

# California Legislative Beat: Transformative Healthcare Bills of 2018 (Pt. 2)

Year two of California's 2017-2018 legislative session continues to be an active one with the introduction of new innovative healthcare bills. As lawmakers work diligently, this month's California Legislative Beat continues to look at some 2018 bills that can potentially change the California healthcare landscape.

**AB 2499**: This bill would increase the medical loss ratio (MLR) by 5%, from 85% to 90% for a health plan or health insurer in the large group market, and from 80% to 85% for a health plan or health insurer in the individual market.

***Why this should pass***: Medical loss ratios limit the percentage of the insurance premium that is attributable to profits and administrative costs. For example, a MLR of 90% would require 90% of the premium to go to "medical care and quality improvement activities," while 10% of the premium could go to administrative cost and/or profits.<sup>[1]</sup> When a health plan does not meet that percentage requirement, they must provide rebates. In doing so, MLRs "ensur[e] value for the premium dollar" and "provid[e] rebates."<sup>[2]</sup> Health plans argue that this bill would be disruptive and that administrative functions must be paid for. However, Health Access, the sponsor of this bill, noted that all plans in the individual market meet the 80% MLR, while only one plan in the large group market fails to meet the 85% MLR.<sup>[3]</sup> This bill would be a welcomed addition to further incentivize plans to limit premiums and find innovative ways to trim administrative costs without too much disruption to the market.

**AB 2502:** This bill would establish the California Health Care Payments Database, an all-payer claims database (APCD). For a more extensive discussion, the Source posted a [Q&A about AB 2502](#) that goes more in depth into the language of the bill. Additionally, detailed analysis about APCDs as a price transparency tool can be found [here](#).

***Why this should pass:*** An all-payer claims database, like the one proposed here, would provide a detailed, complete picture of claims data from all payers. With this information, policymakers and state regulators can better understand health care costs and spending in the state. An APCD can “inform cost containment and quality improvement efforts.”<sup>[4]</sup> This bill would be a very meaningful first step towards understanding and containing health care costs. Additionally, because there is no real repository of healthcare pricing information, this bill would increase transparency on how health care is priced and encourage price comparison.

**AB 2863:** This bill would limit how much a health plan, health insurer, or pharmacy benefit manager (PBM) can charge for a covered prescription. The maximum amount these entities can charge would be the lesser of two prices: (a) the applicable cost sharing amount for the prescription medication or (b) the retail price. Additionally, if the enrollee or insured pays the retail price instead of the cost sharing amount, that amount would be applied to their deductible and out-of-pocket (OOP) maximum in the same manner as if they had paid the cost sharing amount.

***Why this should pass:*** This bill would ensure that consumers pay the retail cost instead of the cost sharing amount if the retail cost is lower than the cost sharing amount. The author noted that “a \$3 drug [sometimes] has a \$5 co-payment.”<sup>[5]</sup> In those

instances, the bill would enable the consumer to pay \$3 rather than \$5 and specifically prohibit a plan, insurer, or PBM from requiring the consumer to pay \$5. This bill should pass because it would protect consumers from being charged higher prices than necessary and ensure that they would be paying the lowest possible cost for prescriptions.

**AB 3087:** This bill would establish the Health Care Cost, Quality, and Equity Commission, which would seek to control health care costs by setting the amounts health plans, hospitals, providers, and other healthcare professionals must accept as payment.

***Why this should be closely followed:*** Perhaps the most controversial bill of all the bills discussed this year, AB 3087 has been called, in its own bill analysis, “an ambitious attempt to systematize prices.”<sup>[6]</sup> The considerable depth of the bill (28 pages of new law), as well as the vociferous support by labor groups and the equally vociferous opposition by hospitals and physicians, requires a closer look at the bill and its provisions. This is not a new idea, however. Maryland has successfully established an all-payer payment system and a global cap, while Massachusetts also implemented a global cap via a target growth rate that limits increases in health care costs.<sup>[7]</sup> The proposed law is a fantastic and possibly bold and innovative one. However, because there are so many moving parts and provisions to this bill, a better examination of this bill is warranted. As the bill continues to evolve, stay tuned for further analysis on whether AB 3087 is a bill that should pass.

While this post provides a brief overview, some of these bills require more in depth discussion. For example, the Source explored whether APCDs, like those proposed in AB 2502, would be the [solution to price transparency](#). Additionally, we also

[compared AB 3087](#) to Maryland's existing rate-setting program and examined whether lessons from Maryland's own experience could serve as model for AB 3087.

In summary, California legislators have been active in proposing innovative ideas to lower health care costs this year, such as increasing MLR ratios, establishing an all-payer claims database, limiting how much consumers pay for drugs, and setting global caps on health care prices. If any of these bills should pass, the California health care landscape will be changed significantly. Stay tuned to and find out on the Source whether any of these bills become law.

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[1] Assem. Com. on Health, Analysis of Assem. Bill No. 2499, 2017-2018 Reg. Sess. at pg. 2 (Ca. 2018) (as introduced Feb. 14, 2018).

[2] *Id.* at 2.

[3] *Id.* at 3-4.

[4] Assem. Com. on Health, Analysis of Assem. Bill No. 2502, 2017-2018 Reg. Sess. at pg. 5 (Ca. 2018) (as amended Mar. 23, 2018).

[5] Assem. Com. on Appropriations, Analysis of Assem. Bill No. 2863, 2017-2018 Reg. Sess. at pg. 1 (Ca. 2018) (as amended Apr. 11, 2018).

[6] Assem. Com. on Appropriations, Analysis of Assem. Bill No. 3087, 2017-2018 Reg. Sess. at pg. 3 (Ca. 2018) (as amended May 2, 2018).

[7] *See id.* at 4.