affiliates. This section does not prohibit a contract from requiring that the health insurer contract with the medical group with which the hospital's medical staff is affiliated.
    3. Require payors to certify, attest, or otherwise confirm in writing that the payor is bound by the terms of the contract between the hospital and the health insurer. A health insurer shall be responsible for including and disclosing relevant terms of the provider's contract in its contract with a payor.
    4. Require the health insurer, as a condition to entering into the contract with the hospital or continuing the contract on its then current terms, to submit to arbitration, or any other alternative dispute resolution program, any claims or causes of action that arise under state or federal antitrust laws. This paragraph does not prohibit a hospital (or any affiliate of a hospital) and a health insurer from entering into a consensual agreement to submit those claims or causes of action to arbitration or any other alternative dispute resolution program, other than as a condition to entering into the contract or continuing the contract on its then current terms.
    5. Require the health insurer to impose the same cost-sharing obligations on beneficiaries when the hospital is in-network but at a different cost-sharing tier than any other in-network hospital …
    6. Require the health insurer to keep the contract's payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments. This paragraph does not prohibit a requirement that any communication of the contract's payment rates to an existing or potential payor be subject to a reasonable nondisclosure agreement.[3]

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Hospital and physician groups are actively campaigning against this bill, while insurers and patient advocacy groups are lobbying for it. Hospital groups argue that the restrictions in the bill will stifle growth, negatively impact timely access, and increase costs. Patient advocacy groups assert that the bill will allow for greater cost control on the part of purchasers (health plans), more price transparency for consumers, and discourage the perceived monopolistic tendencies of some of the large hospital systems.[4]

- Senate Bill 562 – The Healthy California Act (Single Payor):
    - Although SB 562 was shelved in the Assembly in 2017 after passing the Senate, it is likely to reemerge this year (either as this bill or a similar bill), especially as universal health care has become a hot topic in California's gubernatorial race. This bill would eliminate the private insurance industry as it exists today in California, putting in place a universal coverage, government-funded-and-managed system in its place called Healthy California, governed by a nine-member, independent board. Healthy California would subsume the current Medi-Cal, CHIP, Medicare, Covered California, and other such public programs, receiving all of the funding that those programs currently receive and using it to provide health coverage for all Californians via a Healthy California Trust Fund that this legislation would create. Health care providers would be required to negotiate rates with the state, doing away with one of the primary roles health plans play. Additionally, the bill would create a health care cost control system to lower costs across health care fields, although no mention is made as to how this would be accomplished.[5] Patients would no longer pay insurance premiums or any cost-sharing amounts associated with receiving health care, although the bill does mention a consumer's ability to pay, but it is vague about what this would mean.[6] This bill also intends to address and mitigate the effects of high prescription drug prices.

      SB 562 would supply providers with enormous powers. It includes a long list of health benefits that must be covered, far exceeding the essential health benefits currently required under the Affordable Care Act. Although the list appears incredibly comprehensive, it is non-exhaustive because it would defer to a provider's determination of what is considered medically appropriate, seemingly without any checks for the possibility that a provider might be mistaken.[7] The Healthy California board would develop payment methodologies for health care-related services but the primary method would be fee-for-service "unless or until another payment methodology is established by the board."[8] Private health insurance companies would be forbidden from offering the services or benefits offered through Healthy California, although they could offer services not covered by Healthy California; since Healthy California would cover all services a provider deemed medically appropriate, however, it is unclear what, if any, services or benefits private insurers would still be able to cover.[9]

      Creating this system would be hugely disruptive to a wide variety of industries in this state and would require an unprecedented amount of planning, labor, supervision, regulations, etc., costing hundreds of billions of dollars and likely having a significant impact on the economy. While the bill itself does not address costs, cost estimates predict Healthy California would cost about $400 billion annually, with about $200 billion of that money coming from existing federal funding for Medicare, Medi-Cal, Covered California, etc.; the additional revenue would need to come from tax revenues, specifically a new payroll tax.[10] The bill would even establish retraining and job assistance programs for those who had previously been employed in the health insurance industry, the health care service plan industry, or third-party payors for health care; it truly foresees a complete demolition of the managed care industry as it operates today.

- Assembly Bill 315 – Pharmacy Benefit Management:
    - This bill is intended to increase transparency in how prescription drug benefits are managed (currently, there is very little regulation of this process; recent legislation will compel pharmaceutical manufacturers to reveal more pricing information, and this legislation is meant to continue that trend in a different sector of the prescription drug field).[11] If passed, AB 315 would require pharmacy benefit managers (PBMs) to be registered with the Department of Managed Health Care (DMHC). PBMs would be subject to certain requirements that, if unmet or violated, could result in the DMHC suspending their registration (DMHC would develop policies to provide sufficient notice to PBMs and an opportunity for PBMs to respond). The bill would mandate that PBMs present potential conflicts of interest to purchasers (health care service plans) and act in the spirit of good faith and fairness when working with purchasers.

PBMs would be compelled to provide certain information periodically if a purchaser should request it, specifically information pertaining to drug acquisition costs, rebates from pharmaceutical manufacturers, rates PBMs have negotiated with pharmacies, exclusive contracts a PBM might have with a pharmaceutical manufacturer for certain drugs, prescription drug use by an amalgamation of purchaser's enrollees, and payments PBMs make to pharmacies. PBMs would be forbidden from requiring pharmacy network providers to not inform consumers of alternate medication options or from providing a certain amount of prescription medication.[12] This bill would not apply to self-contained insurers whose pharmacy benefit management services are only available to their enrollees.

Insurance groups and the Pharmaceutical Care Management Association oppose this legislation, stating that increased transparency around negotiations between PBMs and purchasers will negatively affect such negotiations and inhibit their ability to lower prices. Additionally, they are opposed to language supported by consumer advocacy groups that would discourage the promotion of PBM-owned mail order pharmacies, stating that this would increase drug costs. Meanwhile, consumer groups, physicians' groups, and pharmacy groups support the bill, believing that increased transparency involving PBMs will help slow the increase in health insurance premiums as well as the costs of prescription drug prices and will force the PBM industry to comply with similar standards by which other players in the health care market must abide. Furthermore, they argue that AB 315 will help combat conflict of interest issues that exist with large PBMs and would restrict the narrowing of pharmacy provider networks.[13]

[1] *Senator Bill Monning, "SB 538 – Health Care Market Fairness Act of 2017," February 16, 2017, p. 3.*

[2] *In portions of the legislation, the same terms are set for "contracting agent[s]." A "contracting agent" is defined as "a third-party administrator or trust not licensed under the Health and Safety Code, the Insurance Code, or the Labor Code, a self-insured employer, a preferred provider organization, or an independent practice association, while engaged, for monetary or other consideration, in the act of selling, leasing, transferring, assigning, or conveying, a provider or provider panel to provide health care services to beneficiaries." California Business and Professions Code, section 511.1 (d)(2).*

[3] *Senator Monning, "SB 538," p. 9.*

[4] *Teri Boughton, "SB 538 Analysis for the Senate Committee on Health" Office of Senate Floor Analyses, May 30, 2017.*

[5] *Senator Ricardo Lara and Senator Toni Atkins, "SB 562 – The Healthy California Act," February 17, 2017, p. 4.*

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

[7] *Ibid.*

[8] *Ibid., pp. 18-20.*

[9] *Ibid., p. 25.*

[10] *Scott Bain, "SB 562 Analysis for the Senate Rules Committee," Office of Senate Floor Analyses, May 26, 2017, p. 11.*

[11] *Le Ondra Clark Harvey, "AB 315 Analysis for the Assembly Committee on Business and Professions," Assembly Committee on Business and Professions, May 30, 2017.*

[12] *Assemblyman Jim Wood, Assemblyman Brian Dahle, and Assemblyman Adrin Nazarian, "AB 215 – Pharmacy Benefit Management," February 6, 2017.*

[13] *Melanie Moreno, "AB 315 Analysis for the Senate Committee on Health," Senate Committee on Health, May 30, 2017.*