California Legislative Beat: Four Chaptered Healthcare Assembly Bills You May Not Have Known About

With 2,913 resolutions and bills passed and signed by the Governor this year, the California Legislature has been busy. This month, we take a look at some Assembly Bills that have been chaptered and discuss their importance to healthcare costs and competition. Next month, we'll look at some Senate Bills ranging from medical loss ratio to prescription discounts.

The Assembly bills we'll explore concern: (a) prohibition on prescription drug discounts [AB 265], (b) revised rules for Attorney General approval of nonprofit health facilities transactions [AB 651], (c) prohibiting Alameda Health System from replacing services of physicians and surgeons who belong to a collective bargaining unit [AB 1538], and (d) renewal of CHBRP [AB 114].

Prohibition on Prescription Drug Discounts

AB 265: This bill prevents prescription drug manufacturers from offering a discount, repayment, voucher, or other reduction to a person's copayment, coinsurance, deductible, or any other out-of-pocket expenses associated with health coverage. This prohibition specifically applies to prescription drugs with therapeutically equivalent, lower cost generic drugs that are (a) covered by the individual's health coverage and (b) nationally available for three months. The bill includes various exemptions including drugs for which an individual has already completed prior authorizations and independent charity patient assistance programs that offer

free prescription drugs.

Why this is important: By offering coupons that eliminate cost-sharing or co-pays, drug manufacturers incentivize individuals to stay with the brand name drug, despite the availability of a therapeutically equivalent generic drug. However, while a person may see a price drop in their prescription drug, coupons actually "mask" the actual price, because they do not necessarily lower the price for the payers. As such, manufacturers are able to retain market share and profits by deceptively driving up drug pricing (and healthcare costs) unbeknownst to the individual. By prohibiting prescription drug discounts when a lower cost generic drug is available, individuals are disincentivized from taking expensive brand name drugs and encouraged to use lower cost generic drugs. In doing so, payers do not have to spend extra money or raise premiums to accommodate the high costs of prescription drugs.

Revised Rules for Attorney General Approval of Nonprofit Health Facilities Transactions

AB 651: This bill:

(a) increases the number of days the Attorney General has to review a proposed sell or transfer of nonprofit health facilities (from 60 to 90 days);

(b) clarifies that Attorney General approval is required for all nonprofit health facilities without regard to whether they are currently operating to provide health care services;

(c) expands the definition of a nonprofit health facility transaction to include sales or transfers resulting from reduction or elimination of emergency medical services;

(d) requires notice of the transaction to be provided "*in the primary languages spoken at the facility and the threshold languages for Medi-Cal beneficiaries;*" and

(e) requires the Attorney General to consider the additional factor of whether the transaction would have a "*significant effect on the availability and accessibility of cultural interests.*"

Why this is important: The Attorney General's review of nonprofit health facilities transactions ensures that such transactions do not diminish competition in the healthcare market and that healthcare is accessible in terms of cost and quality.

First, as sales become increasingly complex with more factors in play, the amount of time the Attorney General spent on nonprofit health facility transactions has increased from 280 hours in 2012 to 1,330 hours in 2013.[1] By extending the deadline, the Attorney General can provide a thorough and fair review.

Second, the clarification to include health care facilities regardless of operation status closes a possible loophole. The Attorney General has expressed concerns that some health facilities may close and suspend its license to avoid review. In one case cited by the Senate Committee on Health, a federal bankruptcy judge ruled that the sale of the closed Gardens Hospital was not a sale of a health facility and did not require Attorney General approval.[2] This revised law would ensure that the Attorney General still has a say in where the health care facilities' assets go, so that these assets may be used to restart healthcare services.

Third, the addition of transactions resulting from "reduction or elimination of emergency medical services" closes another loophole. This change arises from a pair of proposals that would leave the city of Berkeley with no emergency rooms: the first would eliminate the emergency room of Saddleback Memorial San Clemente Hospital, while the second would close Alta Bates Medical Center, which had an emergency room. As the state with the lowest number of emergency departments per

capita,[3] California cannot afford to have a consolidated market of emergency services that would lead to reduced number of emergency rooms as health systems internally consolidate or leave the emergency services market. Patients facing longer waits at emergency departments would lead to increased healthcare costs via worsened health outcomes. This change allows the Attorney General to ensure that any changes to emergency services in nonprofit health facilities are appropriate.

Fourth, the requirement of a notice in the primary languages used at the facility and the consideration of significant effect on cultural interests stem from the 2015 sale of Keiro SeniorHealthcare Clinic, which predominantly served Japanese Americans.[4] The Japanese American community there felt they did not receive proper notice and were not given an opportunity to weigh in. As such, in a culturally diverse state where 44% of Californians speak another language, the Attorney General is now required to ensure that the sale of health facilities do not negatively impact the needs of different communities and that more Californians can be involved in the review process.

Prohibiting Alameda Health System from Replacing Services of Physicians and Surgeons Who Belong to a Collective Bargaining Unit

AB 1538: Existing law (AB 1008) prohibits the privatization (i.e. contracting out) of the services of physicians and surgeons employed at Alameda Health System unless there is "clear and convincing evidence that the service can only be delivered cost effectively by that other person or entity." This bill strengthens existing law by removing the date requirement to include all physicians or surgeons who belong to a collective bargaining unit, irrespective of when they joined. The bill further states that "*no employee's position is contracted out without first determining a cost savings*."

Why this is important: AB 1538 affirms that cost is a significant determination when deciding which healthcare professionals to employ. Additionally, AB 1538 affirms the limitation of a hospital's concentrated power. Here, Alameda Health System cannot single out physicians and surgeons in collective bargaining units and remove them without a proper assessment. This bill also has the continual effect of preventing the privatization of the Alameda Health System, a public agency. All in all, this bill should in theory limit healthcare costs by ensuring that all services contracted out demonstrate cost savings.

Renewal of CHBRP

AB 114: This bill, in part, extends the sunset date for the California Health Benefits Review Program (CHBRP), established in 2002, to July 1, 2020. Additionally, the bill also extends the annual fee on health insurance plans and health insurers to administer the program at the University of California. CHBRP provides the California Legislature with cost analyses of pending legislations that propose a health insurance mandated benefit or service. For example, CHBRP analyses include increases in expenditure for Medi-Cal or private plans as well as measurement of utilization changes.

Why this is important: CHBRP's analyses provide important insight into how potential legislative bills may impact healthcare costs and healthcare in general, including potential effects on the total cost of healthcare, shifting of costs to other payers, and premium and expenses of health insurers, health plans, and enrollees alike. CHBRP also provides policy briefs on healthcare costs, such as "Background on Cost Sharing for Outpatient Prescription Drugs" and "Estimates of Sources of Health Insurance in California". Overall, CHBRP, with its quick 60-day turnaround for public reports, is an important program that provides in-depth and thorough analyses of the impact of any potential enactment or repeal of a healthcare mandate.

From encouraging low cost generic drugs to increasing the Attorney General's oversight of nonprofit health facilities to maintain a competitive health market, the California Assembly has made much progress in 2017. Tune in next month to learn about the California Senate bills! In the meantime, please let us know if there are other interesting bills or additional California Legislature topics you'd like to see us cover on the blog.

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[1] Sen. Judiciary Com., Analysis of Assem. Bill No. 651 (2017-2018 Reg. Sess.) as amended Jun. 27, 2017, p.5.

[2] Sen. Com. on Health, Analysis of Assem. Bill No. 651 (2017-2018 Reg. Sess.) as amended Jun. 27, 2017, p.5.

[3] Assem. Com. on Health, Analysis of Sen. Bill No. 687 (2017-2018 Reg. Sess.) as amended May 26, 2017, p.5.

[4] Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Assem. Bill No. 651 (2017-2018 Reg. Sess.) as amended Sept. 6, 2017, p. 5.