California Legislative Beat: Four Chaptered Senate Bills That Relate to Healthcare Pricing and Competition

With 2,913 resolutions and bills passed and signed by the Governor this year, the California Legislature has been busy. Last month, we reviewed four chaptered California Assembly bills related to healthcare pricing and competition. This month, we take a look at four chaptered Senate bills.

The Senate bills we explore in this post concern: (a) disclosure of prescription drug pricing [SB 17], (b) mandating high medical loss ratio for Medi-Cal managed care plans [SB 171], (c) flexible licensing to establish hospital satellite compounding pharmacy [SB 351], and (d) quality assurance fee on emergency medical transports [SB 523].

Disclosure of Prescription Drug Pricing

SB 17 is a monumental bill that consists of many disclosure provisions "to provide accountability to the state for prescription drug pricing."[1] While many of the disclosures aim to provide insights into how prescription drug pricing affects healthcare spending, two provisions stand out for having a potential direct effect on limiting drug prices. First, starting in 2019, a drug manufacturer must notify the Office of Statewide Health Planning and Development (OSHPD) of (a) any increase in wholesale acquisition cost of a prescription drug on a quarterly basis and (b) factors determining the wholesale acquisition cost of a prescription

drug. Second, a drug manufacturer would be required to notify the purchaser sixty days before the increase in cost of a drug if the increase exceeds more than sixteen percent over a period of two years.

Why this is important: The continued increase in drug pricing and high profile incidents like the sudden price increase of Epipen have brought drug pricing under scrutiny.[2] According to Senator Ed Hernandez, the author of this bill, "[publicly] accessible price information in… the health care market encourage[s] providers to offer more competitive pricing and thereby reduce excess health spending."[3] That said, SB 17 may be sterilized from the start. This bill's mandated disclosure of pricing is already (a) public, as plans are already reporting publicly available list prices and (b) inaccurate, as the pricing would not include confidential rebates and pricing discounts done by pharmaceutical benefit managers (PBMs).[4] As such, disclosures may not accurately reflect the real price of the drug.[5] Further, consumer advocates and researchers do not believe that this bill alone would have a big impact[6] or the muscle to actually limit increases in drug pricing.[7] Nonetheless, the advance notice of a price hike and other disclosures are useful. With mandated public disclosure of drug pricing and the scrutiny that comes with such disclosures, drug companies may be prodded into lower drug pricing or be disincentivized from exorbitantly increasing drug pricing.

For an in-depth look at SB 17, check out the Source's discussion from October 2017 on whether SB 17 will restrict drug pricing and have an actual impact.

Mandating High Medical Loss Ratio for Medi-Cal Managed Care Plans

SB 171: This bill requires Medi-Cal managed care plans

("MCMCs") to comply with an 85% minimum medical loss ratio (MLR) or provide a remittance to the state. The state is also required to publicly post the MLRs of MCMCs and any remittance a MCMC paid to the state.

Why this is important: The Affordable Care Act introduced the concept of MLR, which is the percentage of each dollar that a plan uses toward health care services, excluding costs for administration of the plan[8] The goal of MLR is to control overhead spending by ensuring that administrative costs do not exceed the cost of healthcare by a certain ratio. By setting the MLR at 85%, the bill requires a MCMC to spend at least 85% on health care services.[9] If the MCMC fails to reach that level, it would be required to issue a remittance to the state.[10] The implementation of a high MLR for Medi-Cal managed plans prevents insurers from using administrative costs or desire for profits to perpetually increase healthcare premiums. This bill should limit premium levels for the Medi-cal patient population[11] to a "fair" level.[12]

Licensing Flexibility for Hospital Satellite Compounding Pharmacy

SB 351: This bill provides licensing for hospitals to establish satellite compounding pharmacies outside of the main general acute care hospital campus. The bill specifies that the newly defined hospital satellite compounding pharmacy can only compound, or make individualized drugs based on a patient's specific needs, if the hospital patient is in the same physical building as the satellite compounding pharmacy, and the pharmacy can only use the hospital's main pharmacy to get all of its ingredients.

Why this is important: Mass-produced drugs do not meet every patient's needs.[13] In response, hospitals need to compound, or customize and make their own drugs.[14] However, because of

insufficient ability to produce individualized drugs in-house, hospitals must rely on outsourcing to compounding pharmacies, which has led to the consolidation of compounding pharmacies into two big players that held 70% of the market share.[15] This bill allows hospitals to bring compounding back in-house by providing flexibility for hospital compounding pharmacies to be present in outpatient clinics and areas where there might not be an acute care hospital.[16] Supporters believe this would lower health care costs,[17] as bringing compounding back in-house could save costs in compounding.[18]

However, the effect of this bill may be a double-edged sword in terms of competition. While hospitals are given more flexibility in establishing compounding pharmacies, this bill could pressure independent compounding pharmacies to further consolidate as the source of business from hospitals slowly dries up. Hospitals that previously outsourced to the compounding pharmacies are now able to establish their own competing compounding pharmacies outside of the general acute care hospital setting. In a manner similar to how an ever-expanding store like Walmart can financially outmaneuver and outcompete small grocery stores, big players could better weather the decreasing line of business and increasing competition than independent compounding pharmacies. This may limit choices that consumers and small hospitals have when seeking an outside compounding pharmacy. On the other hand, consumers would now have a choice between a hospital compounding pharmacy and an outside compounding pharmacy, which may increase competition and bring down costs for compounded drugs.

Quality Assurance Fee on Emergency Medical Transports

SB 523: This bill introduces a quality assurance fee (“QAF”) for emergency medical transport (EMT) provided by an emergency

medical transport provider (EMTP).[19] The collected QAF will be deposited into the Medi-Cal Emergency Medical Transport Fund, and will cover, among other items, an increase in the Medi-Cal reimbursement rate for emergency medical transports. This rate has not been increased since 1999.

Why this is important: The purpose of a QAF is to produce supplemental Medicaid (Medi-Cal in California) funding by taxing hospitals or providers. Supporters of QAFs argue that this net benefit is important for Medi-Cal consumers, as QAF revenue covers any Medi-Cal shortfall and provides hospitals extra revenue to preserve Medi-Cal services.[20] However, in 2013, Michelle Steel, then Vice Chair of the State Board of Equalization, warned that QAFs do nothing to stem healthcare costs and may even have "the end effect of raising these [provider reimbursement] rates even more."[21] Those words ring true as a majority of QAFs have been used to increase providers' Medicaid reimbursement rate.[22] QAFs contribute to a higher cost of healthcare to cover low reimbursement rates and budget shortfalls of Medi-Cal services. Rather than addressing the source of cost increases, QAFs imposed on both Medi-Cal and non-Medi-Cal providers encourage a perpetual cycle of fees from the providers and matching federal funds to cover increases in healthcare costs for Medi-Cal. Simply put, QAFs put a band-aid on rising healthcare costs when intervention is needed.

Supporters of this bill claim that Medi-Cal reimbursement has not kept up with increasing costs of emergency ambulance services[23] However, instead of addressing the root cause, this bill intends to bridge the financial difference between increased cost in emergency ambulance services and the unchanged Medi-Cal payment schedule of emergency medical transports.[24] While Medi-Cal consumers may not notice any difference, other consumers may see the QAF pass onto them, thereby increasing their healthcare costs. Similarly, not all EMTPs will benefit from this bill. While the QAF must be paid

by all EMTPs, the revenue subsidizes only the increase of the EMTP reimbursement rate for Medi-Cal. Thus, ambulance companies not involved in Medi-Cal reimbursed emergency transport object that the QAF they pay will be redirected to their competitors,[25] subsidizing increased rates for Medi-Cal ambulance providers at their expense.[26] In short, EMTPs providing more Medi-Cal emergency transports would receive the benefit, while EMTPs not providing as much Medi-Cal emergency transports would receive a net loss. This may lead to a market shift where consumers using non-Medi-Cal emergency medical transport may see increased costs.

From mandating disclosure of prescription drug pricing to imposing a quality assurance fee to increase Medi-Cal payments, the California Senate has made changes that could affect health care pricing in 2018 and beyond. Tune in next month to learn about the new bills filed! 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] Cal. Health and Safety Code Sec. 127676(b)(1) (2017).

[2] Ian Spatz, California Takes On Drug Pricing: Real Progress Or Illusion?, Health Affairs (Oct. 2, 2017).

[3] *Id.* at 4.

[4] Spatz, *supra* note 2.

[5] Pauline Bartolone, Drug Price Transparency Laws May Not Drive Down Spiraling Costs for Consumers, California Healthline (Aug. 10, 2016).

[6] Bartolone, *supra* note 5.

[7] Pauline Bartolone, California Drug Price Bill Sweeping In Scope, Lacking In Muscle, California Healthline (September 18, 2017).

[8] Sen. Rules Com., Off. of Sen. Floor Analyses, Analysis of Sen. Bill No. 171, 2017-2018 Reg. Sess., as amended Sep. 7, 2017, p. 6.

[9] *Id.*

[10] *Id.* at 7.

[11] Tracey Walker, ACA's medical loss ratio provision works, Managed Healthcare Executive (Mar. 27, 2015).

[12] Robert Book, How the Medical Loss Ratio Requirement Could Increase Health Insurance Premiums And Insurer Profits at Taxpayer Expense, American Action Forum (Apr. 2013).

[13] Assem. Com. on Business and Professions, Analysis of Sen. Bill No. 351, 2017-2018 Reg. Sess. as amended April 4, 2017, p. 4 (Cal. Jul. 11, 2017).

[14] Carolyn Y. Johnson, Compounding pharmacies fill important medical niche, The Boston Globe (Nov. 3, 2012).

[15] Jaimy Lee, Compounding effort: Quality control, costs drive hospitals to mix drugs, Modern Healthcare (Mar. 2, 2013).

[16] Sen. Com. on Business, Professions, and Economic Development, Analysis of Sen. Bill No. 351, 2017-2018 Reg. Sess. as amended Mar. 20, 2017, p. 3 (Cal Apr. 3, 2017).

[17] *Id.* at 5.

[18] Lee, *supra* note 15.

[19] Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Sen. Bill No. 523, 2017-2018 Reg. Sess., as amended Aug. 22, 2017, p. 1.

[20] Sen. Com. on Health, Analysis of Sen. Bill No. 239, 2017-2018 Reg. Sess. as amended Sept. 11, 2013, p. 11 (Cal. Sept. 12, 2013).

[21] *Id.*

[22] Richard Cauchi, Health Provider and Industry State Taxes and Fees, National Conference of State Legislatures (Oct. 10, 2017).

[23] Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Sen. Bill No. 523, 2017-2018 Reg. Sess., as amended Aug. 22, 2017, p. 7.

[24] Assem. Com. on Health, Analysis of Sen. Bill No. 523, 2017-2018 Reg. Sess. as amended Apr. 24, 2017, p. 8 (Cal. Jul. 11, 2017).

[25] Sen. Rules Com., Off. of Sen. Floor Analyses, Sen. Bill No. 523, 2017-2018 Reg. Sess., as amended Aug. 22, 2017, p. 8-9.

[26] *Id.* at 9.