

Recapping the 2017-2018 California Legislative Session (Part 2): Incremental Steps Made in Scrutinizing Market Changes and High Health Care Costs

As California begins its 2019-2020 legislative cycle, we look back at the 2017-2018 bills that will affect California health care costs and markets. Previously, we mentioned that last session's health care bills coalesced around four themes: targeting high costs of prescription drugs, attempting to implement single payer, regulating competition, and limiting high health costs. In Part 1 of our review, we covered how the legislature banned pharmacy gag clauses and limited out of pocket expenses but failed to implement single payer. This time, we'll look at 2017-2018 bills that sought to prevent or rein in anticompetitive behavior as well as bills that sought to limit high health care costs. These bills have or would have made nuanced but significant changes to the California healthcare system. As before, we don't have time to cover every bill, but we'd like to highlight some notable bills that have passed (and some that didn't) and caught our attention.

Theme 3: Increased Scrutiny of Changes in Operations and Anticompetitive Behavior of Hospitals and Health Plans

Among the healthcare bills considered, Governor Brown vetoed two bills that aim to regulate changes to health care operation and anticompetitive behavior, while other bills that aim to remove anticompetitive contract provisions and prevent reduction or elimination of emergency services failed to pass. Still, bills strengthening the Department of Managed Health Care's merger review authority and clarifying the Attorney General's merger review authority became enacted. These new laws will have significant reverberations in the years to come.

1. Bills Targeting Anticompetitive Behavior Falter

[AB 2427](#) would have authorized the State Department of Health Care Services to terminate a for-profit Medi-Cal managed care plan contract if the Attorney General determines that the Medi-Cal managed care plan engaged or engages in anticompetitive conduct or practices based on the Cartwright Act, Unfair Practices Act, the federal Sherman Antitrust Act, and the federal Clayton Act. AB 2427 was vetoed by Governor Brown, who wrote in his veto message that the bill was “unnecessary as the department has sufficient statutory and contractual authority to deal with inappropriate or illegal conduct by plans.”[\[1\]](#)

[SB 538](#), known as the Health Market Fairness Act, would have prohibited five anticompetitive provisions in a contract between a hospital and contracting agent:

1. setting payment rates or other terms for nonparticipating affiliates in the hospital;
2. requiring the contracting agent to contract with any one or more of the hospital’s affiliates;
3. requiring payors to confirm in writing that the payor is bound by the terms of the contract between the hospital and contracting agent;
4. requiring the contracting agent 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; and
5. requiring the contracting agent to keep the contract’s payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments.

However, SB 538 did not move forward and died in committee.

2. Notice and Review Requirements for Elimination or Reduction of Emergency Services Fail

Governor Brown also vetoed [SB 687](#), which would have required the Attorney General to review and consent to the sale, transfer, or other transactions resulting from a nonprofit hospital’s reduction or elimination of emergency medical services that occurred on or after January 1, 2016 (see previous [Source Blog analysis](#)).

Governor Brown wrote in his veto message that “[r]emoving a hospital’s authority to determine emergency service needs ... will not solve the underlying financial issues that typically force these decisions [and] [a]n Attorney General decision to prohibit a reduction or elimination of these services may hasten the reduction of other services or closure of the entire hospital.”[\[2\]](#)

A similar bill, [AB 2874](#), which would require a hospital to provide notice to the Attorney General when reducing or eliminating emergency medical services and prevent a health facility from closing a facility or eliminating a supplemental service without a written consent from the AG, also failed. The difference between SB 687 and AB 2874 is that SB 687 (which came first and was vetoed before AB 2874 was introduced) applied only to nonprofit hospitals whereas AB 2874 applied to all hospitals providing emergency services.

3. Changes to Merger Authority Succeed

Changes to the state’s healthcare merger authority, however, found success. [AB 651](#) requires the Attorney General to consider whether the agreement or transaction of a nonprofit health facility may create a significant effect on the availability and accessibility of cultural interests provided by the facility in the affected community. The bill will also increase the AG’s decision time regarding a proposed sale of a nonprofit health facility from 60 days to 90 days. With the passage of this bill, the AG will have more time to consider the increasingly complex and numerous transactions while being cognizant of a growing diverse population in California. Such changes would help the AG provide a more thoughtful review of nonprofit health facility sales.

Similarly, [AB 595](#) grants the Department of Managed Health Care (DMHC) the ability to approve or disapprove mergers, consolidations, and other such transactions involving a health care service plan. This merger review authority also allows the DMHC director to disapprove the transaction if it would substantially lessen competition or create a monopoly in California. With at least four major health insurance mergers proposed in California in the last three years, this new bill lends considerable power for the state to prevent any future mergers that would substantially lessen competition.

While regulatory oversight over contract terms and changes in emergency services did not result in enacted bills, the amendments to the Attorney General's nonprofit hospital merger authority and the newfound authority of DMHC to review health plan mergers provide a significant step forward in the state's ability to keep anticompetitive behavior in healthcare markets in check.

Theme 4: Limiting Health Care Costs Through Price Transparency or Rate Regulation

In an attempt to understand and limit high health care costs, California legislators sought to increase transparency, implement rate setting, and focus on medical loss ratios. Ultimately, medical loss ratios, already codified in federal law, will help reduce administrative costs, while transparency initiatives like **SB 17**'s drug pricing reporting and **AB 1810**'s creation of an all-payer claims database (APCD) will shine a light on what is causing high health care costs.

1. Price Transparency Bills to Understand Rising Healthcare Costs Pass

As discussed extensively in a [previous blog post](#), California (finally) passed a bill to create an APCD. Under [AB 1810](#), the Office of Statewide Health Planning and Development will establish a Health Care Cost Transparency Database by July 1, 2023. Previous attempts during this cycle had failed. [AB 2502](#) sought to create the California Health Care Payments Database while [SB 199](#) tried to mandate an advisory committee to create the California Health Care Cost, Quality, and Equity Atlas. The database will be helpful in understanding health care utilization and costs in California.

Similarly, [SB 17](#), which has also been substantially discussed in a [Health Affairs article](#) by The Source's Katie Gudiksen and Jaime King, will be helpful in understanding how drug costs affect health care premiums.^[3] The bill requires health plans and insurers to report information regarding prescription drug pricing, which will be condensed into a report detailing the overall impact of drug costs on health premiums. The bill also requires drug manufacturers to notify the drug purchaser when a wholesale acquisition cost (WAC) of a prescription drug increases

by a specified amount, or notify the Office of Statewide Health Planning and Development (OSHPD) when a new drug's WAC exceeds the Medicare Part D drug threshold price. This initiative has already yielded fruits in the form of the DMHC's recently released [SB 17 report](#) regarding drug costs in 2017. The report revealed that prescription drugs account for 13.1% of total health premiums, and generic drugs account for 90% of all prescribed drugs but only 23.6% of total spending (See [discussion](#) on The Source Blog for more details). These insights will be critical to the crafting of health care cost containment strategies.

2. Rate Setting Proposal Falters and Fails to Set Global Cap on Healthcare Costs

[AB 3087](#), had it passed, would have created the California Health Care Cost, Quality, and Equity Commission, which would control in-state health care costs by setting a global growth cap and set the amounts accepted as payment by health plans, hospitals, physicians, physician groups, and other health care providers. This radical proposal launched significant support and opposition. In a few weeks, it was abandoned. As an alternative to single payer, rate setting might yet make a comeback. However, with the considerable coalition of doctors, hospitals, and health plans against the proposal, don't bet on it returning too soon.

3. Strengthened Medical Loss Ratio Requirements Further Limit Administrative Spending

Finally, California passed three bills relating to medical loss ratios. Medical loss ratio (MLR) is the percentage of a premium that a health plan or health insurer must use on health care services rather than administrative costs. For example, an 85% MLR means that the health plan or health insurer must use 85% of the premiums it received on health care services, or if below 85%, repay premiums back to get to 85%.

[SB 171](#), effective on July 1, 2019, requires a Medi-Cal managed care plan to comply with a minimum 85% MLR and, effective for contract rating periods commencing on or after July 1, 2023, provide a remittance to the state if the ratio does not meet the minimum of 85% for that reporting year. For other entities, [AB 2499](#) requires medical loss ratio provisions to be consistent with federal provisions in effect on

January 1, 2017. On top of that, [SB 1008](#) requires the MLR annual report to be filed with the Department of Managed Health Care or the Department of Insurance by July 31 of each year. The bill requires the respective department to post a health care service plan's or health insurer's annual MLR report on its Internet Web site within 45 days of receiving the report. [AB 2427](#), had it passed, would have also authorized the State Department of Health Care Services to terminate a for-profit Medi-Cal managed care plan contract if the department determines that the Medi-Cal managed care plan did not comply with the medical loss ratio requirement.

In conclusion, California has made great strides during the 2017-2018 cycle to limit out of pocket expenses, explore single payer system once again, strengthen merger review authority of health care entities with exception to those regarding emergency services, increase transparency in health care costs, and affirm medical loss ratios. With a new governor and bruising battles over single payer and rate setting behind us, this new legislative cycle may bring about more bills that disrupt, regulate, or contain health care markets and prices.

[\[1\]](#) Governor's Veto Message of AB 2427 (Ca. 2018), https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=201720180AB2427.

[\[2\]](#) Governor's Veto Message of SB 687 (Ca. 2017), https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=201720180SB687.

[\[3\]](#) In another blog [post](#), Katie Gudiksen discusses how other states also passed laws to increase transparency in drug prices.