Bills in the Other House: How 2018 California Healthcare Bills Have Evolved

The last two editions of The Source's California Legislative Beat introduced some possibly transformative healthcare bills. However, many of those bills had passed only one house of the legislature at the time of writing. For a bill to become law, it must first be approved by both houses. Since passing the Assembly, some of those bills have gone through additional committees and are steadily progressing to a vote by the Senate. When a bill proceeds to the other house, it can (and have been known to) radically change. A bill can be stripped of its provisions or get new provisions added that may alter the enforcement or execution of the bill.

As the August 31 deadline to pass bills approaches, the California Senate and Assembly begin to consider, amend, and pass bills that have gone through the California Legislature's various policy and fiscal committees. We check back in on three of the bills we previously covered to see how the bills have been changed in the other house.

AB 595 (see October 2017 Post*: Interesting California Bills that Did Not End Up on the Governor's Desk This Year*)

If passed, what will the bill do?: Assembly Bill 595, introduced back in 2017, would:

- Require prior approval from the director of the Department of Managed Health Care (DMHC) when a health plan intends to (a) merge or consolidate with any other entity or (b) purchase, acquire, or gain control of any entity.
- Allow the DMHC director to disapprove a transaction if the transaction would substantially lessen competition.

How has the Senate changed the language?: Among the changes made, the

following are significant:

Broader Discretion Given to DMHC

- The Senate broadened the scope of this bill by replacing "purchases, exchanges, mergers, or other acquisitions of control" with "transactions or agreements." This change would give DMHC discretion over what types of interactions it can review.
- The Senate gave the DMHC Director the ability to impose conditions "specific to the transaction or agreement." Under the Assembly amendments, the DMHC Director would only be able to impose conditions that "require a health care service plan to improve quality and reduce health disparities." With this change, the DMHC Director is given greater discretion over what conditions can be imposed for conditional approval.

Introduction of "Major" Transaction or Agreement

- The Senate amendments introduced a new category, called "major transaction or agreement." A transaction or agreement would be considered "major" if it "(a) affects a significant number of enrollees, (b) involves a material amount of assets, or (c) adversely affects either the subscribers or enrollees or the stability of the health care delivery system because of the entity's market position."
- For any transaction or agreement, DMHC could choose to hold a public meeting. The Senate amendments made public meetings mandatory for any major transaction or agreement.
- Under the Senate amendments, DMHC would be required to have a "an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system," and any other relevant matter. Before the amendments, DMHC was required to prepare an independent health care impact statement only if material assets were involved.

Where's it at as of today?: AB 595 is currently on a second reading in the Senate. For reference, a vote takes place when a bill is read for a third time.

How has Support/Opposition changed?: Since leaving the Assembly, the California Medical Association and the California Department of Insurance (CDI) have come out in opposition of AB 595. Both of these entities argue that the Insurance Commissioner should also have authority over health insurance mergers. According to CDI, existing California law only gives the "Insurance Commissioner approval and disapproval authority over health insurance mergers if the health insurer is domiciled or commercially domiciled in California." Since most health insurers are not domiciled or commercially domiciled in California, the Insurance Commissioner has no authority over the merger.

On the other hand, many more organizations came out to support the bill, including the National Health Law Program, CaliforniaHealth+ Advocates, and the California Chapter of the American College of Emergency Physicians. These organizations believe that giving DMHC the power of prior approval is important to ensure patients access to adequate provider networks and that any merger is not detrimental to the public interest.

AB 2427 (see June 2018 Post: *Transformative Healthcare Bills of 2018 Pt. 1*)

If passed, what will the bill do?: The Department of Health Care Services (DHCS) can 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.
- DHCS determines that the Medi-Cal managed care plan has a pattern or practice of not complying with the Medi-Cal medical loss ratio.

How has the Senate changed the language?: The Senate's amendments changed the language from allowing DHCS to "decline to renew or award a Medi-Cal managed care plan contract" to the allowing DHCS to "terminate the contract for anticompetitive products." The Senate also eliminated the definition for "anticompetitive conduct or practices" and eliminated the section that requires certain criteria for a health care service plan to negotiate with the Exchange.

Where's it at as of today?: AB 2427 has been read a second time in the Senate and

has been ordered to a third reading, after which a vote can take place.

How has Support/Opposition changed?: Since passing the Assembly, Health Access has joined California Medical Association in support of AB 2427. On the other hand, the Department of Finance and Department of Health Care Services (DHCS) (again a theme of departments weighing in) has joined Anthem and the California Association of Health Plans in opposing AB 2427, arguing that DHCS already has methods to address poor plan conduct and the discretion to impose sanctions or terminate contracts.

AB 2499 **(**see July 2018 post: *Transformative Healthcare Bills of 2018 (Pt. 2)***)**

If passed, what will the bill do?: This bill would allow California's medical loss ratios (MLR)[1] to exceed federal law by only requiring it to be consistent with federal law. Under federal law, MLR is 80% for individual markets and 85% in the large group market. The original draft of this bill sought to increase the MLR in California by 5%, to 85% and 90% respectively.

How has the Senate changed the language?: The Senate struck down the 5% increase to the MLRs proposed by the Assembly and kept the MLRs at the same level as before. This change effectively defeats the original purpose this bill: to increase the MLRs.

The Senate amendments also clarify that specialized health care service plan contracts exempt from the medical loss ratio are those that only provide dental or vision services. The amendments also changed the enrollee rebate payment date from August 1 to September 30 for health plans or health insurers that fail to meet the MLR.

Where's it at as of today?: AB 2499 has passed the Senate and the Assembly. It's back in Assembly to concur with the Senate Amendments.

How has Support/Opposition changed?: While supporters of the bill have ever so slightly increased, the Senate amendments have eliminated all the opposition. Previous opposition, including Aetna, Anthem Blue Cross, Association of California

Life and Health Insurance Companies, California Association of Joint Power Authorities, are no longer opposing the bill. The complete lack of opposition by the end of the Senate amendments reveals the fact that the opposition was largely concerned about increased MLRs.

Conclusion

The three bills above have survived a series of Assembly and Senate committee hearings and key votes but have also evolved through the bill-making process. Such changes can dramatically disarm a bill, such as AB 2499, or change how the bill is executed, like AB 595. As such, it's important to take note of the legislative history of these bills, as bill analysis for one committee may be irrelevant or insufficient to address the amendments made. As the California Legislature wraps up its session, it will be interesting to see the final form these bills will take. Stay tuned!

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[1] Medical loss ratio (MLR) was introduced in the Affordable Care Act (ACA). For example, if the MLR is 80%, the insurer must use at least 80 cents of each premium dollar paid for an enrollee's medical claims and activities that improve the quality of care. As such, only a maximum of 20 cents of each premium dollar paid can pay for overhead expenses. If an insurer uses more than 20 cents (i.e. having a lower MLR), the insurer must pay rebates back to the enrollees to achieve the required MLR.