California Legislative Beat: Transformative Healthcare Bills of 2018 (Pt. 1)

Year two of California's 2017-2018 legislative session has been an active one. As lawmakers work diligently, The Source will take a brief look at some 2018 bills that can potentially change the California healthcare landscape.

SB 1021: This bill removes the sunset provision for AB 339 (2015), which was enacted to cap cost sharing for a covered outpatient prescription drug at $250/$500 per 30-day supply.[1] Furthermore, the bill codifies the regulation that "prohibits an enrollee or insured from being charged more than the retail price for a prescription drug when the applicable copayment or coinsurance is a higher amount."[2] Additionally, the bill would prohibit a health plan or health insurer from maintaining a drug formulary with more than four tiers.

Why this should pass: The author of SB 1021 noted that prior to AB 339, "insurance companies would routinely shift drug costs onto consumers by placing high-cost specialty drugs on the upper tiers of their drug formularies, which meant higher cost-sharing for consumers."[3] Additionally, the California Health Benefits Review Program (CHBRP) noted that specialty drugs, which AB 339 would affect, account for a "fairly high proportion of [consumers'] costs."[4] This bill should pass because it would ensure that prescription drug costs are manageable for consumers. While this bill may not completely address high drug costs and may shift costs to premiums, it's a good step in ensuring that consumers are not directly footing the bill for high cost specialty drugs.

AB 2427: This bill would allow the Department of Health Care Services (DHCS) to terminate or decline to renew or award a contract of a for-profit Medi-Cal managed

care plan or insurer when (a) the Attorney General determines that the plan engaged in anticompetitive conduct or (b) DHCS determines the plan has a pattern or practice of not complying with the medical loss ratio (MLR).

Why this should pass: As the bill analysis points out, "[c]ompetitive marketplaces established through antitrust attentiveness help consumers by ensuring fair prices for services, more to choose from, and quality services."[5] Additionally, MLRs were passed to ensure that a health plan spends at least a certain percentage (85%) on health care services, as opposed to administrative costs. This bill would in effect establish a penalty on Medi-Cal plans for engaging in anticompetitive conduct or not committing enough percentage of its received premiums toward healthcare services. With this penalty, DHCS can ensure Medi-Cal plan enrollees are protected from plan misconduct.

AB 2472: This bill would mandate Covered California to prepare a feasibility analysis of a public health insurance plan option by January 1, 2020.

Why this should pass: The author of this bill notes that some counties in California have only one health plan choice, while twenty two counties have two or fewer health plans consumers can choose from.[6] The effect of this bill is to introduce competition (and consequentially limit health care cost increases) by increasing the number of health plan choices. Specifically, this bill seeks to explore the introduction of a public option, which is "a publicly operated health plan choice that directly competes with private health plans."[7] The public option would be beneficial in several ways. The University of California, San Francisco (UCSF)'s report to the Assembly Select Committee on Health Care Delivery Systems and Universal Coverage (Select Committee) stated that a public option would (a) provide "a choice of at least one plan in an area even if private insurers choose not to enter the market," (b) "be less expensive to consumers than private insurance offerings since a public plan does not need to generate a profit and may be able to contract providers at lower reimbursement rates," and (c) "broaden the physicians and hospitals available to consumers."[8] As this bill seeks to examine whether a public option is feasible, it would be a welcomed addition to the exploration of innovative

solutions to lower healthcare costs.

AB 2517: This bill would establish an Advisory Panel on Health Care Delivery Systems and Universal Coverage, with the goal of developing a plan that includes a timeline and steps required to implement a universal coverage and unified publicly financed health care system.

Why this should pass: After the shelving of SB 562, which proposed a single-payer system for California, last summer, a single-payer system seemed less likely to succeed. Reasons for shelving SB 562 included flaws and inability to address several legal and financing issues. Yet, universal coverage is considered to be "essential for ensuring access to care, improving outcomes and controlling costs."[9] The previously mentioned UCSF report recommended that California seek unified public financing and establish a public commission to figure out universal coverage and unified health care financing.[10] This bill would ensure that the much-needed substantive and focused work on how to implement a single payer system can be done. Whether or not one may support the single payer system, California should at least take this opportunity to fully explore whether or not the single-payer system can be implemented.

The above four bills aim to maintain manageable drug costs for consumers, strengthen penalties for Medi-Cal plans that do not act properly, and explore innovative solutions for the growing California healthcare crisis. To learn more about public option (AB 2472) and single market (AB 2517), be sure to check out a fantastic explanation on The Source Blog for Katie Gudiksen's discussion of the distinction between the two systems and analysis of whether either system can contain health care costs. Next month, we'll look at four other bills that have the potential to transform the California health care landscape.

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[1] Specifically, covered outpatient prescription drug for an individual prescription for a supply of up to 30 days would be prohibited from exceeding $250. For a product with an actuarial value at or equivalent to a bronze level, AB 339 limits cost sharing to not more than $500 for a supply of up to 30 days while, for a high deductible health plan, the $250 or $500 limits apply only after an enrollee's deductible is met. Sen. Com. on Health, Analysis of Sen. Bill No. 1021, 2017-2018 Reg. Sess. at pg. 1 (Ca. 2018) (as amended Apr. 16, 2018).

[2] *Id.* at 1.

[3] *Id.* at 2.

[4] *Id.* at 2.

[5] Assem. Com. on Health, Analysis of Assem. Bill No. 2427, 2017-2018 Reg. Sess. at pg. 2 (Ca. 2018) (as amended Mar. 23, 2018).

[6] Assem. Com. on Health, Analysis of Assem. Bill No. 2472, 2017-2018 Reg. Sess. at pg. 2 (Ca. 2018) (as amended Apr. 24, 2018).

[7] *Id.*

[8] *Id.* at 3.

[9] Assem. Com. on Health, Analysis of Assem. Bill No. 2517, 2017-2018 Reg. Sess. at pg. 5 (Ca. 2018) (as amended Apr. 2, 2018).

[10] *Id.* at 6.