Interesting California Bills that Did Not End Up on the Governor's Desk This Year

The California legislature has finished up the first year of a two-year legislative cycle. While enrolled bills await the Governor's signature, today's article will discuss three bills that are still pending in the legislature and why they should pass. These bills include granting a state agency the authority to approve all mergers and acquisitions involving a health care plan (AB 595), developing a commission to examine health care access and affordability (AB 1643), and preventing hospitals from imposing anti-competitive contract provisions (SB 538).

AB 595 (Wood): If this bill passed, the Director of the California Department of Managed Health Care ("DMHC") would need to approve all mergers and acquisitions involving at least one health care service plan.

Prior to the Director's approval, DMHC would have to hold a public hearing and prepare an "independent health care impact statement," if the transaction meets a certain monetary threshold. This impact statement must assess the effect of this transaction on health care costs, quality of care, and access to care.

What's It Like Now? DHMC can only examine whether the resulting health care plan will be in compliance with the Knox Keene Act after the transaction is completed. This review, although not required by statute, can include a public hearing. This limited review process led to DMHC expressing approval for Aetna's acquisition of Humana, Centene's acquisition of Health Net, and Blue Shield's acquisition of Care 1st.

Why This Bill Should Pass: Competition typically results in lower prices for consumers. Mergers, as the Assembly Health Committee duly noted in its analysis, have a habit of raising health care premiums. In California, the continuous mergers and acquisitions have created a highly consolidated market. According to the California Health Care Foundation, four health care plans in 2015 held 90% market share of the private insurance market.[1] Further mergers and acquisitions would only lessen the number of players in the market. In fact, a federal judge blocked Aetna's acquisition of Humana citing that the merger would "substantially lessen competition." Yet, DMHC approved Aetna's acquisition after receiving commitments by Aetna to improve California infrastructure and minimize rate increases. If DMHC had a wider mandate on approving mergers and acquisitions based on the impact on health care costs rather than compliance with the Knox Keene Act's financial solvency, the break-neck pace of mergers and acquisitions of health care plans in California would slow down. The health care market is consolidated as it is, and this bill would be a great first step to prevent further consolidation.

AB 1643 (Bonta): If this bill passed, a nine-member Health Care for All Commission would be created to propose to the Legislature changes that will improve health care access and quality.

This bill is similar to AB 2345 (Ridley-Thomas) of 2016, which sought to create a commission for health care costs. Similar commissions have been formed in Colorado, Massachusetts, and Maryland.

What's It Like Now? There's no official commission for investigating health care affordability and access in California. However, there is a California Health Benefit Review Program (CHBRP) that reviews legislation involving health benefits or services. The Little Hoover Commission also investigates state government operations and policy.

Unfortunately, these two commissions are limited in their scope. CHBRP can only review introduced legislation and not propose new legislation or policy, while the Little Hoover Commission can only review current operations (i.e. what the state is already doing) and not what the state could do.

Why It Should Pass (with Amendments): As drafted, the Health Care for All Commission is laudable for creating a commission that investigates and recommends how to improve health care access and affordability. However, while the commission is full of potential, it lacks the longevity and direction. Massachusetts and Maryland created independent state agencies that monitor health care data and set health care cost benchmarks. On the other hand, California's proposal would sunset in 2021 and will only be able to provide recommendations. The Health Care for All Commission would lack the mandate to review current legislation or be able to advise legislators on health care matters. Notwithstanding a better name change that accurately reflects its mission (perhaps the California Health Care Policy Review Commission?), the bill should be amended to become more of a permanent agency with the power to review legislation and set benchmarks. Health care costs will continue to soar past 2021, and having a commission that can only provide recommendations and lapses after a few years will never solve or stymie the continuously increasing health care costs.

SB 538 (Monning): If this bill is passed, a hospital may not impose anti-competitive contract provisions on a health care service plan, health insurer, or any other contracting agent.

Specifically, the bill prohibits a contracting agent, including a health care service plan and a health insurer, or a hospital or any affiliate of a hospital from contracting to: (a) set payment or other terms for nonparticipating affiliates of the hospital, (b) require a contracting agent to contract with any one or more of the hospital's affiliates, (c) condition the contract on agreement to arbitration or other

alternative dispute resolution, (d) not impose different cost-sharing tiers, and (e) keep a contractor's payment rate confidential from any payor responsible for the payment.

What's It Like Now?: Hospitals cannot impose contract provisions that restrict health plans or health insurers from providing cost or quality information. There's considerable protection for providers from plans, but not too much the other way. This bill would change that.

Why It Should Pass: Preventing anti-competitive contract provisions would prevent hospitals or dominant provider groups from inflating prices for consumers. A 2016 Senate Health Committee Informational Hearing heard testimonies of how anti-competitive agreements imposed by hospitals on health plans and insurers were the "leading cause of the high cost of healthcare in Northern California." These anti-competitive agreements have become more common as hospitals in California continue to consolidate and increase their bargaining power. Just in Sacramento alone, fifteen independent hospitals have been consolidated into four health systems. This hospital consolidation has led to higher charges as well as greater bargaining power that allowed hospitals to impose contract provisions that would be detrimental to health care consumers.

By passing this bill, hospitals would not be able to impose higher-than-competitive pricing or force health care plans or insurers to include all types of facilities regardless of whether consumers would need those facilities. While hospital systems argue that all these are fair contracting provisions, they have led to significant price increases in California. Here, these provisions would prevent higher pricing charged by hospitals and balance the bargaining power between the hospital and the health care plan.

However, the bill can be strengthened by ensuring that its provisions extend to all types of contracts. Some hospitals may avoid written agreements on certain terms to avoid

violating the law, but tacitly agree to engage in the behavior. Hospitals and insurers could verbally agree to arbitration or avoid health plan tiering. To eliminate possible loopholes, this bill should explicitly state that all types of contracts, verbal or written, are governed by this bill.

Within all three bills, a constant theme emerges: rising health care prices is an issue. How to combat that, as evident in the bills, is another matter. Whether the solution may be controlling mergers or contracts or even convening a commission, different avenues exist to tackle the rising health care pricing. But for one reason or another, the solutions these bills proposed were not enrolled. Next month, I'll be writing about health care bills that were enrolled and signed by the Governor to provide a contrast on why these bills moved forward when others did not.

[1] http://www.chcf.org/publications/2015/02/data-viz-health-plans