AB 2098

California Health Facilities Financing Authority Act: nondesignated hospitals: loan repayment. Under existing law, the California Health Facilities Financing Authority Act (act) authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions, as defined, for financing or refinancing the acquisition, construction, or remodeling of health facilities. Under the act, the authority is authorized to issue revenue bonds to provide the funds for achieving these purposes. Existing law appropriates $40,000,000 to provide cashflow loans to nondesignated public hospitals, as needed, due to the financial impacts of the COVID-19 public health emergency. Existing law requires the nondesignated public hospitals participating in this loan program to repay and discharge the loan within 24 months of the date of the loan. This bill would extend the repayment requirements for nondesignated public hospitals participating in the loan program, by requiring those hospitals to begin monthly repayments on the loan 24 months after the date of the loan, and discharge the loan within 72 months of the date of the loan, as prescribed. The bill would require the monthly payments to be amortized over the term of the loan, at 0% interest. By removing restrictions limiting the expenditure of moneys appropriated for purposes of these loans, the bill would make an appropriation.

AB 2110

Medi-Cal: Adverse Childhood Experiences trauma screenings: providers. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires that Medi-Cal provider payments and payments for specified non-Medi-Cal programs be reduced by 10% for dates of service on and after June 1, 2011, and conditions implementation of those payment reductions on receipt of any necessary federal approvals. Existing law, for dates of service on and after July 1, 2022, authorizes the maintenance of the reimbursement rates or payments for specified services, including, among others, Adverse Childhood Experiences (ACEs) trauma screenings and specified providers, using General Fund or other state funds appropriated to the State Department of Health Care Services as the state share, at the payment levels in effect on December 31, 2021, as

specified, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 that were implemented with funds from the Healthcare Treatment Fund, as specified. Existing law requires the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified. This bill would require the department, as part of its above-described duties, to include (1) community-based organizations and local health jurisdictions that provide health services through community health workers and (2) doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would also require the department to update its internet website and the ACEs Aware internet website to reflect the addition of the Medi-Cal providers described above as authorized to provide ACEs screenings.

AB 2129

Immediate postpartum contraception. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally regulates contractual provisions between health care service plans and health insurers and their contracting health care providers. This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a licensed hospital or birthing center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2180

Health care coverage: cost sharing. Existing law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses associated with the individual's health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would require a health care service plan, health insurance policy, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket expenses toward the enrollee's or insured's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's health care service plan contract or health insurance policy. The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

AB 2169

Prescription drug coverage: dose adjustments. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime.

Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. The bill would authorize a licensed health care professional to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met. Under the bill, if the enrollee or insured has been continuously using a prescription drug selected by their prescribing provider for the medical condition under consideration while covered by their current or previous health coverage, the health care service plan or health insurance policy would be prohibited from limiting or excluding coverage of that prescription. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2200

Guaranteed Health Care for All. This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period, and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds. This bill would create the CalCare Board to govern CalCare, made up of 9 voting

members with demonstrated and acknowledged expertise in health care, and appointed as provided, plus the Secretary of California Health and Human Services or their designee as a nonvoting, ex officio member. The bill would provide the board with all the powers and duties necessary to establish CalCare, including determining when individuals may start enrolling into CalCare, employing necessary staff, negotiating pricing for covered pharmaceuticals and medical supplies, establishing a prescription drug formulary, and negotiating and entering into necessary contracts. The bill would require the board, on or before July 1 of an unspecified year, to conduct and deliver a fiscal analysis to determine whether or not CalCare may be implemented and if revenue is more likely than not to pay for program costs, as specified. The bill would establish an Advisory Commission on Long-Term Services and Supports to advise the board on matters of policy related to long-term services and supports. The bill would require the board to convene a CalCare Public Advisory Committee to advise the board on all matters of policy for CalCare, an Advisory Committee on Public Employees' Retirement System Health Benefits to provide recommendations related to public employee retiree health benefits, and a CalCare Health Workforce Working Group to provide the board with input on issues related to health care workforce education, recruitment, and retention. The bill would establish an Office of Health Equity within CalCare and under the direction of the Director of the Department of Health Care Access and Information to ensure health equity under the program and other health programs of the California Health and Human Services Agency and to support the board through specified actions. This bill would provide for the participation of health care providers in CalCare, including the requirements of a participation agreement between a health care provider and the board, provide for payment for health care items and services, and specify program participation standards. The bill would prohibit a participating provider from discriminating against a person by, among other things, reducing or denying a person's benefits under CalCare because of a specified characteristic, status, or condition of the person. This bill would prohibit a participating provider from billing or entering into a private contract with an individual eligible for CalCare benefits regarding a covered benefit, but would authorize contracting for a health care item or service that is not a covered benefit if specified criteria are met. The bill would authorize health care providers to collectively negotiate fee-for-service rates of payment for health care items and services using a 3rd-party representative, as provided. The bill would require the board to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget. This bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. The bill would specify uses for moneys in the CalCare

budget, including special projects for which not-for-profit or governmental entities may apply. Because the bill would create a continuously appropriated fund, it would make an appropriation. This bill would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human Services Agency would be required to publish a copy of the notice on its internet website.

AB 2250

Social determinants of health: screening and outreach. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would make social determinants of health screenings a covered benefit for Medi-Cal beneficiaries and would require the State Department of Health Care Services or a Medi-Cal managed care plan to provide reimbursement for those screenings, as specified.

AB 2258

Health care coverage: cost sharing. This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care

services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.

AB 2297

Hospital and Emergency Physician Fair Pricing Policies. This bill would authorize an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 400% of the federal poverty level. The bill would also clarify that out-of-pocket costs for the above-described definition of “high medical costs” means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing. This bill would define charity policy for those purposes. The bill would prohibit a hospital from considering the monetary assets of the patient in determining eligibility for both the charity care and the discount payment policies. The bill would instead require that the eligibility for charity care or discounted payments be determined at any time the hospital is in receipt of recent pay stubs or income tax returns. The bill would prohibit a hospital from imposing time limits for eligibility. The bill would authorize a hospital to waive Medi-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program. This bill would eliminate the authorization for a hospital or an emergency physician to consider monetary assets in determining the amount of debt the hospital or emergency physician may seek to recover from patients who are eligible under these policies. This bill would prohibit a hospital or emergency physician from using liens on any real property as a means of collecting unpaid hospital or emergency physician bills, and would prohibit a collection agency from conducting a sale of any real property owned, in part or completely, by a patient or placing a lien on any real property as a means of collecting unpaid hospital or emergency physician bills.

The Source Roundup: March 2024 Edition

Health Policy Trends

- **The 2024 CHCF California Health Policy Survey (*California Health Care Foundation*)**

Jen Joynt, Rebecca Catterson, Emily Alverez, Larry Bye, Vicki Pineau, and Lin Liu

The California Health Care Foundation released results from its fifth annual California Health Policy survey. Researchers from the California Health Care Foundation and NORC at the University of Chicago surveyed a representative sample to assess Californian's views and experiences on a myriad of health care topics. This year's survey yielded a number of key findings. Among them, researchers found that there is a high level of dissatisfaction with mental health care access, and that Californians, especially those with low incomes, were continuing to face burdens created by high health care costs and medical debt. Many Californians also reported being concerned about the effects of the weather and environmental factors on their health, and reported waiting for health insurance authorizations before they could receive doctor-approved care.

Healthcare System Mergers and Investments

- **Certificates of Public Advantage: A Valuable Tool or Diminishing Allure? (*Mitchell Hamline Law Journal of Public Policy and Practice*)**

Abdur Rahman Amin

Antitrust in the healthcare sector has become a growing concern for the Biden administration, who have prioritized enforcement by hiring more antitrust lawyers and tasked the FTC and DOJ to investigate merger activity. In this new paper, the author providers a brief primer on key federal antitrust laws and regulations and assesses the current regulatory landscape of antitrust enforcement broadly, while making recommendations for better ways forward in the healthcare sector. Present merger and acquisition activity has created a system where the ten largest American health care systems now control over 25% of the national market. Against this landscape, the author

engages in a discussion of the merits and criticisms of certificates of public advantage (COPAs), a type of antitrust exemption mechanism that lays at the heart of current antitrust controversies. While COPAs offer a method of state control over hospital mergers, they bear potential long-term costs including reduced quality and raised prices due to decreased competition, and thus, requires strong regulation and the addition of potential new approaches.

- **Equity Investment in Physician Practices: What's All This Brouhaha? (*Journal of Health Politics, Policy and Law*)**

Mark V. Pauly and Lawton Robert Burns

Since the passage of the Affordable Care Act in 2010, the U.S. healthcare system has experienced a boom in equity-based investments in physician practices – but this trend isn't novel. In this new article in the *Journal of Health Politics, Policy and Law*, the authors assess the current investment wave against an initial wave of equity-led financings from the 1990s, specifically looking at the parallels and divergences between the two eras. While the 1990 market was more heavily influenced by public equity and physician practice management company (PPMC) investments and the current market is more private equity-centric, the authors discuss similarities in the eras including driving forces, acquisition dynamics, and models to achieve market penetration. The paper ends by delving deeper into private equity investments by asking how these investments may differ from the standard, determining whether they lack and confer competitive advantages, and assessing whether physician practice investments offer opportunities for "super-normal profits." Overall, the authors determine that trends from the 1990s may be likely to repeat and call out the private equity threat as being "overblown."

- **Cross-Market Mergers with Common Customers: When (and Why) Do They Increase Negotiated Prices? (*arXiv*)**

Enrique Ide

Cross-market mergers of supplies to intermediaries that bundle products for consumers have often been viewed as controversial. In this new paper, the author uses modeling to argue that two products can be complements for the consumer but substitutes for intermediaries and applies their findings to explain why cross-market hospital mergers raise healthcare prices. Cross-market hospital mergers involve hospitals in distinct geographies or diagnostic markets and have been contentious because they have been

subject to limited antitrust enforcement despite findings showing that they have led to increases in insurance reimbursement rates with minimal increases in quality. Ultimately, the analysis finds that in the healthcare context, products can be complements for consumers but substitutes for intermediaries, helping explain why cross-market hospital mergers result in higher prices, and that reviewers should put a greater focus on mergers involving specialized providers.